

UNITED STATES DEPARTMENT OF DEFENSE

DEFENSE HEALTH BOARD

TASK FORCE ON PREVENTION OF SUICIDE

BY MEMBERS OF THE ARMED FORCES

OPEN SESSION

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ANDERSON COURT REPORTING  
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1 P R O C E E D I N G S

2 (9:00 a.m.)

3 MAJOR GENERAL VOLPE: If everyone could  
4 please take their seats, we're going to go ahead  
5 and begin.

6 I'd like to welcome everyone to the DOD  
7 Task Force for the Prevention of Suicide By  
8 Members of the Armed Forces. This is a  
9 Subcommittee of the Defense Health Board, and we  
10 have several important topics to discuss today on  
11 today's agenda with gathering data and information  
12 so that we could better understand the challenge  
13 with suicide amongst members of the armed forces.

14 We have with us today Ms. Ellen Embrey  
15 who is the Designated Federal Official. Ms.  
16 Embrey, can you please call the meeting to order?

17 SECRETARY EMBREY: Thank you, Major  
18 General Volpe. As the Designated Federal Officer  
19 for the Defense Health Board which is a Federal  
20 Advisory Committee and a Continuing Independent  
21 Scientific Advisory Body to the Secretary of  
22 Defense via my office and the Surgeons General of

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1 the Military Departments, I hereby call this  
2 meeting of the DOD Task Force on the Prevention of  
3 Suicide by Members of the Armed Forces, a  
4 Subcommittee of the Defense Health Board, to  
5 order.

6 MAJOR GENERAL VOLPE: Thank you, Ms.  
7 Embrey. I carry on the tradition that we do with  
8 all of our boards. I'd like to ask everyone to  
9 please stand for a moment of silence to honor  
10 those men and women who are serving our nation in  
11 harm's way today.

12 (Moment of silence.)

13 MAJOR GENERAL VOLPE: Thank you. Please  
14 be seated. Since this is an open session and for  
15 the purposes of making sure everybody can identify  
16 who the actual board members are, at this time I'd  
17 like to start off at this end and go around for  
18 the board members and the board members only to  
19 please introduce yourselves and say a little  
20 something about yourselves and your participation  
21 on this board. Thank you.

22 DR. LITTS: Good morning. My name is

1 David Litts. I'm the Director of Science and  
2 Policy at the National Suicide Prevention Resource  
3 Center. Prior to that I served in  
4 the Air Force as a medic and was one of the first  
5 leaders of the Air Force Suicide Prevention  
6 Program back in the mid 1990s.

7 DR. JOBES: I'm Dr. David Jobes. I'm a  
8 Professor of Psychology at Catholic University  
9 here in Washington and Co-Director of Clinical  
10 Training. I'm a clinical psychologist by  
11 training. I have worked in suicide prevention for  
12 the last 25 years. My area of research and  
13 expertise is in clinical suicidology and  
14 assessment and treatment of suicidal risk. I've  
15 been a consultant to the VA system and to the DOD  
16 in various task forces, and I'm pleased to be  
17 here.

18 COLONEL CERTAIN: I'm Robert Certain.  
19 I'm an Episcopal Priest in Marietta, Georgia, and  
20 was a combat officer in Vietnam with two tours, was  
21 a POW after that, and serve on the Defense Health  
22 Board's Psychological Health Subcommittee, Medical

1 Ethics Subcommittee and this task force.

2           COMMANDER WERBEL: Good morning. I'm  
3 Aaron Werbel. I'm a Navy clinical psychologist,  
4 and for the last 4 years have been the Program  
5 Manager for the Marine Corps Suicide Prevention  
6 Program.

7           DR. HOLLOWAY: Good morning. My name is  
8 Marjan Holloway. I'm a faculty member at the  
9 Uniformed Services University. Most of my  
10 clinical and research work right now is focusing  
11 on the treatment of suicide attempters within the  
12 United States military.

13           MS. CARROLL: I'm Bonnie Carroll. I'm  
14 Director of the Tragedy Assistance Program for  
15 Survivors representing the families of those who  
16 have lost loved ones to suicide. I'm an Air Force  
17 Reserve Officer and an Army widow.

18           MAJOR GENERAL VOLPE: My name is Phil  
19 Volpe. I'm one of the co-chairs along with Bonnie  
20 here of the task force. I've been an Army  
21 physician for the past 26 years, again serving my  
22 nation, and a family practice physician by trade.

1                   SERGEANT MAJOR GREEN: Good morning.  
2 I'm Sergeant Major Ronald Green. I'm with  
3 Headquarters Battalion, Headquarters, Marine  
4 Corps. I work closely with the Wounded Warrior  
5 Regiment. I've been in the Marine Corps for 26  
6 years.

7                   LIEUTENANT COLONEL BRADLEY: Good  
8 morning. I'm Dr. John Bradley, Chair of the  
9 Department of Psychiatry at Walter Reed Army  
10 Medical Center and the National Naval Medical  
11 Center and Vice Chair of the Department of  
12 Psychiatry at the Uniformed Services University.

13                  DR. KEMP: Good morning. I'm Janet  
14 Kemp. I'm the VA National Suicide Prevention  
15 Coordinator. I'm also the Chief of Education and  
16 Training at the VA Center of Excellence for  
17 Suicide Prevention in Canandaigua, New York.

18                  DR. MCKEON: I'm Dr. Richard McKeon. I  
19 am a clinical psychologist. I serve as the Lead  
20 Public Health Advisor in the Suicide Prevention  
21 Branch at the Substance Abuse and Mental Health  
22 Services Administration. I am also co-chair of

1 the Federal Working Group on Suicide Prevention.

2 MAJOR GENERAL VOLPE: Those are the  
3 members who are in attendance here on the board.  
4 I'd like to have Ms. Ellen Embrey, our Designated  
5 Federal Official, introduce a little bit about  
6 herself and her background.

7 SECRETARY EMBREY: I'm Ellen Embrey. I  
8 am currently performing the duties of the  
9 Assistant Secretary of Defense for Health Affairs.  
10 I will be the primary recipient of this task  
11 force's report and facilitate its deliverance to  
12 the Secretary of Defense and to Congress. I am  
13 very pleased that the task force is meeting. I  
14 have just completed 34 years of federal service,  
15 the last eight of which have been in health  
16 matters for the Department of Defense.

17 MAJOR GENERAL VOLPE: Thank you, Ms.  
18 Embrey, and thank you board members. Commander  
19 Feeks, could you mention some of the  
20 administrative announcements?

21 COMMANDER FEEKS: Thanks, General Volpe.  
22 Good morning and welcome everyone. I want to

1       thank the speakers who have worked hard to prepare  
2       briefings for the board. I want to thank the  
3       members of the Defense Health Board staff, Lisa  
4       Garrett, Elizabeth Graham and Jen Clevaneux for  
5       the arrangements for this meeting. I'm very  
6       pleased to welcome aboard the support staff  
7       dedicated to this task force from Booz Allen  
8       Hamilton. We have Mike Tate, Gail Walters, Dr.  
9       Jennifer Oswald, and Tim Turner.

10               For those of you who are members of the  
11       public and media, please remember to sign the  
12       general attendance roster on the table outside if  
13       you have not done so already. The law requires us  
14       to keep a record of who attends these meetings.  
15       For those of you who are not seated at the table  
16       here, handouts are provided on the table just  
17       outside the room.

18               A little bit of housekeeping now. Rest  
19       rooms are located just out the door to your left  
20       and a quick right, just about 20 steps away. For  
21       telephone, fax, copies or message services, please  
22       see Gail Walters whose hand is raised here.

1 Because the open session is being transcribed,  
2 please make sure that you state your name before  
3 speaking and use the microphones so that our  
4 transcriber can accurately report your questions  
5 and comments. If you find that your name is  
6 easily misspelled like me, please spell your name  
7 into the microphone, or if you prefer, you can  
8 give your name on a slip of paper to the  
9 transcriptionist so that we can record your name  
10 accurately in the transcription. Refreshments  
11 will be available for both the morning and  
12 afternoon sessions for the task force members,  
13 speakers and distinguished guests. We'll also  
14 have a catered working lunch here at the Marriott  
15 for task force members, speakers and distinguished  
16 guests in salon C near this room. Public  
17 attendees may wish to consider the restaurant  
18 located on this floor of the Marriott. Nearby  
19 restaurants include PF Chang's China Bistro,  
20 Timpano Italian Chop House, the Cheesecake Factory  
21 and Bertucci's, all less than one mile away. I'd  
22 like to request that no flash photography be taken

1 at the task force meeting as it may be distracting  
2 to the speakers and the public. Also, if you  
3 wouldn't mind, this is a good time to silence your  
4 electronic devices if you would, please, your cell  
5 phones, Blackberries, turn them to a silent mode.  
6 If time allows, we will take questions and  
7 statements from the public at the end of each  
8 session. We ask that you register to speak at the  
9 desk outside this room. Everyone, however, has  
10 the opportunity to submit written statements to  
11 the task force. Such statements may be submitted  
12 today at the registration desk or by email at  
13 dhb@ha.osd.mil, or they may be mailed to the  
14 Defense Health Board office, and the address is  
15 available on fliers located on the registration  
16 table. Finally, the next meeting of the task  
17 force will be held on Thursday, October 8, one  
18 week from today, in the San Diego area at the  
19 Hilton San Diego Resort and Spa. Please visit the  
20 Defense Health Board website for more information.  
21 And that concludes my administrative remarks, sir.

22 Let me go ahead and move to the

1 introduction of the first speaker. We have for  
2 our first session this morning Mr. Bruce Shahbaz  
3 and Mr. Walter Morales. They will be speaking on  
4 the service data review for the Army. Very  
5 briefly, Mr. Bruce Shahbaz is a Department of the  
6 Army civilian assigned to the Army Surgeon  
7 General's Office. He is currently serving on the  
8 Army's Suicide Prevention Task Force. He is a  
9 health care manager with more than 26 years'  
10 experience in the military health system. He  
11 began his military career as an enlisted  
12 psychiatric technician before being commissioned  
13 as an Army Medical Service Corps Officer. He's  
14 served in leadership positions in Army units in  
15 the USA, in Egypt and in Germany. He is  
16 responsible for serving as the Army Surgeon  
17 General's representative on the Army's Suicide  
18 Prevention Task Force conducting trend analysis  
19 and congressional affairs coordination.

20 With him, Mr. Walter Morales, is the  
21 Program Manager and Policy Analyst for the Army's  
22 Suicide Prevention Program in the Army G-1

1 Personnel Office. Mr. Morales has devoted over  
2 28 years of military and civilian service to  
3 improve the professional development and well-  
4 being of soldiers, families and Department of the  
5 Army civilians Army-wide. Mr. Morales oversees  
6 the execution of Army Suicide Prevention Program's  
7 strategic initiatives to build resilience,  
8 encourage help-seeking behaviors, eliminate the  
9 stigma associated with seeking mental-health care,  
10 and minimize suicidal behavior through  
11 synchronized and integrated suicide prevention,  
12 intervention, and post- event efforts and policies  
13 to effect change. Other areas of expertise  
14 include developing and conducting suicide  
15 prevention training of small unit leaders, of  
16 gatekeepers at the installation, state and  
17 territory and Reserve Support Command levels. Mr.  
18 Shahbaz and Mr. Morales, the floor is yours.

19 MR. MORALES: Good morning. I'm Walter  
20 Morales, once again the Army's Suicide Prevention  
21 Program Manager. General Volpe, members of the  
22 task force and ladies and gentlemen, good morning

1 once again. Thank you for the opportunity to be  
2 here this morning and provide to you information  
3 related to the efforts that have been undertaken  
4 by the Army when it comes to health promotion and  
5 reduction and suicide prevention. I will go ahead  
6 and get started, and then Mr. Shahbaz will come  
7 and provide the second half of the briefing.  
8 General Volpe, I would like to say that I send  
9 regrets from General Maguire the director of the  
10 task force who cannot be here this morning.

11 Here you have what our Vice Chief of the  
12 Staff of the Army, General Chiarelli, continues to  
13 say when he meets the press and when he goes to  
14 Congress, and that is that the problem of suicide  
15 prevention is larger than the issue itself. He as  
16 you know has been nominated by the SEC Army to  
17 lead the efforts for the campaign plan which is  
18 being led obviously by General Maguire, and what  
19 General Chiarelli has said on many occasions is  
20 that we are taking an holistic approach to suicide  
21 prevention focusing on many, many areas that we  
22 feel that are important to focus on when it comes

1 to addressing anxiety and stress that is  
2 manifested in many risk behaviors. The commitment  
3 from the Vice and the Army is evident. We formed  
4 the task force back in February of this year and  
5 will continue to be in place until we integrate  
6 and synchronize our efforts in a way that we are  
7 taking care of our soldiers and families in a  
8 well-synchronized manner.

9 I'd like to move to the next slide which  
10 shows you suicide numbers. This slide that you  
11 see in front of you is for active duty confirmed  
12 and pending suicides. Once again, active duty are  
13 those folks who are in the service whether in the  
14 active Army or active Guard and Reserves and  
15 mobilized for any contingency operations. What  
16 you see here is that obviously numbers have  
17 increased since 2004. We continue to see that  
18 rise on suicides in both of those components, and  
19 I will show you the numbers in a minute here for  
20 non-active duty. Here you can see that as of 20  
21 September we already have 117 active-duty  
22 suicides, last year we ended up with 140

1 active-duty suicides, so that there is a pretty  
2 good chance that when the year is over we may end  
3 up with more suicides than we had in 2008.  
4 The majority of these suicides fall into the  
5 category of active Army as you can see by the  
6 slide, followed by the National Guard on active  
7 duty and USAR soldiers. Today we have about 31  
8 cases pending determination as to the manner of  
9 death by the Armed Forces Medical Examiner. As  
10 you may know, this takes time. Usually it could  
11 range from a month to a year to find out the final  
12 manner of death. So this is how we look as of  
13 now.

14 The next slide shows you how do we  
15 compare to previous years at the same time, and  
16 the trend continues to be the same. The numbers  
17 have increased as you can see right here from 41  
18 cases in CY 2004 up to once again 117 active-duty  
19 suicides for the Army. You can see the yellow  
20 which means that those were the pending cases that  
21 we had at the time. There are no pending cases  
22 for CY 2004 through CY 2007. There is still one

1 pending case for CY 2007, and as you can once  
2 again, there are 37 pending cases for CY 2009.

3 On this slide you can see the number of  
4 suicides now for not on active duty confirmed or  
5 pending suicides. We are seeing the same trend.  
6 Numbers have continued to increase. As you can  
7 see right here from CY 2004, to date we have 59  
8 cases which has already surpassed last year's by  
9 two cases of 57 that we had in CY 2008. The  
10 challenge obviously with obtaining data from those  
11 soldiers who die in local communities is that it's  
12 hard to get the data. We have a full-time  
13 official within the task force whose primary job  
14 is to contact local officials on a daily basis to  
15 obtain the data to provide to senior officials and  
16 be able to draw some conclusions and see the  
17 trends and the like. We have taken data gathering  
18 to a new level. We have standardized our data  
19 elements that we capture on all suicides and those  
20 data elements are provided to the Vice and to the  
21 senior leaders on a daily basis. As you can see  
22 here, these are the total numbers as it relates to

1 non- active-duty suicides.

2           This slide shows once again the  
3 year-to-date comparison, and the trend as I said  
4 before continues to climb, once again 59 with 24  
5 cases pending. The challenge obviously once again  
6 is the determination for suicide for those not in  
7 active duty is done at the local level. It is  
8 done by local coroners and medical examiners. We  
9 rely on them to provide that information to the  
10 Army, and it's hard to come up with a  
11 standardization methodology and good trends per se  
12 as you can see here on the slide to come with a  
13 basic standard of what is really happening for  
14 those suicides not on active duty.

15           I'd like to address how we convert this  
16 raw data into a rate which is the common way for  
17 us to show the impact of suicide on the Army. As  
18 you can tell right here by the slide, active-duty  
19 suicides -- in red was below a  
20 demographic-adjusted rate that we did for the U.S.  
21 Population up to 2006-2007. Last year we went  
22 above that by having a rate of 20.2 where normally

1 that rate stayed at 19.2 to 19.5 when it was  
2 adjusted. Based on the numbers that we have right  
3 now, we foresee that our active-duty rate may once  
4 again surpass that of CY 2008 and we're looking at  
5 a rate of more or less 24.5 for active duty.

6 On this slide you can see some of the  
7 raw data. Obviously more analysis is needed when  
8 you provide just raw numbers. What we have done  
9 here is to show you the breakout by military  
10 occupational specialties and branches. As you can  
11 see right here, much of the raw data of suicides  
12 fall into the 11-B category which is an  
13 infantryman, then followed by 63-B, mechanics, and  
14 then 88-M, transporters. Once again, we are  
15 working diligently to further analyze this type of  
16 data obviously to support our Army efforts as well  
17 as the DOD task force.

18 Here you see the same data for not on  
19 active duty suicides. It resembles that of the  
20 active duty. You can see where the numbers also  
21 fall into the 11-B as the highest category of  
22 suicides, then followed 21-E, engineers, and then

1 the 31 series, the MPs. Once again, it is very  
2 challenging to be able to draw good conclusions  
3 based on this data for not on active duty, but  
4 nonetheless, taking an holistic approach, we are  
5 tracking them as well as other categories within  
6 the Army community in the future to include IR  
7 soldiers and the like as family members perhaps  
8 and civilians.

9 With that in mind I'll go ahead and  
10 bring over Mr. Shahbaz who will provide you the  
11 rest of the briefing.

12 MR. SHAHBAZ: Good morning. I'm Bruce  
13 Shahbaz with the Suicide Prevention Task Force.

14 As Walter described in the numbers,  
15 early in the year, the first quarter, the Army was  
16 averaging about 18 suicides active duty a month,  
17 about seven to eight on the non-active duty side,  
18 and the Vice decided to take dramatic action in  
19 order to try and stem the tide and reverse the  
20 trend.

21 As a result, in March he stood up a task  
22 force that consists of members throughout the Army

1 staff, chaplain, medical, personnel, operations  
2 and information as well as Mr. Morales's team, the  
3 Suicide Prevention Program Management Office which  
4 had been in existence for several years, bringing  
5 all of those together to create a fusion center to  
6 serve as the central point of information. We  
7 have CID, Criminal Investigation Division,  
8 personnel with us to help us liaison with local  
9 law enforcement and military law enforcement in  
10 order to get data faster and help to identify  
11 trends. This is as Mr. Morales said briefed every  
12 day to the Vice and forwarded up to the Secretary  
13 of the Army and the Chief of Staff of the Army.  
14 Every month the Vice convenes a worldwide video  
15 teleconference with his senior leaders and they do  
16 an after-action review of approximately 12 recent  
17 suicide events where the leaders have an  
18 opportunity to talk about what happened and how  
19 they can improve, and they do it in a forum with  
20 all the other senior commanders present as well so  
21 that we can help accelerate our lessons-learned  
22 process and disseminate information across all

1 commands. We published a campaign plan and we  
2 have a synchronization matrix of about 240 tasks.

3 As for our methods, we want to  
4 synchronize and transition programs and policies.  
5 The intent of the task force is not for it to be a  
6 long-term body, but a short-term body that comes  
7 in and changes regulations some of which had not  
8 been updated in 20 years. We're modifying those  
9 regulations and updating those regulations to  
10 reflect current Army organization and structure,  
11 and then we're going to return the pieces back to  
12 the organizations from whence they came to then  
13 sustain operations. So the Vice viewed this as a  
14 short-term effort to focus a lot of attention to  
15 make programmatic decisions to address the issues,  
16 get things back on track and then return it to the  
17 organizations and the leaders who have day-to-day  
18 responsibility for it.

19 One of the most significant areas we're  
20 looking at is what the Army calls the Army Force  
21 Generation process, ARFORGEN, and that is how  
22 frequently units and service members are deploying

1 and what the human dimension is of the ARFORGEN  
2 cycle. The Army created this Army Force  
3 Generation process as a means of repairing  
4 equipment, and now we are realizing that the human  
5 dimension is much more fragile than repairing  
6 equipment, and so now the senior leaders are  
7 seriously engaged in looking at that and making  
8 changes to policy to impact both areas. Just in  
9 the last several months we awarded a \$50 million  
10 grant with the National Institute of Mental Health  
11 to bring in some outside experts. That grant was  
12 awarded to the Uniformed Services University,  
13 Harvard University, Columbia University, and the  
14 University of Michigan, which is really a  
15 top-notch team of outside experts who are going to  
16 help us look at this issue, do the data  
17 collection, assist our analysis efforts and make  
18 recommendations. Although it's a 5-year grant, it  
19 is designed so that they are providing us quarterly  
20 updates so that it isn't going to be an issue of  
21 in 5 years they're going to come back and tell us  
22 everything we were doing wrong for the last 5

1 years, but they're going to help us adjust in  
2 stride to improve.

3 As I said, there are approximately 240  
4 in our synchronization matrix going across the  
5 Army areas of policy, doctrine, organization,  
6 training and material leadership, people,  
7 facilities and resources. A task is green if it  
8 is being worked and on track for being  
9 accomplished by its established suspense date.  
10 Amber means that it is going to miss its suspense  
11 date and needs a new suspense date. The Vice  
12 Chief of Staff of the Army approves all changes to  
13 suspense dates. Black is a completed task meaning  
14 that we have accomplished it and that we have made  
15 the change to the regulation or the policy. Red  
16 means that it is a frustrated task, meaning that  
17 the Army in and of itself cannot accomplish that  
18 task and that it needs outside help in order to  
19 accomplish it. This may be changes in  
20 legislation, this may be changes in other  
21 policies, but those are being worked. So there's  
22 a total of 240 as of right now and about 70

1 percent have been completed. Many of those were  
2 the easy ones, and now we're addressing many of  
3 the much more difficult programmatic long-term  
4 issues.

5 We have a two-pronged approach with a  
6 program called Comprehensive Soldier Fitness which  
7 is designed to build resilience in soldiers as  
8 well as the Health Promotion Risk Reduction  
9 campaign which is designed to respond to the  
10 immediate needs of restoration and helping  
11 soldiers. So it's a two-pronged effort in terms  
12 of trying to build more resilience in the force,  
13 while at the same time providing help to those who  
14 need it right now.

15 Ahead we're looking to expand from just  
16 suicide prevention into other wellness issues,  
17 such as substance abuse to create that more  
18 holistic effort. I expect us to add probably  
19 about a hundred more tasks to our synch matrix in  
20 the next 4 months or so to get to some of these  
21 other issues; continue the collaboration with  
22 NIMH; develop metrics to measure program success;

1 and identify and resource programs as appropriate.  
2 The end state is to optimize and address the  
3 health promotion risk reduction, address the  
4 stigma issues both from a leadership and  
5 individual with regard to stigma so that leaders  
6 encourage help-seeking behaviors and service  
7 member, soldiers, know that it's okay to seek  
8 behavioral health services. We're trying to move  
9 some of the barriers. We're looking at expanding  
10 the use of telebehavioral health and VTC and other  
11 services in order to provide remotely located  
12 service members access to behavioral health  
13 services, to inform leaders and empower soldiers.

14 General Mcguire asked that I carry two  
15 messages forward today. One is while the DODSER  
16 is an excellent and mechanism and means, right now  
17 the rules of engagement are that units only begin  
18 to enter information into DODSER once it is  
19 considered a confirmed suicide. Given that time  
20 lag, we feel that with leadership changes,  
21 providers changing, we would like to begin  
22 entering information into the DODSER sooner in

1 order to begin data collection sooner. The DODSER  
2 is the Department of Defense Suicide Event Report.  
3 It's a standardized web-based system. The ASER is  
4 the Army Suicide Event Report. It is a web portal  
5 for entering all of the pertinent information  
6 regarding a suicide event, both suicide  
7 completions and suicide attempts.

8 Also within the suicide attempts right  
9 now, the rules of engagement for an attempt is  
10 that it is only entered into the DODSER-ASER if  
11 the service member is hospitalized overnight or  
12 for 24 hours which means I think that we're  
13 missing a significant amount of data on suicide  
14 attempts that don't result in overnight  
15 hospitalization. General Mcguire feels that that  
16 may indeed be an early warning sign for cluster  
17 events at an installation and would like to be  
18 able to increase visibility on that.

19 A second area is increased visibility  
20 across the services on all research efforts. We  
21 all know that there is a lot going on, and the  
22 Army has recently taken steps to try and increase

1 that visibility, but would like in addition for  
2 this task force to consider giving that  
3 information out across the services so that we  
4 have situational awareness of other research  
5 programs that are going on and can quickly adopt  
6 lessons learned and early results from those  
7 different research opportunities.

8           Finally, I'd like to say in terms of  
9 data-collection efforts, and I know several board  
10 members talked about this this morning, I would ask  
11 that we start at a baseline of those existing  
12 data-collection efforts that exist. We are  
13 already gathering quite a bit of data. We're  
14 happy to share that with you with the means that  
15 we have. What I personally would not like to do  
16 is to give a different format for the data so  
17 that I have to expend several- hundred man hours  
18 to convert my data into a format for you to look  
19 at, and if we could figure out a way of leveraging  
20 what already exists in the way that it exists, I  
21 think that we could more quickly respond to your  
22 needs rather than having to resort the data,

1 reformat reports, and provide you the same  
2 information that we currently have but just in a  
3 different view for you. Also I'd like to offer that  
4 the Army is very interested in piggybacking on any  
5 travels that you take to installations. We'd like  
6 to help inform you on those as well. Fort  
7 Campbell was a post that had a lot of emphasis  
8 placed on it, but there are other posts that we  
9 think have significant issues as well and perhaps  
10 we would be best served by going to a place that  
11 hasn't had the level of visibility as Fort  
12 Campbell, as well as going to a couple of the  
13 installations that appear to be more successful than  
14 other installations to capture what is going right  
15 at a place like Fort Bragg, the largest Army post,  
16 but it has a third of the suicides as any other  
17 post near its size. So I think we both need to  
18 look at where we need to improve, but how can we  
19 migrate what is working well to other  
20 installations. The bottom line is that the Army  
21 task force wants to work with the DOD task force.  
22 We're willing to do anything necessary in order to

1 facilitate your efforts. We believe that we've  
2 been doing this for a while and have a lot of  
3 information that we'd like to share with you  
4 however is most appropriate. That concludes our  
5 portion.

6 MS. CARROLL: I have just a few  
7 questions. Walter, thank you both for the  
8 briefing. That was tremendously informative and I  
9 appreciate that. Would it be possible for the  
10 members of the committee who are not within the  
11 Defense Department to do a demonstration of the  
12 DODSER and ASER at some point and the type of data  
13 that you are collecting? Maybe we could do that  
14 online. That's just a recommendation for a later  
15 point.

16 MR. MORALES: Yes, that shouldn't be any  
17 problem. The DODSER is the document that we  
18 produce on an annual basis. We're more than glad  
19 to share that with the task force definitely. We  
20 can schedule a time to share that with the board  
21 members.

22 MS. CARROLL: I have just a few

1 definitions. When you were talking about duty  
2 status, are you talking about Guard and Reserve  
3 members not in a federal status or are you talking  
4 about a Guardsman who is back home and not in a  
5 weekend drill status? Are you tracking Guard and  
6 Reserve regardless of their status?

7 MR. MORALES: That's correct, Bonnie.  
8 We are tracking the Reserve component regardless  
9 of status. In other words, if they are on federal  
10 status on active duty, we track them obviously.  
11 If they are not, let's say they are Title 32 or  
12 they're on state status or a soldier that is on  
13 weekend drill, we also track those and those fall  
14 into the non-active-duty category.

15 MS. CARROLL: What about a Guard or  
16 Reserve who is at their civilian job at the time  
17 of their suicide?

18 MR. MORALES: Most of the suicides occur  
19 when they are civilians and those are the ones who  
20 offer the most challenges to the task force to  
21 capture that data, and we are tracking those. As  
22 I stated, we have an official dedicated every day

1 to go down to the local level, to the local  
2 police, to get that information and capture it in  
3 our template that Bruce was talking about, a  
4 standardized template that we have developed to  
5 gather that data. So, yes, we do gather that as  
6 well and we're happy to share that with you.

7 MS. CARROLL: Excellent. I'm glad to  
8 hear you're doing that. How are you tracking  
9 those where the suicide occurs post-120 days of  
10 ETS?

11 MR. MORALES: That in itself poses  
12 another challenge because when the soldier ETSes  
13 and goes into the civilian sector, we are working  
14 very closely with the VA to make sure that if that  
15 person is in the system that we have a mechanism  
16 to grab the information and see what are the cases  
17 and get the trends. So we get that data from the  
18 VA, but one of the challenges is if the soldier is  
19 not in the system and ETSes with a clean bill of  
20 health and goes back to small-town America, that's  
21 where the challenges occur in trying to find that  
22 soldier.

1                   MR. SHAHBAZ: If I may add to that, the  
2 Reservists who are not on active and who we are  
3 tracking, our two biggest challenges in that  
4 population are Individual Ready Reserves because  
5 they don't belong to a unit and so there isn't a  
6 chain of command that notifies us that that  
7 happens, so that that is very challenging for us.  
8 We're working hard to try to capture all of those,  
9 but I'll be honest that we're not getting 100  
10 percent. Then once they've left active duty, that  
11 also is a challenge for us. We're working and we  
12 have a research project out of Medical Research  
13 and Materiel Command to try to look it, but again  
14 we're not getting a lot of that information right  
15 now. We recognize that it's a shortfall and we're  
16 trying to make changes. We're learning every day  
17 how to do it better, but it is a very difficult  
18 issue for us.

19                   MS. CARROLL: I think the overlay that  
20 was done by one of the news organizations when  
21 they tracked death records, state-recorded death  
22 records that checked veteran and in a certain age

1 category, and the category of self- inflicted  
2 might be of help in tracking that. You did a  
3 wonderful overlay on MOSes. How does that track  
4 with MOS distribution throughout the Army?

5 MR. MORALES: That's further analysis  
6 that we have to conduct. Yes, we do have the raw  
7 data. We just have to go back and keep working on  
8 making sure that we compare those to the overall  
9 population of the Army to see really what's the  
10 baseline here. These are small numbers as you saw  
11 before, 5, 6 or 11, so what? How does that relate  
12 to the overall effect that it's having on that  
13 specific population? We're working on those  
14 issues as well, Bonnie.

15 MR. SHAHBAZ: In general in very broad  
16 terms, what we do know right now is that infantry  
17 as a percentage of its population still is the  
18 number-one MOS density. Once you exclude some of  
19 the very low-density MOSes, for example, a  
20 chaplain's assistant, we've had one suicide this  
21 year with a chaplain's assistant which is a very  
22 small population. As a percentage of that force,

1 that appears to be an extreme outlier, so that if  
2 you adjust for the low- density specialties,  
3 infantry still is number one in terms of aggregate  
4 numbers and as a rate as a size of its force.

5 MS. CARROLL: Thank you very much.

6 MAJOR GENERAL VOLPE: Just one question.  
7 You showed these 240 tasks that you're tracking  
8 and monitoring. I'm making the assumption  
9 that each task has an intended impact or outcome.  
10 Is there a method that measures whether you're  
11 achieving that outcome or impact with those tasks  
12 or is that work to be done yet in the future? I'm  
13 not sure how it relates to what you're doing to  
14 actual outcomes, or how do you know if the task is  
15 working to get its intended impact?

16 MR. SHAHBAZ: Sir, we are learning  
17 lessons every day on that. In general to be  
18 honest, when we originally stood up we were moving  
19 so fast that we didn't spend a lot of time  
20 thinking about those metrics. That has been our  
21 focus now and we have started to go back and look  
22 at some of those and have begun a process. For

1 example, we created a policy change so that every  
2 soldier while out-processing an installation has  
3 to go by the substance-abuse counselors to  
4 out-process just like every soldier has to go by  
5 the library to out-process. It doesn't matter if  
6 you've ever been there or checked a book out, you  
7 have to go by. So now every soldier has to go by  
8 and give a copy of their orders telling them where  
9 they're going so that those counselors can then  
10 forward treatment records to the gaining unit of  
11 substance abuse and notify the command. We have  
12 gone back several times, we've put this issue, how  
13 is it happening, how is it working? Compliance is  
14 improving in that area. For all of the 170 green  
15 tasks, we have not done that with. We have  
16 prioritized our efforts for the big ones. Some of  
17 them are simply policy memos that really don't  
18 need a lot of compliance or follow-up, but we have  
19 prioritized and we have begun measures to go back.  
20 That is part of what I mentioned when I said that  
21 the Army is looking at going to do installation  
22 trips so that we can see not just did we make a

1 change to the regulation, but did that change make  
2 it down to the organizational level and have they  
3 internalized it and made the changes necessary to  
4 support those changes in the program. We've  
5 brought in a preventive health nurse who's helping  
6 us out of CHPMM to do that, but it's a challenge.

7 MAJOR GENERAL VOLPE: Thank you.

8 MR. MORALES: If I may add to your  
9 question, we have also developed with the campaign  
10 plan what we call an Annex D which is all the  
11 research we did that we changed into policies, new  
12 programs and new initiatives. We turned that into  
13 questions that the commanders and the leaders  
14 could ask themselves, Am I doing this? Am I doing  
15 policies that relate to identification of soldiers  
16 on referral to **ASAP**. So we have taken all of that  
17 and added it as an annex to the campaign plan, and  
18 this week or maybe next week we are planning on  
19 providing leaders through the Army G-1 website  
20 Suicide Prevention Office a checklist for  
21 compliance that the leader can take and see  
22 whether or not they are meeting the intent of the

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1 new changes promulgated by the task force, sir,  
2 and we will be happy to share that with you as  
3 well.

4 DR. CERTAIN: I have a couple of  
5 questions that I didn't see in the reports. Are  
6 you tracking at the point of suicide how many  
7 combat tours the person had had, the time between  
8 tours, type of action seen? Do you have a  
9 comparison between suicides among those who've  
10 seen combat and those who have been deployed in  
11 other ways?

12 MR. MORALES: Yes, sir, we have. We  
13 have gone back and conducted an analysis since  
14 2003 and the analysis is telling us right now that  
15 the vast majority of the suicides that we are  
16 seeing are in the population of never deployed or  
17 first-time deployers, being led by never deployed,  
18 second by first-time deployers. The data is also  
19 showing us that the more tours a soldier has, the  
20 less suicides we're seeing in that population.  
21 Nonetheless, we are also seeing obviously an  
22 increase in suicides by those post-deployed. So

1 if the soldier already went to the theater and  
2 came back, we are seeing that there is an increase  
3 in that category for those who have returned from  
4 deployment over a year. That's what we're seeing  
5 right now, contrary to what perhaps most people  
6 tend to believe, that the suicides are more in  
7 that category for those who have multiple  
8 deployments.

9 DR. CERTAIN: I'm hoping that I  
10 misunderstood you. Are you saying that even  
11 though the multiple deployments have had an  
12 increase in suicides, the majority of suicides are  
13 among those who have never deployed?

14 MR. SHAHBAZ: If I may, sir, the  
15 analysis that we've done indicates that the  
16 deployment profile of suicides tracks very, very  
17 closely to the Army population deployment profile.  
18 The Army does not have a lot of soldiers who have  
19 four or more deployments, very few soldiers with  
20 four or more deployments have committed suicide in  
21 terms of numbers. If you lay the Army population  
22 deployment profile out, about a third of the Army

1 has never deployed, 70 percent has deployed one or  
2 more times. Of those deployments, the vast  
3 majority have deployed one time. The suicide  
4 deployment history profile matches within a couple  
5 percentage points the Army population profile so  
6 that we're not seeing a greater risk for multiple  
7 deployers. Their rate is not higher than it is  
8 for the rest of the Army.

9 Obviously when we start looking at that,  
10 we're getting to very, very small numbers so that  
11 I am not willing to tell you statistically that of  
12 the 80 guys who have deployed more than seven  
13 times in the Army, hypothetically, those numbers  
14 are so small. But in general, if you overlay  
15 those two distribution curves on top of each  
16 other, they're very close. What I tell my senior  
17 leadership is I am not seeing a strong correlation  
18 and that it looks like the population profile.  
19 Did that clear it up?

20 DR. CERTAIN: Yes.

21 COMMANDER FEEKS: We're running about 14  
22 minutes behind schedule. So much about this task

1 force's work is going to be very fascinating and  
2 is going to generate a lot of discussion and  
3 fortunately we do have a panel discussion  
4 scheduled for 2 o'clock this afternoon for 2  
5 hours. If we didn't get you to yet, please write  
6 your question down or your comment down and that  
7 way it will be fresh in your mind when we get to  
8 the panel discussion this afternoon. I think  
9 right now what we need to do is roll on to the  
10 second speaker. Mr. Morales and Mr. Shahbaz,  
11 thank you very much.

12 MR. SHAHBAZ: Thank you.

13 MR. MORALES: Thank you, sir.

14 COMMANDER FEEKS: Our second speaker  
15 this morning is Navy Commander Aaron Werbel who  
16 will present the Service Data Review of the Marine  
17 Corps. You may already know, the Marine  
18 Corps looks to the Navy for medical, dental and  
19 chaplain support. Commander Werbel currently  
20 serves as the Behavioral Health Affairs Officer and  
21 Suicide Prevention Program Manager with the United  
22 States Marine Corps in Quantico, Virginia. He is

1 also an adjunct assistant professor in the  
2 Department of Clinical and Medical Psychology at  
3 the Uniformed Services University of the Health  
4 Sciences. And he is a certified trainer for  
5 mental health providers in assessing and managing  
6 suicide risk. Commander Werbel previously served  
7 as Staff Psychologist at the United States Naval  
8 Academy in Annapolis, Maryland, where he was also  
9 a regimental psychologist for plebe training. A  
10 plebe is the term that we use for college freshmen at  
11 the Naval Academy. He was also the head of  
12 Behavioral Health Care at the Capodichino Branch  
13 Medical Clinic, in Naples, Italy, and his slides  
14 may be found in the binder at the dark blue tab.  
15 Commander Werbel, thank you for being here, sir.

16           COMMANDER WERBEL: Thank you very much.  
17 One of the nice benefits of being on the task  
18 force and presenting is I get to stretch my legs  
19 while the rest of you have to sit there through  
20 another presentation. It's my pleasure to speak  
21 today on behalf of the Marine Corps Suicide  
22 Prevention Program and share with you a little bit

1 about some of the data and the initiatives in that  
2 program.

3 Historically, suicides have been the  
4 second leading manner of death in the Marine  
5 Corps. It recently during this time of war moved  
6 to the number-three spot. As you see, deaths  
7 resulting from hostile action took over as number  
8 two. In the Department of Navy which the Marine  
9 Corps is a part of for those of you less familiar  
10 with the military system, it's still the  
11 number two leading manner of death even though for  
12 the Navy and the Marine Corps specifically in  
13 those services it's number three. We oftentimes  
14 still refer to it as the second leading cause of  
15 death because we fully expect that when this  
16 conflict is over it will regain its spot back at  
17 number two again.

18 This gives you an overview of the  
19 numbers. If you look at the yellow, that's our  
20 suicides, and that includes confirmed and  
21 suspected suicides. They've been confirmed except  
22 for one in 2008, but there are still nine as the

1 next slide will show you, suicides pending  
2 confirmation in 2009. The Marine Corps rate  
3 historically has fluctuated much more than the  
4 other services in light of the fact that the  
5 Marine Corps is the smallest of the services, only  
6 recently reaching about 203,000 I think right at  
7 this moment. But because it's smaller, changes in  
8 one or two suicides in any given year really makes  
9 our rate fluctuate much more. Through 2007 where  
10 we had 33 suicides, all of those fluctuations  
11 remained within the box so to speak, within what  
12 we would expect with random fluctuations from year  
13 to year. We clearly went outside of that box in  
14 2008 when we had 42 suicides, and we've expecting  
15 to be outside of that box again this year.

16 Suicide attempts we put on there. We  
17 have had less confidence in our suicide attempt  
18 numbers as far as reporting as I think all of the  
19 services have, and we have been working very  
20 diligently to try and find processes that would  
21 improve the accuracy of that reporting. I think  
22 despite that, however, the trend is still relevant

1 because the errors and the reporting problems  
2 throughout the years have been similar throughout  
3 the years. So the trend is still very relevant,  
4 and you can see that has gone up as well over  
5 recent years. Just a note on the bottom there.  
6 We had the DONSIR, the Department of the Navy  
7 Suicide Incident Report, but when we standardized  
8 in January 2008, all of the services switched to  
9 the DODSER, the Department of Defense Suicide  
10 Event Report. We did that for suicides and we're  
11 implementing that for all suicide attempts in  
12 January 1, 2010 coming up.

13 This gives you a little bit more detail  
14 into the suicides themselves. We adjust the  
15 civilian rate for the Marine Corps based on age,  
16 gender and race. So we take the civilian rate and  
17 say if the civilian population looked like the  
18 Marine Corps, this is what the rate would be. The  
19 most recent number to come out from the CDC, the  
20 2006 number, when we adjusted that came to a 20.0  
21 rate. Like you heard from the Army, we also  
22 historically have been statistically significantly

1 below the civilian rate, and that is not the case  
2 anymore as our rate went to 19.5 in 2008. The  
3 other breakdown that you see here, and this also  
4 tracks and I've got another slide that will show I  
5 think the explanation you were just hearing from  
6 Mr. Shahbaz very clearly, that our deployment  
7 history also tracks very closely, the deployment  
8 history of our suicide population, with the  
9 overall deployment history of the population of  
10 Marines. So in that box what you see is that  
11 there is 69 percent of currently active-duty  
12 Marines have a history of deployment in support of  
13 Iraq or Afghanistan, OEF or OIF, and 73 percent of  
14 our suicides have that same deployment history.

15           This shows you if we focus for a moment  
16 on the left-hand side of this slide that the  
17 monthly numbers fluctuate also very dramatically.  
18 What you see here which is immediately going to  
19 beg the question, What in the world happened in  
20 June and July? The Marine Corps to be best of my  
21 knowledge has never had nine suicides in a given  
22 month, and we had nine in June and we had nine

1 suicides in July. Unfortunately, I don't have a  
2 good answer to that. Leadership in the Marine  
3 Corps obviously wants to know and everyone wants  
4 to know, and these 18 suicides do not provide any  
5 identifiable trends in terms of geographic  
  
6 location or other characteristics, any of the  
7 demographics, they just match the demographics of  
8 all of our suicides. The typical Marine who dies  
9 by suicide is a young junior enlisted white male  
10 which matches the demographics of the Marine  
11 Corps, and historically none of those demographics  
12 stood out, that it tracks pretty closely exactly  
13 what the demographics are of the Marine Corps as  
14 you heard one of the explanations from the Army as  
15 well.

16 I'll share with you that we have not put  
17 our numbers for September yet, but I guess I'm  
18 putting them out now since this is a public forum.  
19 We've had one suicide in the month of September.  
20 Again folks look at they say nine in June, nine in  
21 July, two in August, one in September. I would  
22 love to have a great explanation for why that

1 happens from month to month but there just isn't  
2 out. Again, we haven't found identifiable trends.  
3 I'd love to say that's a sign now based on 2  
4 months of data that our program is working. We'll  
5 see what the next month holds for that.

6 This gives you a little bit more a  
7 graphic display, and I give all the credit for  
8 this to my colleague from the Navy, Lieutenant  
9 Commander Chavez, because I stole the style of  
10 this slide right from one of her presentations in  
11 the past year. For example, in age, the pie in  
12 the center of this chart is the 2008 Marine Corps  
13 suicides. The ring on the outside is the entire  
14 population of the Marine Corps. What you can see  
15 on that slide on age is that while most of the  
16 Marines to die by suicide are 18- to 25-year-olds,  
17 it matches almost exactly the percentage of the  
18 Marine Corps that is 18 to 25 years old. There  
19 are similar circumstances with pay grade and  
20 similar with all of these things. I'll share with  
21 you by MOS, and like the Army, the most likely  
22 Marine MOS to die by suicide is infantry, and they

1 are slightly overrepresented in the population.  
2 You see that infantry makes up about 20 percent of  
3 the Marine Corps, and made up approximately 32  
4 percent of the suicides. What compounds the  
5 difficulty of understanding what that means is  
6 that infantry also is most likely to be our  
7 youngest, most male MOS, and we've already seen  
8 there also the largest population of our suicides.  
9 Is that because there is something unique about  
10 being infantry? Quite possibly. They handle  
11 weapons the most. If you look at Dr. Thomas  
12 Joyner's model and habituation, that would fit  
13 nicely in that model with infantry that they're  
14 most likely to be using the weapon all the time,  
15 seeing combat, experiencing those kinds of things  
16 and habituating to using that weapon, and most of  
17 our suicides are by handgun. But it could also  
18 just be a reflection that that's most of the young  
19 white men, a very significant demographic for that  
20 population.

21 Deployment similarly. We've looked as  
22 the Army has at multiple deployments and we find

1 the same type of phenomenon, that the demographics  
2 there also tend to match the numbers within the  
3 population. The one that really sticks out is  
4 three deployments. If you have three deployments  
5 in your history, only 3 percent of the Marine  
6 Corps has three deployments or more, about 10  
7 percent of our suicides did. The problem with  
8 that while it jumps out is that it's one or two  
9 suicides and it's very hard to use that as  
10 actionable intelligence to address a program which  
11 it's based on one or two events because that could  
12 change from 10 percent next to a half of 1 percent  
13 or 0 percent compared.

14 I'm not going to go through this whole  
15 side with you. I rebel very strongly against  
16 slides like this that have all sorts of text. I  
17 knew that we would be handing this out and that  
18 the task force members would all have a copy of  
19 it, I'd be happy to ask questions about it, but I  
20 won't read through it. I thought it was important  
21 to give you the global overall picture of what our  
22 Suicide Prevention Program looks like in the U.S.

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1 Marine Corps. On the left-hand side of this slide  
2 you see training requirements. I put those in red  
3 for the required training elements, things like  
4 annual training for all Marines, recruit training  
5 in boot camps, formal drill instructor school.  
6 They have training also not only in training the  
7 recruits at the Marine Corps Recruit Depots, but  
8 also for themselves. I'll spend a little bit more  
9 time talking about the NCO Suicide Prevention  
10 Course. We have suicide prevention that's  
11 required in leadership continuum in all of the  
12 professional schools across the Marine Corps. We  
13 also have many optional training programs out  
14 there, one of those being we have a  
15 distance-learning course. We don't require that  
16 distance-learning course because we think the best  
17 suicide prevention training is going to be small  
18 units face to face receiving that training, but  
19 that's available for some of our Marines who are  
20 more geographically separated and don't have  
21 access to a small unit to get that training and  
22 they can go online and complete that course. One

1 of the things I've loved in working with Marines  
2 is they tell you what they think. I know we've  
3 hit the mark on some of this stuff when a Marine,  
4 and this is a little off-color, so accept my  
5 apologies, but it drives the point home that we  
6 had a sergeant come out of a focus group when we  
7 were putting this distance-learning course  
8 together who said, "That's the first suicide  
9 prevention course I ever went to that didn't make  
10 me want to kill myself." That say something about  
11 how our service members have been perceiving the  
12 annual training requirement year after year after  
13 year and that we have to do things new and to  
14 shake that up a little bit to reach them.

15 There are many optional programs as  
16 well. Are You Listening Training is very unique  
17 training across DOD which was developed by our  
18 recreation staff of all places. I had nothing to  
19 do with it. They came to me with the program as  
20 they were wrapping it up. They used the Leader's  
21 Guide for Managing Marines in Distress and they  
22 developed a program for frontline recreation and

1 retail staff, because what they realized was that  
2 the typically young, attractive female behind the  
3 desk where you checked in to go to the gym is  
4 where a lot of these young guys were stopping off  
5 to chat and talk about their problems once in a  
6 while, and the young person behind the desk was  
7 suddenly confronted by I really think something is  
8 going on with this Marine. I don't know what in  
9 the world to do about it. He's talking about all  
10 these problems and his stress and maybe even  
11 talking about thinking of killing himself and they  
12 didn't know what to do. So this is a 2-day  
13 training program not to turn these frontline  
14 retail and recreation staff into providers or  
15 counselors, but to make sure they know what the  
16 resources are available on their installations and  
17 when they need to bring that up to the attention  
18 of their supervisors, and that's been very well  
19 received.

20 A lot of other initiatives that have  
21 been ongoing include every General Officer, now  
22 the first General Officer in the chain of command

1 and their Sergeants Major are making videos  
2 refreshed annually about suicide prevention and  
3 tying it into leadership or upon change of  
4 command. We are working right now to bring 23  
5 full-time civilian positions to every installation  
6 across the Marine Corps just focused on suicide  
7 prevention who will provide coordination and a  
8 link between the Headquarters, Marine Corps  
9 Suicide Prevention Program and the small unit  
10 suicide prevention program officers as collateral  
11 duties. The Marine Corps has formally joined now  
12 with the Army NIMH study, the STAR-D study. We  
13 appreciate the willingness on the part of NIMH and  
14 the Army in letting us pay and come and join that  
15 study so that now it's even bigger than what  
16 you've heard, \$50 million a year, but the Marine  
17 Corps is very happy to be a part of that.

18 There's lots of other stuff on here and  
19 I'd be happy to answer questions about it. Again,  
20 there's a long list also of collaborative programs  
21 just to give you an example of the type of support  
22 that's out there. That also leads to some

1 difficulties because some of these are stovepiped  
2 at the installations and sometimes we overwhelm  
3 our service members with all of the different  
4 types of resources available so that we have to do  
5 a good job of helping steer them into different  
6 resources.

7 Just a little bit on the NCO Suicide  
8 Prevention Course. Some of you may have heard a  
9 little bit about that. The Marine Corps is very  
10 hopeful that this is really going to make a  
11 difference. This course is a half-day course that  
12 we just launched. We started to train the  
13 trainers in August and every NCO, 70,000 NCOs  
14 across the world, will receive this by the end of  
15 October. It's a 3 to 3-1/2 hour course which is  
16 very heavily video. There are very few PowerPoint  
17 in this across the 3 hours. There is a 3-minute  
18 Hollywood-style drama that takes place in  
19 Afghanistan, that takes place back here, that  
20 notably is very different than any professional  
21 military education video that I've seen in the  
22 past in that it uses the language that our NCOs

1 speak. It's nothing like you'd see on TV because  
2 that's much worse, but it's filled with F bombs  
3 and different language that you'd get out there in  
4 a group of corporals and sergeants. The feedback  
5 that we've gotten from them has been, wow, that's  
6 us, that's actually our lives. That's how I talk.  
7 Those are my experiences. But then we also put a  
8 lot of documentary videos in there so that one of  
9 the things they see for example is Staff Sergeant  
10 Jeremiah Workman. He was awarded the Navy Cross  
11 for combat duty in Fallujah and came back from  
12 that and ended up developing PTSD and made a  
13 suicide attempt. He was later promoted after that  
14 and is still in uniform. For a Marine to see  
15 that, a Marine's Marine and him talk about what  
16 happened and his suicide attempt is going to have  
17 a lot more impact than a Navy psychologist no  
18 matter how much respect they give me talking about  
19 it. So this course is peer taught and it's  
20 reality based, and we're very hopeful that it's  
21 going to have an impact.

22 This slide, and I'll thank my Air Force

1 colleague because I stole this. I tend to do this  
2 a lot. I don't have a lot of support so that I  
3 can just steal from the Navy, steal from the Air  
4 Force, steal from the Army and then turn it into  
5 my own. I give credit where credit is due though.  
6 The format from this slide came from them, but  
7 these are Marine Corps numbers. What this shows  
8 you and I think what's significant about this is  
9 all of the services put their formal suicide  
10 prevention programs into place in 1997 or 1998.  
11 Aaron's understanding for the reason for that was  
12 May 1996 that some of you may remember. That was  
13 when Admiral Boorda, the Chief Naval Officer, died  
14 by suicide and he was the most senior military  
15 member I believe to ever die by suicide and the  
16 attention that got across the services and across  
17 the media was very significant, and I believe that  
18 led to a lot of focused attention on suicide.  
19 It's very difficult for us to know what element of  
20 a suicide prevention program is effective or not  
21 effective and, frankly, we don't study most of  
22 them. The Air Force, wonderfully and kudos to

1       them, scientifically studied their program and  
2       showed this drop after they initiated from before  
3       they initiated. We are studying with the  
4       Uniformed Services University specifically the NCO  
5       Suicide Prevention Course to see whether it's  
6       effective in changing behaviors of Marines.

7               But we also had this significant drop  
8       after, very significantly within the 4 years  
9       before and 4 years after, but a drop that holds  
10      even through our increase in 2008 statistically  
11      that it's lower from 1998 through 2008 than it was  
12      in the 8 or 9 years before that program. I think  
13      what this shows especially if all the services had  
14      similar findings is that one of the things would  
15      could probably say from this is that paying  
16      attention to suicide and paying attention to  
17      suicide prevention makes a difference. I don't  
18      know if we're ready yet to be able to tell you  
19      exactly what elements of our programs make a  
20      difference, but certainly paying attention to them  
21      has had some impact.

22              The last slide to share with you is that

1 we try very hard not to go this alone. All of the  
2 services work very closely together in the Suicide  
3 Prevention and Risk Reduction Committees sharing  
4 resources with other so that I can steal slides  
5 from them to make myself look good when I'm  
6 presenting. We work with other elements of the  
7 federal government. I chair on behalf of the  
8 Department of Defense the Federal Executive  
9 Partners Work Group on Suicide Prevention. Also  
10 we work very closely with our international  
11 colleagues, and I chair the International  
12 Association for Suicide Prevention Task Force on  
13 Defense and Police Suicide Prevention so that we  
14 try and gain best practices from foreign  
15 militaries also who have had these problems and  
16 who have worked out some solutions to try and find  
17 answers to them.

18 There's not data in this presentation  
19 but I did previously share with the task force in  
20 a report that's available to the public from the  
21 Naval Health Research Center that summarizes all  
22 of the data and analysis from 1999 through 2007,

1 and the 2008 report is coming from the Defense  
2 Center of Excellence and that should be out  
3 sometime in the coming months. I'd be happy to  
4 take any questions at this point.

5 DR. MCKEON: I wanted to follow-up on  
6 your referencing of the report that you said was  
7 available and I think it would be important for  
8 all of us to be able to get copies of any reports  
9 related to these efforts such as the Army Suicide  
10 Prevention Task Force because I think what we've  
11 heard so far is an excellent introduction or  
12 overview of the efforts around looking at data and  
13 looking at programs, but we're going to need  
14 further data and information to be able to assess  
15 that.

16 Let me ask you this question. In terms  
17 of the different efforts, how would you summarize  
18 the view in the Marine Corps in terms of your  
19 suicide prevention efforts, the reasons for why  
20 you're doing what you're doing, what is guiding  
21 you in terms of trying to determine what suicide  
22 prevention efforts are most likely to be of help?

1 Usually having some sense of what we think is  
2 leading to suicides or if we give some guidance to  
3 suicide prevention efforts, so there's a lot of  
4 work from both the Army and the Marines. What's  
5 leading you to take the steps that you're taking?

6           COMMANDER WERBEL: That's a great  
7 question. Thank you. We're always trying to hone  
8 in on that better so that we can really be  
9 targeting what we're doing to the populations that  
10 we need to address. I'll give you an example, the  
11 NCO Suicide Prevention Course which was probably  
12 the biggest new initiative that we've just  
13 launched. The Assistant Commandant of the Marine  
14 Corps, that's our Vice Chief for the Marine Corps,  
15 holds every 6 months an Executive Safety Board  
16 Meeting which consists of all the three-star and  
17 some of the two-star generals across the Marine  
18 Corps. They bring their sergeants major. At this  
19 last meeting each of them brought a corporal or  
20 sergeant with them, and NCO. NCOs really are the  
21 backbone of the Marine Corps. They run the show  
22 out there, and there are 70,000 of them out of the

1 200,000 active Marines. The NCOs at that meeting  
2 said to all the generals give this to us. Give us  
3 more tools. Give us more training. Give us  
4 relevant training. We'll fix this. We'll take  
5 care of it. We know it's a problem. We want to  
6 stop these suicides. Then what we did as we were  
7 developing the NCO course which I don't believe  
8 we've ever done before, we didn't sit in our ivory  
9 tower at Headquarters, Marine Corps, and create  
10 something that we thought was relevant for the  
11 NCOs. The class started with a concept in my  
12 mind, but then the NCOs would have seen it and  
13 they would have said that's great, that clearly  
14 was developed by a Navy psychologist. I've got a  
15 Master Gunnery Sergeant who was working with me on  
16 this. He completely changed it into something  
17 that would be relevant for the Marines, but if the  
18 NCOs had seen that, they would have said that's  
19 great. That was something from my salty Master  
20 Gunnery Sergeant who doesn't get what I experience  
21 as a young Marine.

22 So then we put together a focus group of

1 corporals and sergeants. The script was from a  
2 Hollywood screenwriter. They rewrote that script  
3 11 times, the NCOs, the 20 corporals and sergeants  
4 and some corpsmen to make it relevant for them.  
5 Then we had sergeants on the set telling the  
6 director that the actor who was playing the  
7 sergeant wasn't screaming enough at the Lance  
8 Corporal because they would have been louder.  
9 Then we pilot tested it with 100 NCOs out at Camp  
10 Pendleton and 100 out of Camp Lejeune and we  
11 dropped parts of the course because they told us  
12 what was boring them still and what didn't make  
13 sense to them, and we changed it completely.  
14 That's why I think our feedback from the NCOs has  
15 been uniformly positive, because we're actually  
16 going out to the audience, we're going to the  
17 folks who are dying by suicide, and we're asking  
18 them what do you need.

19 One of the things we've been working  
20 really hard at lately over the last 3 or 4 years  
21 is we have spouse who are survivors who are in  
22 this course in the videos talking about losing

1 their husbands to suicide. In the Marine Corps at  
2 least and I think the other services as well, we  
3 have not historically reached out to survivors.  
4 We've always had some post-intervention support  
5 for them, not enough, but we've not reached out to  
6 them in terms of education and outreach and we've  
7 not reached out to them to help guide program  
8 development, and we're doing that a lot more now  
9 because we have a lot of lessons to learn from  
10 surviving spouses about what their experiences  
11 were in surviving family members. I hope I'm not  
12 talking around the question. What we're really  
13 trying to do is go right to the source and find  
14 out what do you need and how should we providing  
15 it to you to combat the problem.

16 SPEAKER: A couple of questions about  
17 the data. On one of your early slides you showed  
18 an increase in suicides for the last 2 years, 2008  
19 and 2009. Is that statistically significant yet  
20 do you know?

21 COMMANDER WERBEL: The increase in 2008  
22 is statistically significant and we don't know yet

1 what's going to happen with 2009, and I hate  
2 making predictions, but it's likely to be higher  
3 than 2008. We've also grown do that our  
4 denominator has gotten bigger, so even if the  
5 numbers go up higher, the rate may not change as  
6 much, but the 19.5 is statistically significantly  
7 outside of our normal range compared to all of the  
8 previous years.

9 SPEAKER: What qualifies an attempt to  
10 get included in the database? Are they  
11 hospitalized like the Army was suggesting?

12 COMMANDER WERBEL: No. We track all  
13 attempts regardless of what the intervention was  
14 following that attempt so that it doesn't matter  
15 if they were hospitalized or EVAC'd or saw someone  
16 in the emergency room and then received outpatient  
17 follow-up. It needs to have come to someone's  
18 attention.

19 SPEAKER: Medical attention?

20 COMMANDER WERBEL: In the end, medical  
21 attention. We require that if there's a suicide  
22 attempt, of course the unit is required to bring

1 that person to medical, but we rely on Navy  
2 medicine to make the determination as to the  
3 characterization of what was this behavior, was it  
4 a suicide attempt or was it something else. If  
5 it's been decided by medical that it was a suicide  
6 attempt, then that's a reportable event by the  
7 unit to Headquarters, Marine Corps, and that shows  
8 up in our statistics regardless of what the  
9 intervention was.

10           COMMANDER FEEKS: Thank you very much,  
11 Commander Werbel. We are scheduled to take a  
12 break now. Again, if we didn't get to your  
13 questions or comments, please write them down and  
14 we'll welcome them at the panel discussion this  
15 afternoon.

16                           (Recess)

17           COMMANDER FEEKS: Very briefly,  
18 Commander Werbel during his presentation in the  
19 last segment made mention of a Staff Sergeant  
20 Workman who had been awarded the Navy Cross for  
21 action at Fallujah, and for those who don't know,  
22 I just wanted to let you know that the Navy Cross

1 is one step below the Medal of Honor is awarded  
2 for extraordinary heroism, so indeed I think he  
3 can be called a Marine's Marine.

4 At any rate, our third speaker this  
5 morning is Lieutenant Commander Bonnie Chavez who  
6 will present the Service Data Review of the Navy.  
7 Lieutenant Commander Chavez currently serves as  
8 the Navy's Behavioral Health Program Manager  
9 working on Navy suicide prevention and operational  
10 stress-control policies at the Navy Personnel  
11 Command in Millington, Tennessee, just outside  
12 Memphis. As for past assignments as a clinical  
13 psychologist include mental health departments at  
14 the Branch Health Clinics at Naval Air Station,  
15 Meridian, Mississippi, and Marine Corps Recruit  
16 Depot, Parris Island, South Carolina, not far from  
17 Hilton Head. Lieutenant Commander Chavez is a  
18 1992 graduate of the United States Naval Academy  
19 and has served as Legal and Personnel Officer at  
20 Light Helicopter/Antisubmarine Squadron 41, better  
21 known to its friend as HSL-41 at Naval Air  
22 Station, North Island, and she has taught physics

1 at the Naval Academy before completing her Ph.D.  
2 in clinical psychology at the Uniformed Services  
3 University of the Health Sciences, and she also  
4 completed a clinical internship at the National  
5 Naval Medical Center in Bethesda. She resides in  
6 Bartlett, Tennessee, with her husband and three  
7 daughters, and her slides can be found at the  
8 second light-blue tab in your binders. Lieutenant  
9 Commander Chavez, thank you for coming.

10 LIEUTENANT COMMANDER CHAVEZ: Thank you.  
11 Major General Volpe, Ms. Carroll, and members of  
12 the task force, I appreciate the opportunity today  
13 to speak to you about Navy suicide trends and  
14 programs.

15 Ultimately we have to remember that  
16 suicide is not about numbers, that it's about  
17 people. Each and every life counts and any life  
18 lost has a significant impact and is a significant  
19 tragedy. Likewise, it only takes one person at  
20 the right time and the right place to make a  
21 difference in saving a life, and the work that  
22 everyone here is doing does make a difference and

1 I want to thank you for the work and time you're  
2 devoting to this. As an overview I want to review  
3 some of the data and trends, give an overview of  
4 our program approach and policy, discuss what we  
5 have as far as compliance and efficacy  
6 information, and review initiatives and the way  
7 ahead.

8 I'm sure this slide is looking familiar  
9 by now, but suicide prevention has been on the  
10 Navy radar screen for quite a while and we've had  
11 training for a long time, but it became more  
12 systematized and centralized in 1998 which did  
13 result in a measurable reduction in the years that  
14 followed in suicide rates. Unfortunately, since  
15 2005 we've seen a slow but steady increase and  
16 that trend is continuing on into 2009. What you  
17 can see midway down the slide is the confirmed and  
18 pending, many of these are still pending, suicides  
19 by month for calendar 2008 and 2009. The numbers  
20 in parentheses are Selected Reserve individuals.

21 The Navy and Marine Corps had used the  
22 Department of Navy Suicide Incident Report for

1 gathering surveillance information from 1999 to  
2 2007. As you've heard, we've switched to a  
3 standardized DOD Suicide Event Report as of 2008.  
4 But because it's difficult to gather trends in any  
5 one year's worth of data, it's useful to look back  
6 at that aggregate. What we have found is that  
7 with a few exceptions that are few statistically  
8 significant differences in any demographic factor.  
9 Those few exceptions include are men more at risk  
10 than women similar to the civilian population?  
11 There's a slight difference that enlisted are very  
12 statistically significant but very small effect  
13 more at risk than officers. As you can see on the  
14 profile of the sailor, while the majority of the  
15 folks who we've lost have been Caucasian male  
16 enlisted E-4 to E-6 in the 17 to 24 age range,  
17 that essentially reflects the end strength  
18 proportions for those particular demographics. As  
19 far as what factors and stressors were found in  
20 that DONSIR data, about 30 percent had some sort  
21 of psychiatric history and a lot of that was  
22 substance abuse. This recent emotional state is a

1 little misleading because that's based on whatever  
2 the individual post -- tried to discern what was  
3 the individual's state or guess after the fact.  
4 Relationship problems is something that all the  
5 services have seen that jumps out and that in no  
6 way implies causality because often when  
7 individuals are experiencing a downward slide due  
8 to any number of factors such as an underlying  
9 health condition or other stressors, one of the  
10 first casualties may be that relationship, so that  
11 may just be one of those red flags that we include  
12 in our training to be watching for and paying  
13 attention to, not necessarily that that is a cause  
14 per se.

15           One of the important pieces of  
16 information that I believe that have pulled from  
17 that DONSIR data collection is that the majority  
18 of the sailors that we lost had not received any  
19 formal support in that month before their death.  
20 In other words, there wasn't any record that they  
21 had gone to the chaplain, to family services or to  
22 medical. Conversely, the folks who do get in the

1 door and do get into services have a pretty good  
2 prognosis. The challenge is in part how do we get  
3 to those folks and get them in the door?

4 Recapping the last couple of years of  
5 suicide demographics, I'm not going to go into  
6 great detail. Part of this is provided as  
7 reference material. Some of the key outcomes or  
8 conclusions that we've reached are, one, that the  
9 demographics generally reflect the Navy's  
10 population, that really anybody can be at risk  
11 with the right combination of events at a given  
12 time. Similarly to the other services, there is  
13 not an overrepresentation among deployers versus  
14 non-deployers, but we've looked at the deployments  
15 over time and preliminary information suggests  
16 that for those individuals who have deployed, they  
17 would be more likely to die by suicide in the  
18 first 6 months after deployment than either on  
19 deployment or further down the line. It gets a  
20 little confounding when you go too far out because  
21 then they're just prepping for their next  
22 deployment. We do believe that for traditional

1 shipboard deployment there are some predictive  
2 factors in place, a very close-knit environment, a  
3 very clear mission, some limitation on access to  
4 means and other protective factors so that we  
5 don't lose too many people on traditional  
6 deployments, but that first 6 months afterwards  
7 are where those transitions and some of the other  
8 factors come in needs to be on our radar screen.

9 Navy's approach and philosophy to  
10 deployment prevention is heavily focused on  
11 primary prevention at the top of this triangle.  
12 The primary prevention programs don't usually fall  
13 under the rubric of suicide prevention, but  
14 included are physical readiness programs, alcohol  
15 and drug abuse prevention, family programs and our  
16 new Operational Stress Control Program which I  
17 will be talking as well. The goal with that is to  
18 build resilience and prevent the kinds of factors  
19 and problems that can eventually lead to  
20 difficulties and risk factors. Once risk factors  
21 are present, once an individual is having a  
22 relationship difficulty, a discipline or a health

1 concern, et cetera, we want to focus at that point  
2 on vigilance and early intervention. A lot of our  
3 focus in that regard include things like frontline  
4 supervisor training, preparing those deployed  
5 supervisors to be creating an environment where  
6 they know what's going on with their folks and can  
7 get individuals as early as possible before things  
8 snowball and that includes addressing alcohol  
9 incidents on their first incident. Most of our  
10 traditional annual training has taken place at  
11 this next level once there are warning signs.  
12 Once an individual is showing any classic or overt  
13 warnings signs of a suicide risk, we certainly  
14 don't want to pass up that opportunity to  
15 recognize and intervene when it's there, and so  
16 most of that annual training has been focused on  
17 understanding the warning signs and risk factors  
18 and how to competently respond.

19 We can't entirely rely on that point to  
20 prevent suicides, however, because that window of  
21 opportunity may be very narrow and there may not  
22 be anyone else around who has an opportunity to

1 see those factors and respond. If a DUI occurs on  
2 a Friday night, the death occurs over the weekend  
3 and by the time the command is aware on Monday  
4 morning, they didn't observe any of those crisis  
5 signs for example. When those types of things  
6 occur it's very important that we learn from each  
7 and every instance in terms of our reporting and  
8 surveillance, but also more importantly, provide  
9 support and assistance to survivors left behind.  
10 And for individuals who survive attempts, get them  
11 back and reintegrated and re-facilitate their  
12 ongoing rehabilitation.

13 At the individual command level, the  
14 elements of the overall Navy programs that are  
15 expected to be in place will revolve around  
16 training, intervention, response and reporting.  
17 Training includes annual all hands awareness  
18 training as I mentioned. As of August and the new  
19 OPNAV Instruction 1720.4(a) now requires that to  
20 be extended to our civilian employees as well  
21 which was one of those recognized gaps. At this  
22 point we're also including some required targeted

1 training for our installation emergency responders  
2 and we're also looking at some additional enhanced  
3 training products that are targeted more at  
4 specific populations of leaders, junior sailors  
5 and so forth that augment that annual training.

6           On the intervention side, each command  
7 is required to have a written crisis response  
8 plan. This isn't an overwhelming, comprehensive,  
9 every possible scenario, but it's a duty office  
10 go-by so that if they have an individual who may  
11 be at imminent risk there is some thought to what  
12 are the safety precautions, what are the immediate  
13 concerns to get that individual safely to an  
14 evaluation of treatment. If they are getting a  
15 text message or a phone call or an alert from  
16 somebody's loved one, how do they go about  
17 accessing the resources to get to the person in a  
18 timely fashion, and we don't want people figuring  
19 that out on the fly because time may be of the  
20 essence. So we've asked them to think through  
21 that and develop and plan. The Navy moves around  
22 a lot so that what makes sense in port may not be

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1 the same resources and emergency responses if  
2 you're in a foreign port or you're underway, and  
3 so that has to be a fairly flexible and individual  
4 command plan, and also set up how those  
5 individuals have access to support resources.

6 For reporting we require a message  
7 report for all suicide-related behaviors that come  
8 to a command's attention and that includes  
9 everything from ideation all the way through the  
10 spectrum. We require the DODSER for deaths as of  
11 2008, and as of April of this year we expanded  
12 that DODSER requirement for attempts with a  
13 slightly different administrative process where it  
14 has to go through our medical facility and be  
15 verified with the nomenclature definitions that  
16 this meets the criterion of an attempt, and then  
17 the medical provider resource will be entering  
18 that DODSER, and we've also expanded that to  
19 include our Selected Reserve members who may not  
20 be on active duty at the time of the event or may  
21 not be on drill but do still have a command to  
22 which they report and that's the mechanism whereby

1 we're getting those reports.

2 Response includes support to the  
3 families from a casualty assistance calls officer,  
4 family service center counselors and chaplains are  
5 often called upon to provide that support, and  
6 another resource available are our SPRINT teams,  
7 our Special Psychiatric Rapid Intervention Teams.

8 The key to this whole idea is that each  
9 command has a trained suicide prevention  
10 coordinator who is not an expert interventionist  
11 by any means, but is an individual who understands  
12 what the policy is and can help that commanding  
13 officer make sure that training is occurring, that  
14 they have a conduit of information as far as  
15 training resources, that they're making sure that  
16 plan is in place, and that access and information  
17 about support resources are readily available to  
18 the sailors. One of the forward- moving  
19 directions that the Navy is trying to develop  
20 through this network of suicide prevention  
21 coordinators is to really get the ownership out to  
22 the local level because that's the level where

1 lives can be saved and not at headquarters per se,  
2 but with support and resources from the central  
3 level.

4 Compliance and effectiveness has always  
5 been a question. We've started to try and get  
6 some information in that regard. We did what's  
7 called a quick poll in May that looked at a range  
8 of topics of behavioral health which was a  
9 representative sample of about 2,400 sailors.  
10 Some of the questions include are they getting  
11 training? We say that annual training is  
12 required. Are they actually receiving it? By and  
13 large the answer was yes with 83 percent of  
14 sailors having had that training in the last 12  
15 months and remembered it well enough to tell us  
16 from what source they had that training that was  
17 split out between command-provided training,  
18 computer-based training and other resources.

19 We then asked how would they prefer to  
20 get the training? While the computer-based  
21 training is a good resource for some of our  
22 isolated folks, our recruiters and some of the

1 more geographically separated, a 3-to-1 ratio of  
2 sailors said they'd rather get live training, that  
3 they'd rather have a live facilitator. We've been  
4 using the acronym ACT, ask, care, treat, similar  
5 to what the Army is using in terms of ask, care,  
6 escort, ACE. That's been in some of the newer  
7 training materials and our newer communication  
8 materials and 72 percent of sailors correctly  
9 identified that on the poll so that the word is  
10 getting out and we would consider that some level  
11 of success as far as training retention. The  
12 majority report that they have the confidence that  
13 if somebody has talked about suicide, in other  
14 words if it was clear and in front of them, that  
15 they would know what to do and would either talk  
16 to the individual in terms of the ask, care, treat  
17 piece, tell the chain of command or refer the  
18 person to one of the support agencies, and most  
19 people would have done all of those.

20 Are commands doing things? About  
21 two-thirds of sailors believe that, yes, their  
22 commands are taking action, so this gives us a

1 snapshot of where we are and where we need to  
2 improve. In about half of the commands,  
3 individuals could identify the suicide prevention  
4 coordinator, and we've just recently changed that  
5 instruction clarifying that role in August so that  
6 that half is pretty good at this point and would  
7 expect that to continue to rise. This doesn't  
8 tell us everything, but it's a bit of a snapshot  
9 as to is what we're doing being done and is it  
10 working.

11 One of the big challenges as I mentioned  
12 before is that most of the folks who have died did  
13 not get in the door to help. The question comes  
14 up as to why. As we were looking at it, if someone  
15 were to seek help, what would the result be? What  
16 do you expect would happen? The vast majority  
17 believe that the person would get help, but many  
18 believe that it would have a career impact or that  
19 the person would be treated differently by their  
20 peers or their supervisors, and most expect that  
21 they would lose their clearance. In addressing  
22 this, some of this is myth busting because some of

1 that is not accurate. Another is more a review of  
2 how are our policies and our practices influencing  
3 whether there's a viable career reintegration  
4 pathway when someone does get assistance because  
5 that's going to be a essential to getting people  
6 to get help when they might need it or getting  
7 people to get help for their shipmate when they  
8 might need it and the belief that this isn't going  
9 to cause them harm, this is going to create the  
10 pathway for them to move forward and have a good  
11 life.

12 The Chief of Naval Operations this past  
13 February with raising concern about this issue  
14 called together a task force across functional  
15 teams to conduct an analysis and provide some  
16 recommendations. He was particularly interested  
17 that with finite resources how do I know I'm  
18 putting the right resources in the right spot to  
19 do the most good. That is an ongoing activity,  
20 but analysis was conducted and some of the actions  
21 that have come out of that have been including the  
22 Reserve Component in our data which was a gap in

1 the past, continuing to develop that network of  
2 suicide prevention coordinators, and establishment  
3 of a Family Outreach Working Group that is one of  
4 the key components. We have trained up our  
5 members, but often it's the family member who  
6 knows that something is going on or recognizes a  
7 concern if they have the information, awareness  
8 and education and know the resources for accessing  
9 assistance. One of the forums that we've used to  
10 expand our training and awareness efforts have  
11 been various conference and summit venues at fleet  
12 locations. Fifteen of those have occurred at 13  
13 locations in the past year. That has provided a  
14 venue to raise leadership awareness, to get those  
15 suicide prevention coordinators trained, and to  
16 begin seminars with those emergency first  
17 responders. In addition, our operational stress  
18 control program which is in its infancy so to  
19 speak, one of the first stages of that is some  
20 familiarization training with the concepts, an  
21 awareness briefing to understand the language of  
22 what it is, it's kind of a new thing, and that

1 awareness has gone out to 51,000 people so far.  
2 The goal is a sustained program, not a blitz at  
3 any given time, all efforts aligned in a  
4 constructive fashion in a program that will be  
5 sustained.

6 I mentioned operational stress control.  
7 This is the line-led medically supported Navy  
8 program that is aimed at moving away from a go,  
9 no-go mentality to integrating stress mitigation  
10 and navigating stress into our organization and  
11 into our operational decision making at an  
12 individual, at a family and at a command level.  
13 We realize that with the current missions, some  
14 that we've always had, some folks are out there  
15 doing ground support for the Army and Marine  
16 Corps, doing pirate interdiction, doing drug  
17 interdiction, doing humanitarian, we cannot afford  
18 to be experiencing a detriment due to stress  
19 impact and we certainly can't afford to lose  
20 anybody, but we can't even afford to have people  
21 out there at less than their optimum in this type  
22 of an environment. The operational stress control

1 program is moving forward in terms of developing a  
2 training curriculum from boot camp through flag  
3 officer courses. Boot camp just started this  
4 month, but they're being phased in at different  
5 levels of leadership. The goal is to develop both  
6 individual and organizational skills to build  
7 resilience, recognize stress effects early and  
8 start to take actions before they need to get even  
9 to the medical treatment level, and facilitate  
10 reintegration when that is the case. This also  
11 includes an analysis and assessment piece, an  
12 ongoing communications effort, and again the goal  
13 is organizational cultural change, so it's a  
14 long-term project.

15 Some of our outreach efforts on suicide  
16 prevention include ongoing messages in media. One  
17 fairly successful program has been Navy Reserve  
18 Psychological Health Outreach Coordinators. There  
19 are teams of about five at each of our Reserve  
20 regions. They have been training out in our  
21 Reserve units, but have also been a key link. All  
22 of them are social workers or credentialed so that

1 each suicide-related event in our Reserves are  
2 following-up with that individual which has been  
3 of great assistance. It's also enabled us to  
4 begin data collection for that population that was  
5 harder to reach. You seen here last year's poster  
6 series. This year we held a contest and I was  
7 delighted with the quality and quantity of entries  
8 from throughout the fleet. It really indicated  
9 especially when you understood the stories behind  
10 each one how much people really do care about this  
11 issue. They really do want to people to stay  
12 alive. In any given survey, about half our  
13 population has known somebody in their lives who  
14 has died by suicide. So as we move out in our  
15 training it's important to keep that in mind. We  
16 have a new Web URL that's in place and has been in  
17 place about a year that's a little bit easier to  
18 remember than some. This is [suicide.navy.mil](http://suicide.navy.mil) and  
19 is a resource for commands and individuals, and  
20 again that family outreach working group. I know  
21 Aaron mentioned a video. We have a new video as  
22 well that's called "Suicide Prevention: A Message

1 from Survivors" and it's about to hit the streets.  
2 It's all interviews of individuals who have either  
3 lost a family member or who have overcome a  
4 challenge or successfully assisted somebody.

5 As far as the way ahead, for training,  
6 and again it was mentioned, we have to understand  
7 what we expect training to do and what we don't  
8 expect it to do. At this point, training cannot  
9 necessarily protect someone from becoming  
10 suicidal, it may provide them the skills and  
11 resources that lessen the likelihood, but we  
12 certainly learned from Admiral Boorda who put out  
13 an excellent NAVOP a few months before his death  
14 that indicated that he got it, he understood the  
15 leadership factors, he understood the various  
16 issues, the alcohol and guns, and it didn't  
17 protect him so that it's not just a matter of  
18 knowledge. What training can do is it can assist  
19 leaders in preparing a good climate, it can  
20 improve our ability to assist others in distress,  
21 it can improve responder and provider skills  
22 certainly and we continue to upgrade those, and

1 one thing is it can provide a chance to ask  
2 questions and seek assistance and it's a pretty  
3 common phenomenon that when training is conducted  
4 for one or two people to come up afterwards and  
5 ask the presenter a question, maybe they're going  
6 through grief, maybe they're struggling  
7 themselves, maybe they're worried about a buddy,  
8 but it provides a pretty safe entre to start to  
9 have that dialogue that's sort of a side benefit  
10 of training. Through that suicide prevention  
11 coordinator network and moving from the continuum  
12 of trying to build resilience, early intervention  
13 skills, awareness, trying to supplement that as  
14 our sister services have done in upping the level  
15 of training to something that's more useful,  
16 engaging and hands-on practical and then on to the  
17 post-type training, trying to address the gaps is  
18 getting all over the world, there's a lot of  
19 places to reach including our civilian force,  
20 including our families in our outreach efforts,  
21 recognizing that coordination of the first  
22 responders is also key when you have that

1 opportunity, trying to get that comprehensive,  
2 integrated approach. On our support way ahead,  
3 recognizing that there are contributing factors.  
4 There are outside influencers that can have a  
5 positive influence from the community  
6 organizational policies and practices, of course  
7 all the way down. There are still some barriers  
8 and those are individuals' attitudes. One of the  
9 quandaries of all of this that I know the MHAT  
10 studies found and in our own behavioral health  
11 quick poll is that the more distressed people are  
12 the less likely they are to think that help is  
13 going to be good for them. The more they need it  
14 the more likely they're going to expect that it's  
15 going to have an adverse outcome. So I think it's  
16 part and parcel of the thought process of that  
17 tunnel vision that occurs, but the further folks  
18 get down that, the harder it is for them to reach  
19 out for help.

20 Our policies and work tempo may also be  
21 creating barriers and so we're doing a review of  
22 all of our policies. At this stage it's still

1 ongoing, but it hasn't turned up quite as many  
2 policies that were barriers as we might have  
3 expected, but more just how those policies are  
4 interpreted and practiced that may be creating  
5 some of the barriers. We want to continue our  
6 communication efforts to break down some of the  
7 myths where they really aren't a barrier but  
8 they're perceived to be, and also working on  
9 shoring up some of our support resources by  
10 filling our gaps in the Chaplain Corps and mental  
11 health.

12 I know the question came up earlier as  
13 to where might the task force go. I know that  
14 it's useful at times to really dig into what are  
15 the causes, what can we learn from each and every  
16 case, and each case has some lessons to learn.  
17 But I believe that there might also be value in  
18 looking at what may be working. If individuals  
19 are stepping forward to get help, what enabled  
20 them to do that? If individuals are successfully  
21 intervening, how were they able to do that? If  
22 programs are in place where individuals have maybe

1 even had an attempt and successfully reintegrated  
2 back on with their careers and their units, what  
3 pieces were in place that enabled that successful  
4 reintegration? In other words, it might be useful  
5 to look at a solution-focused approach as well as  
6 a problem-focused approach because sometimes  
7 chasing the problems takes us down a rabbit hole  
8 to some degree so that that would certainly be  
9 something worth considering. Thank you very much.

10 DR. MCKEON: Thank you for a very  
11 helpful report. My question was, can you describe  
12 the Navy's crisis response system that you  
13 referenced in your presentation? And in that if  
14 you can also say a little bit more about the role  
15 of the Special Psychiatric Response Intervention  
16 Teams.

17 LIEUTENANT COMMANDER CHAVEZ: The crisis  
18 response system is a fairly new thing in terms of  
19 being formalized and each command being required  
20 to have a plan in place. What we've asked them to  
21 do is to consider given your circumstances, are  
22 you on a submarine under the water, are you in

1 port at a shore command, because obviously that  
2 creates very different considerations. If you're  
3 on a submarine under the water and someone may be  
4 at imminent risk, the type of watch or the type of  
5 environment that you may want to put them in to  
6 make sure that safety considerations are in place  
7 while that person gets to a more advanced  
8 assessment are slightly different than if you're  
9 right at a medical facility for example. The  
10 other piece that we've asked them to do is to  
11 understand how would they go about getting  
12 resources to somebody. If they've got somebody  
13 deployed, an individual augmentee which is a  
14 phenomenon that the Navy has experienced during  
15 these operations is that we've been sending  
16 sailors out from a ship or from a facility  
17 individually to be embedded into the Army and  
18 support whatever their mission might be and it's  
19 something that sailors weren't traditionally  
20 trained for, and supporting the families has taken  
21 some years to develop the structure as to we were  
22 used to going to see and how would the family be

1 supported and we're preparing for deployment and  
2 coming back, but when people are going  
3 individually to very different environments, how  
4 do we provide the support. If you have one of  
5 those family members saying I'm worried about my  
6 sailor in Afghanistan, how are we going to go  
7 about getting ahold of their chain of command in  
8 Afghanistan without having to stop and spend a lot  
9 of time figuring it out in the middle of the  
10 situation. Those are the kinds of things that  
11 we've asked them to think about, not to be crisis  
12 hotline workers, we don't have that level of  
13 skill, but if somebody is calling that command so  
14 that they have some basic idea that I want to get  
15 this information, I want to know where the person  
16 is, is somebody with them, do they have a means to  
17 hurt themselves, because we are seeing that  
18 somebody will send a text message for example and  
19 how do you get the help to them? Once an  
20 individual is in hand so to speak, there are a  
21 variety of different ways, whether it's having  
22 that local support, the chaplain or the corpsman

1 talk to them, we ask that everybody get a medical  
2 assessment particularly for any behaviors. That's  
3 not always an immediate thing and depending on the  
4 operational environment it may be at the level  
5 again of a corpsman or a chaplain. I'm not sure  
6 if I've completely answered your question. I  
7 think we need to clarify that more. It's one of  
8 those areas that we need to lay out a little more  
9 systematically.

10 DR. MCKEON: That was very helpful. The  
11 Special Psychiatric Response Intervention Team?

12 LIEUTENANT COMMANDER CHAVEZ: There are  
13 two formal teams, one in San Diego and one in  
14 Norfolk that can be called out. For example, when  
15 the "Cole" event occurred, a team went out.  
16 They're sometimes called out in the events of  
17 suicide or other disasters. It used to be along  
18 the model of a schism. We've moved away from that  
19 and are moving toward what's called a combat  
20 operational stress first aide model and that's a  
21 resource. But at the local level, there's a lot  
22 of informal SPRINT teams that may be composed of

1 some of the chaplains from the installation, some  
2 of the family service center professionals, who  
3 are prepared to go in after there's been a death  
4 to assist with small groups or larger groups or as  
5 needed, or maybe just to provide advice to the  
6 command. They can play a lot of different roles,  
7 but the formal SPRINT team is headed up by  
8 mental-health assets and is available. They can  
9 always be called in at the command's request.

10 DR. LITTS: Do you have data on career  
11 impact of seeking mental health care also  
12 including loss of clearance?

13 LIEUTENANT COMMANDER CHAVEZ: I do not  
14 have data on career impact. It would be very  
15 useful to have. I do have some data in terms of  
16 clearance. I do know that of the clearances that  
17 were denied or revoked from the DONCAF, Department  
18 of the Navy Central Adjudicating Facility, that  
19 less than 2 percent were due to mental health. I  
20 think that was in 2005-2006. I don't have the  
21 most recent years. Eighty percent were due to  
22 financial reasons, and that's part of that

1 myth-busting piece. Generally when individuals in  
2 my experience as a psychologist doing DONCAF  
3 evals, if I saw somebody who had been through  
4 alcohol treatment or who had had depression and  
5 had been through treatment, that indicates good  
6 judgment and reliability. That isn't something  
7 that you lose a clearance for. In fact, the only  
8 case that I've personally observed where people  
9 lost a clearance was when they were obviously  
10 lying and were actively engaged in alcohol use or  
11 were lying about it and it was obvious that that  
12 didn't match. Those cases that would likely lead  
13 to clearance loss are thought disorders and that  
14 type of thing. Usually the clearance is the last  
15 thing on the list people are worried about because  
16 they're looking at a medical board and so  
17 clearance is sort of a subsidiary issue on those.

18 Most people are not thinking when they  
19 go buy their new car I might lose my clearance.  
20 What they are thinking is if I go get help for  
21 depression I might lose my clearance, and that's  
22 just not accurate based on that relatively small

1 percentage of clearances lost. But I don't know  
2 as far as career impact research. It would be  
3 important for us to get that. It will help us  
4 start addressing the issues or educating in  
5 busting the myths, whichever the case may be.

6 DR. LITTS: But even that information on  
7 the clearances, it seems like it would be valuable  
8 to get that word out.

9 LIEUTENANT COMMANDER CHAVEZ: I know one  
10 of the challenges that's particularly strict is  
11 our submarine community, our nuclear community,  
12 which has always had a very zero tolerance  
13 mentality. Partly because of the nature of what  
14 they're doing and that high level of responsibly  
15 they just don't want to take any chances at all.  
16 So the vast majority of folks who speak up within  
17 that community end up out of that community. They  
18 may not end up out of the Navy, and I don't know  
19 if that's necessarily meeting the goals. Do you  
20 want a submariner out there struggling through  
21 without treatment or with assistance? Which one  
22 is the more dangerous situation? So that's

1 something that that community specifically has  
2 looked at a lot of things and that's ongoing in  
3 our policy review. They are not necessarily  
4 overrepresented in our suicides per se, but I do  
5 know that that fear of career impact is perhaps  
6 more so in that community.

7           COMMANDER FEEKS: Thank you very much,  
8 Commander Chavez. We'll have another opportunity  
9 to address questions to her at the panel  
10 discussion this afternoon. For now our next  
11 speaker is Lieutenant Colonel Michael Kindt. He  
12 is a clinical psychologist and he is assigned to  
13 the Air Force Medical Operations Agency at  
14 Lackland Air Force Base in San Antonio, Texas, as  
15 the Air Force Suicide Prevention Program Manager.  
16 He has served as the Chief of Mental Health  
17 Services at Moody Air Force Base in Valdosta,  
18 Georgia, and at the Royal Air Force Base in  
19 Molesworth, United Kingdom. He subsequently  
20 commanded the 382nd Training Squadron at Sheppard  
21 Air Force Base in Wichita Falls, Texas. The  
22 mission of that squadron was to train various

1 kinds of medical support personnel. Lieutenant  
2 Colonel Kindt is a graduate of the Air War College  
3 at Maxwell Air Force Base in Montgomery, Alabama,  
4 and he has served as the Director of  
5 Counterterrorism Studies at the Air Force  
6 Counterproliferation Center at the Air War  
7 College. I regret to say that his slides are not  
8 in the binder right now, but we will make them  
9 available sometime during the lunch hour today.  
10 Without further ado, Lieutenant Colonel Kindt.

11 LIEUTENANT COLONEL KINDT: General and  
12 Ms. Carroll, thank you very much.

13 It's a pleasure to be here with you this  
14 morning to talk a little bit about what we're  
15 doing in the Air Force regarding suicide  
16 prevention. I do apologize. I was late in  
17 getting the slides to Commander Feeks so that you  
18 do not have those in front of you, but I'll be  
19 happy to take time and go back over those slides  
20 with you this afternoon if you have any questions  
21 after you have hard copies in front of you.

22 Some of the things that I want to go

1 over with you today are the development of our  
2 current program, the results of that, current risk  
3 factors and data, along with current execution  
4 issues and recent initiatives.

5 Preventing suicide as we've talked about  
6 very much already this morning, we need to look at  
7 this as two levels. It's an individual who  
8 commits suicide, an individual who may be in  
9 crisis, but within the Air Force we have somewhere  
10 between 30 and 40 suicides a year out of 320,000  
11 or 300,000 individuals. So to try to identify  
12 those 30 or 40 at an individual level is extremely  
13 difficult. What we really need to work at and  
14 what the Air Force has worked on and you've heard  
15 to this at greater or lesser extent from the other  
16 services, is a community-level intervention where  
17 we need to involve a public-health model and  
18 ensure that the entire community is aware of risk  
19 factors, how to intervene, and how to identify and  
20 get those at risk to help.

21 As you've heard, many of the services  
22 have developed suicide-prevention programs going

1 back in history. 1996 and 1997 is when the Air  
2 Force stood up their program. Dr. Litts who's  
3 with you here on this panel was part of that  
4 effort. The idea here was to embrace suicide  
5 prevention as an organizational priority and to  
6 set up some responsibility and accountability  
7 among leadership and among the entire community to  
8 engage on this issue. The vision is that it is a  
9 community responsibility. One of the issues that  
10 we wanted to do was move this away from being a  
11 mental-health issue to becoming a community issue.  
12 Most of our suicides are not engaged with any  
13 helping agencies, but they are engaged on a daily  
14 basis with their supervisors, with their  
15 commanders, and with their friends and coworkers  
16 and we need those people to be engaged in the  
17 process to prevent those suicides.

18 Active leadership involvement is  
19 critical for this to be successful. If the  
20 leaders are not emphasizing this, if they're not  
21 engaged and concerned, then it's not going to be  
22 helpful and we need to affirm and encourage this

1 help-seeking behavior as a sign of strength. We  
2 need early intervention and education, and we  
3 organized this entire program around 11  
4 initiatives in an integrated network of policy and  
5 education.

6           The key functional components of this  
7 are leadership. They need to role model that  
8 acceptance of mental-health issues, of seeking  
9 help and being agents of change within each  
10 organization, setting policy to establish clear  
11 guidelines and expectations for behavior,  
12 educating the entire community on their roles and  
13 responsibilities, and then a surveillance piece to  
14 make sure that we're tracking whether we're doing  
15 what we're supposed to be doing and so that we can  
16 inform changes to the program.

17           These are the 11 elements or initiatives  
18 that were initially put forward in 1996-1997.  
19 Some of these we've already addressed and I want  
20 to highlight some others that have not come out so  
21 clearly so far. Certainly leadership involvement  
22 is key. We made efforts on that point to

1 integrate suicide prevention in all of our  
2 professional military education programs. So in  
3 our Airmen leadership schools, NCO academy, Senior  
4 NCO academy, our squadron officer schools for our  
5 junior officers, Air Command and Staff College,  
6 and our Air War College, to make sure that people  
7 are understanding what their different roles and  
8 responsibilities were in suicide prevention at  
9 different levels of their careers. We developed a  
10 commander's guide for managing personnel in  
11 distress. It was available on CD and online and  
12 we now have little flip books of this that let  
13 commanders know as a quick reference what to do  
14 when you have an individual in your unit who is  
15 experiencing financial problems, martial problems,  
16 possibly suicidal, return from deployment issues,  
17 so that they have a quick reference of who to go  
18 to for help and where they should be sending that  
19 Airman.

20 Community Prevention Services was an  
21 initiative to create a medical accounting code to  
22 allow our mental- health officers to go out into

1 the leadership to do prevention work, to do stress  
2 management, to do suicide prevention briefings, so  
3 that they were getting credit for that because  
4 they're not seeing patients and getting what we  
5 used to get patient count for those activities,  
6 and how can we account for that and show that this  
7 is a productive thing that's valued by the  
8 organization? We established education pieces.  
9 We had an investigative interview policy. We  
10 identified that individuals who are undergoing  
11 criminal investigation or inspector general  
12 investigations may be at increased risk for  
13 suicide, so we established a positive handoff  
14 policy so that if an individual were interviewed  
15 by our Office of Special Investigations for  
16 example, that person was not allowed to leave  
17 after the interview, a representative from the  
18 command, the commander, first sergeant or other  
19 senior NCO had to come and have a positive handoff  
20 with that and they were given information about  
21 potential risk factors for suicide and how they  
22 could get that person to help so that we weren't

1 just turning these people loose to wander about  
2 the base.

3 We established a Criminal Incident or  
4 what we now call Traumatic Stress Response Teams  
5 on each base to deal with issues that might  
6 develop. The integrated delivery system was a  
7 regular working group established on each base to  
8 bring chaplains and our Family Support Center  
9 folks, family members and others, mental-health  
10 professionals, together to talk about what the  
11 needs were on each base and how we could establish  
12 a more seamless community helping program.

13 The Limited Privilege Program allowed  
14 individuals who were under investigation and were  
15 identified as being at risk for suicide to have  
16 privileged communication with their mental-health  
17 provider so that they could talk about what was  
18 going on in this investigation process or what was  
19 going on in their life without fear of that  
20 information being used against them either in a  
21 court-martial procedure or in the characterization  
22 of their discharge to hopefully make these

1 individuals be able to speak more freely and more  
2 willing to seek mental-health care when they were  
3 at risk. We had a consultation assessment tool  
4 which was a survey that commanders could use along  
5 with our integrated delivery system personnel to  
6 get a sense for how things were going in their  
7 unit, and initially we had used the Suicide Event  
8 Surveillance System to track our data which is  
9 similar to the DONSIR for the Navy and has since  
10 transitioned to the DODSER, the DOD Suicide Event  
11 Report.

12           The results of this program were very  
13 positive. There was a study published in the  
14 "British Journal of Medicine" where Dr. Litts was  
15 one of the authors that looked at Air Force  
16 suicide data from 1990 to 2002, and although there  
17 were no significant changes in our population  
18 demographics, we did see that over that time  
19 period we realized a 33 percent reduction in  
20 suicides. We also noted because we were using a  
21 community-wide intervention that was not just  
22 focused on suicides a decrease in a number of

1 other significant issues as well. So by engaging  
2 the entire community looking for risk factors,  
3 establishing this kind of new environment within  
4 our bases, we were able to make significant  
5 changes in a number of areas of interest within  
6 our bases, and our program has been recognized on  
7 the Substance Abuse and Mental Health Service  
8 Administration's National Registry of  
9 Evidence-Based Programs and Policies as being one  
10 of the 10 programs that has shown to be effective  
11 over time.

12 This gives you a look at some of our  
13 current suicide data. As you can see, we have the  
14 black line through the middle at about 1997 where  
15 our program was fully implemented, and from our  
16 pre-program period to the post-program period  
17 we've had about a 30 percent decrease in suicides,  
18 and our average since program implementation has  
19 been about 9.9 suicides per 100,000. This has  
20 been consistently below civilian adjusted  
21 demographic rates, we have seen that the rate  
22 varies considerably from year to year and we are

1 concerned that last year and this year we are  
2 above our average so that we have some concern  
3 about this and are relooking at the program but we  
4 don't consider this to be a crisis phase in our  
5 program yet. What we've done is gone back and  
6 relooked at how we've been implementing the  
7 program and are there things that we need to  
8 revitalize and reenergize to get the effect that  
9 we're looking for.

10 To look at risk factors between 2003 and  
11 2008, we've had 232 suicides in the Air Force.  
12 Seventy of those had relationship problems as one  
13 of the key issues that was going on leading up to  
14 the suicide. You can see some of the other data  
15 there. Of note, only 25 percent of the people who  
16 committed suicide had been seen by mental health  
17 within the last 6 months. I'm going to talk a  
18 little bit more about how we've responded to that  
19 piece of data, but when I talk to our line  
20 commanders what I say is what this tells you is  
21 that the vast majority of people who are going to  
22 kill themselves are not engaged with mental health

1 and they will not be engaged with mental health  
2 unless we find a way to help them get there. So  
3 the vast majority of those folks who are risk are  
4 folks who are still in the community who are not  
5 being engaged and we need everyone to stay  
6 involved to make that happen.

7 We have increased the number of  
8 mental-health providers in the Air Force to make  
9 sure that we have access for those individuals, we  
10 have frequent mental-health screenings, and we  
11 have financial and personal counseling services  
12 via our Airmen and Family Readiness Center where  
13 we've hired military family life counselors, and  
14 also of course via Military One Source.

15 Consistent with what the other services  
16 have found, we do not see a significant  
17 relationship yet between deployments and suicide  
18 within the Air Force. The majority of our  
19 suicides in the last 5 years had never been  
20 deployed and the time between deployment and  
21 suicide was over 500 days for those 99 Airmen who  
22 did have a deployment history and who committed

1 suicide during that timeframe. We've had very few  
2 suicides in which significant deployment issues or  
3 PTSD were noted as primary concerns, and we've had  
4 very suicides within theater. Since I started on  
5 these slides a couple of weeks ago, we have had  
6 another suicide in theater which brings us to  
7 three for 2009 and we're beginning to look more  
8 clearly at our processing for clearing folks and  
9 the reviews that we're doing of them before they  
10 deploy to make sure that we don't have issues in  
11 that process.

12 We have senior leader involvement. The  
13 Secretary of the Air Force and the Chief of Staff  
14 are notified immediately regarding a suicide via  
15 our Air Force Watch Program, and I send a weekly  
16 update on suicides to the Vice Chief and senior  
17 leaders each Friday so that they get an update on  
18 where we're at and any recent suicides that have  
19 occurred. And our Air Force Community Action  
20 Information Board which oversees our Suicide  
21 Prevention Program is briefed on suicides on a  
22 quarterly basis, how many suicides we've had,

1 where we're at with our training statistics and  
2 those sorts of issues so that our senior leaders  
3 maintain regular oversight of those. We've  
4 recently changed the policy through the to Vice  
5 Chief of Staff so that the reports of the Suicide  
6 Event Review Boards that are occurring at our  
7 individual bases are briefed up through their base  
8 level IDS and CAFE to their major command and up  
9 to the Air Force level IDS and CAFE to make sure  
10 that our line leadership is getting visibility of  
11 those issues. And we send an annual Lessons  
12 Learned Report that summarizes statistics and risk  
13 factors out to all commanders on an annual basis.

14 We do have collaboration both within our  
15 functional areas within the Air Force and across  
16 services working with the Defense Centers of  
17 Excellence and with the Suicide Prevention and  
18 Risk Reduction Committee to share best practices  
19 and to be aware of what's going on in the other  
20 services and standardize our reporting issues, and  
21 across agencies with the VA our personnel in  
22 streamlining the medical evaluation and disability

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1 process to make sure that folks are not falling  
2 through the cracks as they're leaving the service.

3           Along with medical actions, our Family  
4 Readiness Support Centers have done a number of  
5 things to help improve suicide prevention efforts.  
6 I mentioned earlier the hiring of family life  
7 consultants and looking at a variety of risk  
8 factors related to military service, frequent  
9 relocations, transitions, deployment and  
10 reintegration support, we're continuing to build  
11 on those services to help identify folks who may  
12 be at risk and to provide preventive services to  
13 them. We have financial education available from  
14 retention through retirement, Military One Source  
15 is certainly available, and we have domestic  
16 violence education advocacy and intervention  
17 through our Family Advocacy Program.

18           Chaplains are also very much engaged in  
19 our suicide prevention efforts. They keep track  
20 of the types of issues that they talk to  
21 individuals about and they are reporting a  
22 significant increase in the number of individuals

1       who admit to having thought about harming  
2       themselves from 2006 to 2008 which certainly  
3       causes us concern, and the chaplains are  
4       increasing their abilities to cope with those  
5       sorts of issues. Since 2005, all of our chaplains  
6       and chaplain's assistants have been trained in the  
7       Assist Program which is a 2-day intervention  
8       training for talking about and ferreting out  
9       suicide risk signs, and they've developed what's  
10      called the Safe Talk Program which is a 3-hour  
11      course that they train others on in how to talk to  
12      individuals about suicide risk factors, identify  
13      those at risk and get them to the appropriate  
14      helping agencies.

15                 All of this is part of what we in the  
16      Air Force call Wingman Culture where psychological  
17      health is rooted in this idea that we are all  
18      wingmen. This goes back to the early days of  
19      flying where we don't go out alone, we always go  
20      out with a wingman, and we're checking each other  
21      to make sure that we're safe and doing the right  
22      things, and we're applying this to everything that

1 we do in the Air Force. It's not just when we fly  
2 an aircraft, it's when we go to a bar, it's when  
3 we're having marital problems, anything that might  
4 be going on we should have a wingman looking after  
5 us. We have held an annual Wingman Day over the  
6 last 4 or 5 years to focus on this concept, and  
7 we'll do suicide prevention training on those  
8 days, safety types of training where we try to  
9 focus on breaking things down into small groups  
10 within organizations to emphasize that I'm not in  
11 this alone, you are in it with me and we all need  
12 to take care of each other to prevent suicide and  
13 a variety of other dangerous behaviors.

14 In talking about some of the recent  
15 initiatives, to enhance the 11 elements of the  
16 Suicide Prevention Program we've done a number of  
17 things. As I mentioned earlier, we had identified  
18 that 25 percent of our suicides had been engaged  
19 at some point with a mental-health provider. One  
20 of the things that we did was to develop, and Dr.  
21 Jobs was a part of this program, a Clinical Guide  
22 to Managing Suicidal Behavior that we've

1 distributed to all of our mental-health providers  
2 and provided training on 18 steps to help both  
3 adequately assess and then manage suicidal  
4 behavior within patients within their clinics.  
5 We've developed a Frontline Supervisor Training  
6 Program which is 2-hour, very often peer-led  
7 program to look at those individuals who have  
8 immediate Airmen underneath them so that typically  
9 this is at the Staff Sergeant, Tech Sergeant  
10 level, E-5 and E-6, so that those folks are  
11 getting more interactive training on how do I ask  
12 these questions, how do I talk to my troops, how  
13 do I look for these risk signs, and where do I  
14 send them when I identify them as being at risk?  
15 We're working at improving access to mental-health  
16 care as I mentioned earlier and decreasing the  
17 stigma of mental health by educating people about  
18 some of the things Commander Chavez was just  
19 talking about, issues about what happens to me if  
20 I go to mental health? Is my commander going to  
21 be informed? Is there going to be career impact.  
22 The Air Force has conducted a study several years

1       ago that found that of individuals who self-refer  
2       to mental health as being opposed to being made to  
3       go by their commander, 97 percent experienced no  
4       adverse career impact, and when there is career  
5       impact, it's usually because of the things that  
6       they did prior to coming to mental health, so that  
7       one of the things that we're doing is constantly  
8       educating folks that seeking mental-health care  
9       does not get you in trouble, it's the things that  
10      you may do before you come to mental health or the  
11      things that you may do rather than going to mental  
12      health like getting a DUI, doing other dangerous  
13      behaviors, breaking laws, showing up late for  
14      work, those sorts of issues are what get you in  
15      trouble, coming to mental health is a way to  
16      protect yourself from those things happening.

17                    We have initiated a recent Suicide  
18      Prevention Working Group where we've gone back and  
19      looked at are we doing what we say we're doing  
20      within the Suicide Prevention Program and can we  
21      doing better in any of these areas? We had a  
22      cross-functional group with the Surgeon General,

1 our Safety Office, chaplains, Office of Special  
2 Investigations, and we had Guard and Reserve  
3 representation as well to really review this  
4 program. We made some recommendations, I won't go  
5 through all of them, but they tend to cluster in  
6 this areas of leadership, policy training, our  
7 data collection and professional military  
8 education.

9           The big emphasis is we've been doing  
10 suicide prevention since 1997 and as many people  
11 know, demands change, and what we focus on and pay  
12 attention to changes over time. The Air Force had  
13 been doing pretty well with suicide prevention. I  
14 think one of the things that happened over time  
15 was that this move away from a line focus and into  
16 more of a medical issue and the working group has  
17 made some recommendations to push that back to a  
18 community focus so that we can make sure that  
19 everyone is engaged in this process. One of the  
20 things that hinders this is that on an annual  
21 basis on most Air Force bases, we have 77 some odd  
22 bases depending on how we count, will not

1 experience a suicide. So if I'm a commander, it's  
2 very likely that if I do nothing at all, no one  
3 will commit suicide within my organization. How  
4 do I continue to motivate commanders and base  
5 commanders at all levels to be active in this area  
6 when the reality is that even if they do nothing  
7 there probably won't be a suicide at their  
8 installation? So we've refocused this effort.  
9 The Chief of Staff put out a letter calling for  
10 Airmen to be all in to suicide prevention, just as  
11 we're all in with the joint fight, we need to be  
12 all in in preventing suicide. Everyone needs to  
13 be engaged and we need to be focusing our efforts  
14 there.

15 The new ACE card, the ask, care, escort  
16 model highlighting ACE tailors nicely with the Air  
17 Force tradition of flying aces and transitioning  
18 this to being a good Air Force and being a good  
19 wingman being an ace in taking care of the people  
20 that you're working with.

21 One of the issues that we've had with  
22 data collection is that previously under the

1 Suicide Event Surveillance System data was  
2 collected by our Office of Special Investigations  
3 and was not being looked in a cross- functional  
4 way when we've had a suicide. We've established a  
5 new policy that requires Event Review Boards at  
6 each base following a suicide where individuals  
7 from the OSI, from the unit, from the medical  
8 community, will get together and talk about what  
9 was going on in this individual's life to ensure  
10 that the data we're collecting and putting into  
11 the DODSER is the most accurate possible data and  
12 that we're really gathering a cross-functional  
13 look at what was going on in this individual's  
14 life. They'll then report that not only into the  
15 DODSER system, but through their local IDS and  
16 CAFE up through the MAJCOM level and ultimately to  
17 the Air Force level so that we can make sure that  
18 those lessons learned and ideas are getting out.

19 One of the big issues that we're working  
20 right now is that in 2007 we moved away from doing  
21 live suicide prevention briefings to doing  
22 computer-based training. The idea was that this

1 would be easier to ensure that everyone was  
2 getting the training and it would streamline the  
3 process. In my opinion what it's done is it's  
4 taken away part of the vital community element of  
5 our Suicide Prevention Program. If we're going to  
6 believe that this is a community effort then I  
7 think we should talk about it in a community  
8 environment, that we should do it at a squadron  
9 level and have these briefings opened and closed  
10 by the squadron commander so that that senior  
11 leader within that organization can put their  
12 stamp of approval or their personal opinions about  
13 what's going on with suicide prevention at the  
14 base level. We're working on getting this policy  
15 formally changed to go back to live briefings. I  
16 have a number of meetings with what we call our  
17 Air Force Learning Council in the next couple of  
18 weeks to validate this briefing, but I believe  
19 that change is going to go through. We will  
20 retain the option for our Guard and Reserve  
21 members to have this training via computer-based  
22 training, but they also want to do this in a live

1 briefing whenever possible. We're also working to  
2 begin developing training materials for our family  
3 members. One of the things that we've seen is  
4 that in many of the cases, the last person to see  
5 the individual before they died was a spouse or  
6 significant other and we want to provide some  
7 training materials for those folks so that they  
8 can help identify risk factors within their loved  
9 ones, not just their military member loved ones,  
10 but their teenage children and their other  
11 significant others in their lives so that they  
12 know how to intervene on a more global level. And  
13 we've also just begun looking at how we might be  
14 able to conduct outreach to the employers of our  
15 Guard and Reserve personnel in their civilian  
16 capacity. How might we be able to provide some  
17 outreach to them so that if they have concerns  
18 about that individual when they're away from the  
19 military how they might be able to let us know and  
20 how we might be able to intervene with them.

21 I talked about this to some extent  
22 already, improving our data-collection and

1 lessons-learned process. As mentioned earlier,  
2 it's very difficult to get data on Guard and  
3 Reserve members who are not in active federal  
4 status. Their death might not be reported to us  
5 for some time, we probably will not have access to  
6 the vast majority of their medical information, so  
7 that the data-collection process is difficult  
8 there. We do have mechanisms now where we're  
9 confident in the data that we gather regarding  
10 both our Reserve and Guard members when they die  
11 out of status, but some of the other background  
12 information about risk factors is still difficult  
13 to access. But our new IDS CABE structure is  
14 going to make sure that those lessons learned are  
15 getting moved more easily and more consistently  
16 from the local level up to the Air Force level.

17 We've also found that over the last 10  
18 or 12 years although we started out with suicide  
19 prevention well integrated into our military  
20 education programs, that over time the consistency  
21 and quality of that education has varied and we're  
22 conducting a full review now through our Air

1 Education and Training Command to look at what  
2 precisely is being taught at each level of  
3 professional military education and is this  
4 sufficient, is this what those leaders at that  
5 point in their careers need to be learning about  
6 suicide prevention? The initial look is that it's  
7 not and that we need to revisit how we're doing  
8 that and what material we're putting into those  
9 programs.

10 In summary, the Air Force Suicide  
11 Prevention Program has proven to be effective over  
12 time in reducing suicides across our population.  
13 We have had rates above average although not  
14 statistically significantly outlying over the last  
15 2 years, but they're still below our pre- program  
16 levels despite years of high ops tempo and we're  
17 undergoing ongoing program enhancements and action  
18 to look at what we're doing within suicide  
19 prevention and how we can enhance that to further  
20 drive down our rates. Are there any questions  
21 that the board might have?

22 LIEUTENANT COLONEL BRADLEY: Have you

1 done any deconstruction of our overall program to  
2 see what is the most efficacious part of it,  
3 because it seems very comprehensive and I commend  
4 you on that, but have you been able to tease that  
5 apart to see what you think you're getting the  
6 most bang for the buck out of?

7           LIEUTENANT COLONEL KINDT: That's a very  
8 difficult thing to assess. My personal feeling is  
9 that a big piece of it was the attention and the  
10 annual training requirements that we put on  
11 particularly when those were conducted at a  
12 community level. It was very helpful for me as a  
13 psychologist back in the day to walk into a flying  
14 squadron or a maintenance squadron that I normally  
15 wouldn't have had access to and talk about Air  
16 Force mental health and suicide prevention. As  
17 Lieutenant Commander Chavez mentioned before,  
18 invariably I would have two or three or four or  
19 five people lined up to ask me questions about  
20 somebody in that unit or somebody who they know  
21 that they might be concerned about. If I had to  
22 pick one thing that I think was it, that would be

1 it. We are working with Dr. Carrie Knox who was  
2 one of the original authors of that paper that I  
3 mentioned. We have done some checklists where  
4 bases have self-reported are they doing the 11  
5 initiatives, and Dr. Knox is in the process now of  
6 looking at self-reported compliance rates with  
7 those 11 elements and suicides, and she's looking  
8 at it over a several-year period because as I  
9 mentioned, you might do nothing at your base for a  
10 year and still have no suicides. So we're playing  
11 with very small numbers and it's difficult to  
12 assess that. I would argue for the board that one  
13 of the areas where I think we need help is  
14 establishing measures of effectiveness for many of  
15 these things other than just rates of suicides  
16 because it's very, very difficult. If we have  
17 four fewer suicides this year than last year, it  
18 probably doesn't mean anything at this point  
19 because we have significant variability across  
20 time regardless of what we've been doing.

21 DR. HOLLOWAY: I was very impressed by  
22 what you said about the Air Force's emphasis on

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1 leaders and understanding that and promoting the  
2 idea that it's a sign of strength to seek help. I  
3 was wondering if you could comment on how the Air  
4 Force has promoted that idea or reinforced that  
5 idea for leaders to really communicate that  
6 message.

7           LIEUTENANT COLONEL KINDT: Part of that  
8 I think has been through our Professional Military  
9 Education Programs where at least several years  
10 ago we were doing a pretty good job of talking to  
11 commanders about their responsibility for setting  
12 the tone within their organizations that it's okay  
13 to ask for help. We expect people to have  
14 problems. We're asking you to do stressful  
15 things, at times traumatic things, to move away  
16 from your families and to deploy to hostile  
17 environments, and it's natural for people to have  
18 problems in those areas. So through professional  
19 military education and I think primarily through  
20 our very senior leaders, communicating downward  
21 that this is what we expect you to be doing. We  
22 expect you to talk to your troops about it being

1       okay to get help. We expect you to talk to your  
2       troops about perhaps times in your life when  
3       you've needed help. That's one of the things that  
4       I do when I go out and get a chance to talk to Air  
5       Force, is to show that many folks have had those  
6       experiences.

7                   One of the very powerful things that  
8       happened in my career just to tell a short story,  
9       I was working at RAF Molesworth which is an intel  
10      base with lots of people with very, very high  
11      security clearances, and a very senior leaders  
12      within that organization came to me at the club  
13      one day and said, "Doc, I think I need to talk."  
14      Very often when senior leaders do that they want  
15      to do it off the record and away from the  
16      spotlight, but this person said, "I want to do it  
17      like anybody else." They came and they sat in the  
18      waiting room and they filled out all the paperwork  
19      and they did all that stuff, and things got better  
20      in their life. What I didn't know and I wish they  
21      had told me was that at an upcoming commander's  
22      call they got up and talked about how helpful it

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1 was to seek help and how they career had not been  
2 damaged and they still have their very high  
3 security clearance and that it's really a good  
4 thing to go to talk to Dr. Kindt. If I had known  
5 that, I would have cleared my schedule for about 4  
6 weeks because the phone was ringing off the hook.  
7 So the intervention of a senior commander doing a  
8 little bit of revelation, talking about what's  
9 going on in their life and reinforcing that notion  
10 can go a long way toward breaking down those  
11 barriers.

12 DR. JOBES: I'm struck by this data you  
13 presented that 25 percent of the deaths in the Air  
14 Force had a mental-health contact, and I'm really  
15 thinking about this tension between  
16 destigmatization and then the experience that Dr.  
17 Holloway and I had and me with the safety board of  
18 the Marine Corps, because I know before we met  
19 with the Marine Corps I talked to every Marine I  
20 knew and asked how do you fix the problem, and  
21 basically every Marine said we don't have a  
22 problem. I said here's the data, and they said,

1 we don't have a problem so that that was a denial  
2 factor. But then what an enlisted guy told me was  
3 you don't ask a Marine in front of his unit to  
4 step out and say I need help, that that's just  
5 unrealistic and that you don't do that. So then  
6 this other more senior colleague said the Marines  
7 have this thing about pushing leadership downhill  
8 and you ask your NCOs to fix it, and that that was  
9 in part what Aaron was describing in terms of the  
10 NCO program.

11 I'm really struggling because I have my  
12 biases as a clinical psychologist and I clearly  
13 like the idea of destigmatization and getting  
14 better help and I love the data that 97 percent of  
15 Air Force who sought help didn't have an adverse  
16 event. But I really do wonder if this is an  
17 mental-health issue as much as it is a larger  
18 systemic cultural issue. One of the things I  
19 think for the board to consider is, for example,  
20 the Air Force has the OSI which does these  
21 investigations of completed suicides in the course  
22 of doing investigations of ruling out foul play,

1 that that's some of the best data we've got in  
2 terms of only 25 percent having contact with  
3 mental-health care. Are your efforts best  
4 targeted toward bolstering mental- health care and  
5 destigmatization or is that really a misplaced  
6 focus, and I say this with a bias for mental-  
7 health care, and that what we may need to may  
8 think more about is a broader scope which I  
9 suspect is what the Air Force's program -- I agree  
10 that the Air Force's program success was modeling,  
11 but also trying to push out into the force a  
12 sensibility that my buddy is in trouble, go out  
13 and get them drunk, you may take them to the  
14 chaplain, or not necessarily see a clinical  
15 psychologist, but for the wingman model to take  
16 place, so that those are a couple of thoughts  
17 associated with your presentation. But all the  
18 branches have these mechanisms whereby they can  
19 study the completed suicides and I really think we  
20 need to pay attention those data and put our  
21 biases aside because that at least from a  
22 mental-health standpoint is going to strike us

1 that a lot of these folks don't come into contact  
2 with people like me.

3 DR. LITTS: I have a couple of  
4 observations here too. Marjan, if in 1998 I had  
5 been standing there and you had asked me the  
6 question about how you convey those leadership  
7 messages, I would have given you the exact same  
8 answer, and that to me is just amazing that 12  
9 years later the same drumbeat is coming, the same  
10 themes, this idea that it's a sign of strength to  
11 get help, that it's actually responsible  
12 behavior that we heard Bonnie mention, that she  
13 would not take away a clearance for someone who  
14 exhibits that kind of responsible behavior.

15 The statistics on the number of people  
16 who have legal problems and have sought mental  
17 health, I was also struck that that's almost  
18 exactly the same as they were in 1996, so that  
19 that profile hasn't changed at all. One last  
20 observation. In 1999 when the Air Force suicide  
21 rate was at its bottom, and I think we'd gone 140  
22 or 150 days without a single suicide, that that

1 was at a period of time when psychiatry was  
2 undermanned by 40 percent. So is it a medical  
3 problem? Is it a mental-health problem? Is it a  
4 public health problem? Is it a community problem?

5 MAJOR GENERAL VOLPE: I'm probably going  
6 to re- ask this question when we form up as a  
7 panel because I think I need to have everybody  
8 there. I'm probably going to ask some pretty  
9 blunt questions that I believe we really need to  
10 get an answer from you on and that is because all  
11 of the services gave us this great overview of the  
12 general statistics and trends and data and  
13 probably didn't drill into enough of the detail I  
14 think for the members here, but that's something  
15 that we're going to address at future meetings on  
16 the data so that we can really get a better  
17 understanding of some of the details.

18 All of the services have identified  
19 suicide as a major service challenge. They have  
20 all shown data of increases or staying about the  
21 same, but it's still a high- priority program in  
22 each service regardless and they all show that

1 while there are many similarities in their  
2 programs, they each have different programs and  
3 different ways of tackling it and different  
4 strategies and the comprehensiveness in the way  
5 they approach it appears to be different. Maybe  
6 I'm off target here, and I have no problem with  
7 anybody telling me I'm off target, but what I'm  
8 wondering, and I'm going to ask this afternoon, is  
9 the fact that we tell each service from the  
10 department level or higher that you're responsible  
11 for your program within your service helpful or  
12 inhibitory to more cross-pollination across the  
13 services? Because every presented their data in a  
14 different fashion and in a different orientation  
15 and what appeared to me to be in a different  
16 prioritization if you will or emphasis and  
17 everybody is doing stuff and it's high-priority  
18 stuff in each of the services, but they're all a  
19 little different and I'm not sure if overall the  
20 way we view it from the strategic level creates  
21 this separation and if we need to do something to  
22 bring it back. I just want folks to think about

1 that for a second because this was presented in a  
2 lot of different formats and methods and data and  
3 it's very hard to put apples with apples and  
4 oranges with oranges and to compare and contrast  
5 and make logical conclusions from what is being  
6 presented at this point, but that's just my  
7 initial impression. It's all very good stuff, but  
8 I know for me it's difficult -- and I'll just  
9 speak for myself on the board here because there  
10 are some people who are experts in this field who  
11 have done this for many, many decades and years --  
12 to see a unity of effort in collection of  
13 information, collection of data, analysis of the  
14 data, sharing everything and a cooperative effort  
15 in developing systemic-wide programs to address  
16 and then the appropriate metrics to measure to see  
17 if the impact is being achieved by those programs,  
18 but that just might be me and I'll just throw that  
19 out there as a general thing and maybe people  
20 could think about that over lunch and over the  
21 admin session for the board. I think we have some  
22 administrative comments. I think when we do the

1 panel I would ask all the members to really think  
2 about these that while we have the four services  
3 here, these real deep questions of collaboration  
4 and cooperation, the thought process and analysis  
5 behind the data that was presented, and I'm again  
6 trying to get us prepped and geared toward future  
7 meetings too and what it is that we would be  
8 looking for.

9 I'll ask the board members too during  
10 the administrative session if we could have a  
11 discussion of what is the clarity on the data that  
12 we want presented because I think we're going to  
13 have to dig a little deeper into some of the data  
14 that was already presented by the services, what  
15 exactly is the data? And if we could get that and  
16 share it and communicate that, I think it would be  
17 a lot easier for the folks presenting, some common  
18 data elements that we want to get. Commander  
19 Feeks, do you have any administrative comments  
20 before lunch?

21 COMMANDER FEEKS: No, sir, not now.

22 Thank you.

1 MAJOR GENERAL VOLPE: We're going to  
2 break for lunch.

3 COMMANDER FEEKS: The catered working  
4 lunch for task force members and speakers,  
5 distinguished guests and task force and Defense  
6 Health Board staff will be in Salon C. It will be  
7 a working lunch. For those other attendees,  
8 please consider the restaurant options that I  
9 mentioned at the beginning this morning. There is  
10 a restaurant here in the hotel and there are  
11 several others within a mile of the hotel. We'll  
12 reconvene at 1:00 p.m. and resume the open session  
13 of the meeting.

14 (Recess)

15 MAJOR GENERAL VOLPE: Looked at the  
16 agenda and thought it best to make a minor change  
17 to the order of events for this afternoon. It  
18 just makes sense to have the Armed Forces  
19 Institute of Pathology briefers present before the  
20 panel discussion. That way there won't be an  
21 inadvertent repetition of information, and they  
22 can participate in the panel discussion once

1       having presented their information. So on your  
2       agenda where it says 1345 and lists a "break" at  
3       that time; instead at 1345 we'll have the Armed  
4       Forces Institute of Pathology briefers give their  
5       presentation. And then at 1445, we'll take a  
6       break, and then at 1500, we'll start the panel  
7       discussion with the Service Representatives and  
8       the other briefers.

9       Okay, now, let me just roll right into the  
10       introduction of our next speaker. We are actually  
11       getting a team presentation by Colonel Ritchie and  
12       Lieutenant Colonel Paul Bliese -- is that how he  
13       pronounces it?

14                   COLONEL RITCHIE: Paul Bliese, but he  
15       won't be able to join us.

16                   MAJOR GENERAL VOLPE: Oh, I'm sorry.  
17       Okay.

18                   COLONEL RITCHIE: He had to brief a  
19       four-star conference this afternoon, so we decided  
20       to divide and conquer.

21                   MAJOR GENERAL VOLPE: All right then.

22       Well, Colonel Ritchie is the director of the

1 Proponency of Behavioral Health at the office of  
2 the U.S. Army Surgeon General. She has held  
3 numerous leadership positions within Army medicine  
4 to include the psychiatry consultant. She trained  
5 at Harvard, George Washington, Walter Reed, and  
6 the Uniformed Services University of the Health  
7 Sciences, and has completed fellowships in both  
8 forensic and disaster psychiatry. She's a  
9 professor of psychiatry at the Uniformed Services  
10 University of the Health Sciences. Her  
11 assignments and other missions have taken her to  
12 Korea, Somalia, Iraq, and Cuba.

13 She has over 130 publications, mainly in  
14 the areas of forensic, disaster, and military  
15 combat operational psychiatry and women's health  
16 issues. Recent major publications include the  
17 textbooks, "Mental Health Interventions for Mass  
18 Violence and Disaster" and "Humanitarian  
19 Assistance and Health Diplomacy:  
20 Military-Civilian Partnership in the 2004 Tsunami  
21 Aftermath." She is currently the senior editor on  
22 a forthcoming military medicine text on combat and

1 operational behavioral health.

2 An internationally recognized expert,  
3 she brings a unique public health approach to the  
4 management of disaster and combat mental issues.  
5 Colonel Ritchie, thank you for being here.

6 COLONEL RITCHIE: Thank you. It's a  
7 real pleasure. You know, there's a lot of past  
8 friends, people I haven't seen for a while. As I  
9 mentioned, LTC Bliese cannot join me today because  
10 he did have to go down and brief the four stars  
11 this afternoon. I have a lot of material to  
12 share, and I'm going to tease you with it because  
13 you're going to come back and say, I want more  
14 information on this. And that's part of what we  
15 want to do there is give you the range of what  
16 we've got from the mental health advisory teams,  
17 from the epidemiological consultation teams, and  
18 from the databank that we now have at CHPPM. And  
19 then we're going to flood you with papers  
20 afterwards for your trip to the West Coast so  
21 you'll have good reading material.

22 MAJOR GENERAL VOLPE: Now I neglected to

1 mention that the Colonel's slides are at the  
2 second red tab in your binders.

3 COLONEL RITCHIE: I can't do a talk  
4 without talking a little bit about history, but  
5 having said that, we know a lot more about  
6 psychological reactions to combat other than  
7 suicide than we do about suicide. Until just the  
8 last few years, our suicide information was often  
9 confined to numbers, and that's what you saw this  
10 morning was numbers. What I'm going to come to is  
11 a little bit more of granularity on both suicides  
12 and the issues around it. I think I'm preaching  
13 to the choir here when I say suicide is a tip of  
14 the iceberg in that it's a marker in many cases  
15 for mental health distress in the population,  
16 although not always.

17 The point that I want to make with my  
18 history slides is first of all that we have  
19 learned a lot which we are applying in combat now.  
20 There are differences between this war and others  
21 in terms of the repeat deployments and numerous  
22 stressors, and the connection with home -- the

1 e-mail, the Internet -- which is very relevant to  
2 our suicide since unfortunately a number of them  
3 happen after the "Dear John" e-mail.

4           The other thing that's very important is  
5 this is a war which has incredibly strong support  
6 from the American public. When I fly in uniform,  
7 as I will this afternoon when I'm going down to  
8 Fort Campbell, people come up to me in the airport  
9 all the time and say thank you. Having said that,  
10 we still have suicides; it's the major focus of  
11 attention for Army staff as you heard this  
12 morning, and we've got a ton of new programs.

13           This is a volunteer Army who know  
14 they're going to war. It's no longer people who  
15 come in simply for the education. Large reserve  
16 component. We have been doing surveillance  
17 ourselves and been studied by other people like  
18 never before. You all are here partly because of  
19 the DOD mental health task force. While there's  
20 been deficiencies found in our system, we've been  
21 given a lot of money to correct the deficiencies.  
22 One of the things we're conscious of is we've got

1 a lot of surveillance on soldiers -- and again  
2 you're going to see part of that -- we have less  
3 on families. We're moving to correct that. RAND  
4 is going to be doing a number of studies.

5 It's not all about post-traumatic stress  
6 disorder. It's not all about suicide. There's a  
7 range of different behaviors which are related;  
8 however, they range from the moderate to the  
9 completed suicides. People talk a lot about PTSD,  
10 and I just want to clarify for those who may not  
11 be familiar with it, what it is and what it isn't.  
12 And by the way, one of the bottom lines is PTSD  
13 does not equate to suicide. About 5 percent of  
14 our suicides have a diagnosis of PTSD, but that's  
15 rising over time. There's criterion that are  
16 covered in the Diagnostic and Statistical Manual,  
17 which include with the first criteria there what  
18 we call Criterion A, which includes the threat and  
19 intense fear. Now this is something that we've  
20 got a lot of internal debate about because many of  
21 our soldiers are trained to, when the bomb goes  
22 off, to pick up their weapon, lay down fire, and

1 go on and not to feel fear. But they may have the  
2 other symptoms nonetheless later. And the  
3 symptoms fall into the category of re-experiencing  
4 the trauma, numbing and avoidance, fight or flight  
5 response, which may cause impairment in  
6 functioning. And PTSD by definition has a  
7 persistence of symptoms.

8           So again a couple of big picture slides.  
9 I want to talk about where we've been and where we  
10 are and where we're going. We have been doing a  
11 lot of surveillance in the Army, and I'm going to  
12 come to that. We have -- under the leadership of  
13 Colonel Hoge over there who just retired and his  
14 colleagues -- we've done an incredible amount of  
15 surveillance in theater and back here. We've had  
16 problems, especially around the issues of access  
17 to care and stigma, which continue to be a problem  
18 now. Again, we'll come back throughout the course  
19 of your twelve months, but the bottom line I think  
20 for the rise in the suicide rate -- having been  
21 looking at this very hard for a while -- is that  
22 there's a lot of reasons, but fractured

1 relationships and getting in trouble are two of  
2 the main reasons. We know that our Services are not  
3 completely integrated, and we're working to fix  
4 that. And ever since the Department of Defense  
5 Center of Excellence stood up almost two years  
6 ago, we've been working closely with them.

7 We have some new programs and  
8 strategies. You heard about CSF, comprehensive  
9 soldier fitness, and the campaign plan this  
10 morning. We've also got a Child and Adolescent  
11 Center of Excellence. You are not going to hear  
12 about MHAT VI today because that's not been  
13 released. You'll hear about the other MHATs. But  
14 one of the things that we're very conscious of is  
15 the need for more behavioral health providers in  
16 Afghanistan. Again, we've spent a lot of money  
17 and we do have improved access to care. We've got  
18 almost 50 percent more providers than two years  
19 ago, and we've done better in terms of policies.  
20 Stigma is persistent. And where we're going is  
21 really trying to improve what we've got already.  
22 And then CHPPM, Center for Health Promotion and

1 Preventive Medicine -- I'm going to talk about  
2 them -- has really developed a very nice suicide  
3 analysis cell, and we're looking at doing, say,  
4 quick reactions when there's a cluster of suicides  
5 -- I think that came up this morning -- being able  
6 to send a team in right away. And we've actually  
7 already done that.

8 The other piece that's very important  
9 that you all may not have heard too much about is  
10 pain management. We're seeing a very high suicide  
11 rate in our warriors in transition. We are  
12 starting up an epidemiological consultation team  
13 to look at our warriors in transition.

14 Okay, so coming back to surveillance,  
15 again, we have been doing surveillance for the  
16 last eight years. We've got data from theater,  
17 which are the mental health advisory teams which  
18 are anonymous surveys. We've got clinical data  
19 from people going into the hospital. We've got  
20 the MHATs. We've got epidemiological consultation  
21 teams, EPICONS. That's a theme or idea that's  
22 drawn from investigations of infectious disease

1 outbreak like rotavirus, but what we are doing is  
2 that we have now done these in a number of places  
3 and we've learned some valuable lessons.

4           The Army or now the DOD suicide event  
5 report -- one thing that kind of got left out this  
6 morning that I wanted to come back to is that the  
7 ASER is new. Until 2001 we were doing  
8 psychological autopsies on our cases. And the  
9 psychological autopsies yielded a lot of very good  
10 information. They were usually thirty-page  
11 reports, and they sat in a desk drawer. And so  
12 for a number of reasons, we stopped doing them in  
13 2001, and the Army suicide event report was  
14 started in 2004. The DODSER just started last  
15 year. So this is -- as you come through and  
16 critique it, knowing that it's a recent and  
17 evolving process is very important. And we all  
18 know that it's got limitations, but we're trying  
19 to fix those.

20           And again, a number of other people who  
21 are looking at us, a RAND study came out a couple  
22 of years ago and then the suicide analysis scale

1 teams that I mentioned. We've sent a team into  
2 theater every year. And incidentally, when I was  
3 -- when we were first asked to present here, we  
4 were asked to present on the MHATs. And so I'm  
5 going to talk about them, but they're only a piece  
6 of the story because the suicides are -- they  
7 don't look at index cases in theater. They look  
8 at overall suicide rates, but not an analysis of  
9 the cases. Coincidentally, back in 2003 was when  
10 we had the first USA Today articles on the  
11 increased numbers. We had five in July of 2003 in  
12 theater, and five in October. And that was one of  
13 the factors behind the first mental health  
14 advisory team.

15           And so I'm going to give you some  
16 snapshots of MHAT V, and there's a lot more  
17 information -- again, I'm teasing you with the  
18 information. You're going to get more, but we  
19 have -- when you look at the difference between  
20 MHAT IV and V, these are all, again, anonymous  
21 self-report surveys -- so we've got depression,  
22 anxiety, acute stress -- not that much change.

1       What's more interesting is looking at over time.  
2       And the numbers are remarkably consistent over  
3       time at between about 15 and 20 percent of  
4       soldiers have symptoms of anxiety, depression, or  
5       acute stress. When the war went well in 2004  
6       before it went sour, things got better, and then  
7       when things were sour and then the surge, it went  
8       up again. And now it's beginning to come down.  
9       So this is OIF, Operation Iraqi Freedom, data.  
10      And again, MHAT VI is being staffed right now.

11                 Another thing that the data has shown us  
12      is the risk with multiple deployments. Morale  
13      goes down and any mental health problems go up.  
14      You heard a discussion earlier today about  
15      multiple deployments and suicide, and it's  
16      absolutely correct that as the people with  
17      multiple deployments do not have a higher suicide  
18      rate. It's more with the single deployment. But  
19      what sometimes gets lost in the discussion is the  
20      healthy-worker effect. In other words, people who  
21      are having mental health symptoms may well get out  
22      of the Army either through their own ETS or

1 medical board and not be around to deploy two or  
2 three times. So the data is a little bit more  
3 complicated than is there.

4 Stigma is a persistent problem. We  
5 measure it every year with our MHATs. And, again,  
6 these are the six standard questions we use. It  
7 actually got a little better between MHAT IV and  
8 MHAT V -- and to confuse you, MHAT IV and V  
9 doesn't mean that that's the year they did it in  
10 because we first started in 2003. So MHAT V was  
11 in late 2007 -- but the data that's not yet  
12 released and the data that's consistent, we  
13 haven't cured this problem yet. And this is very,  
14 very important to suicide prevention because still  
15 too many people never get the care; or if they get  
16 the care, they drop out and then they end up  
17 killing themselves.

18 So that's -- another thing that is  
19 relevant to this group is this is self-report  
20 data, and what you found is that the report of  
21 suicidal ideation increased during deployment and  
22 then decreased slightly again. And however,

1 there's -- and this is over time the rates -- now  
2 again, it went down in 2004 a little bit and then  
3 climbed. So the suicide rate in theater has  
4 tracked very closely with the other mental health  
5 symptoms.

6 Now one of the things about this is this  
7 is self report, so self report of suicidal  
8 ideation is not the same as completed suicides;  
9 but again, it's another piece of data that's  
10 interesting.

11 Now this is Afghanistan, little bit  
12 different from Iraq. And what you saw -- what we  
13 saw -- we've done three visits to Afghanistan.  
14 What you saw in 2005, things were doing pretty  
15 well in terms of morale. In 2007 when combat had  
16 gone up, morale came down, and depression,  
17 anxiety, and acute stress went up. So as combat  
18 gets worse, all these symptoms get worse as well.  
19 And the other thing that's striking about OEF is  
20 the level of combat experiences that soldiers now  
21 have. It's an incredible amount that have been  
22 attacked or ambushed, been wounded, been

1 responsible for the death of a combatant. And  
2 what you're going to see when MHAT VI comes out  
3 that all these numbers go up pretty dramatically.  
4 So the fight is now in Afghanistan.

5           You saw this slide earlier. This is the  
6 one that tracks and shows that the rate's  
7 increasing as compared to the general population.  
8 This one has an overlay of the conflicts on it.  
9 But until this current conflict, we really didn't  
10 find a direct relationship between conflicts and  
11 suicide. Many cases the suicide rate was lower in  
12 theater. And again, the rate over time has been  
13 going up.

14           So a couple of things about how we look  
15 and how we get the data. Back -- we've had since  
16 the First Gulf War, or after the First Gulf War,  
17 we put in the post- deployment health assessment,  
18 which was used to look actually mainly for  
19 physical symptoms, exposure to toxins -- remember  
20 Desert Storm syndrome? And we -- that was in  
21 place in 1998. We modified it as this war went  
22 on, and then we put into place a post- deployment

1 health reassessment. So the health assessment is  
2 as you're coming back, either in Kuwait or back  
3 here, and the reassessment is three to six months  
4 later. These were not created as suicide  
5 surveillance or suicide screening forms, but now  
6 there's a lot of interest in going back to them  
7 and seeing if they could be more robust in terms  
8 of suicide screening and DCOE is looking very hard  
9 at that issue right now. Bottom line, by the way,  
10 for those who haven't studied this is there's no  
11 quick and simple tool that's going to pick up  
12 people who are going to complete suicide. There  
13 are some tools that are normed on patient  
14 populations, but to apply them to our soldier  
15 population is something they've been working on.

16           And then the DODSER, which you heard  
17 about before, we implemented it based on the ASER  
18 and they're submitted for suicide behaviors that  
19 result in death. They are due within sixty days  
20 of the time that it's declared a suicide. And the  
21 nice thing about them is you get a lot of data in  
22 forms that you can slice and dice the data. The

1 bad thing about them is that they don't have the  
2 richness of the narrative that was in the  
3 psychological autopsy. So again, a lot of  
4 conversations about, should you go back to the  
5 psychological autopsy? Our strategy has actually  
6 been to take this data and combine it with all the  
7 other data we've got -- medical data, PDHA data,  
8 PDHRA data -- those are the assessment tools, all  
9 of the medical encounters, substance abuse data,  
10 and put that into a database. And again, CHPPM is  
11 working with the Army G-6, who is the Army  
12 information manager, working with Armed Forces  
13 Institute of Pathology and others, to let's  
14 integrate the data that we've got rather than  
15 create a new report.

16 One of the other things about suicides  
17 is besides the DODSER is the commander does a  
18 report that's a 15-6. If they -- in the Army we  
19 have a policy that if they died within two weeks  
20 of being seen by outpatient behavioral health,  
21 they get a root cause analysis done. So that's a  
22 J-code quality assurance document. CID has a

1 report, the criminal investigative department. So  
2 there's lots and lots of reports out there. The  
3 question is how do you integrate them and then put  
4 them in a format that you can get the lessons  
5 learned, which is what we're trying to do.

6 I wanted to talk a little bit about the  
7 EPICONS. As I mentioned, they're epidemiological  
8 consultation teams. We did the first one back at  
9 Fort Leonard Wood. Charles Hoge was on that team.  
10 And then we did one at Fort Bragg after the  
11 suicide/homicides. Fort Riley, Fort Hood, Fort  
12 Campbell were all suicide focused; and Fort Carson  
13 -- Mike Bell and his folks did and looked at both  
14 homicides and suicides. Why both? We find in  
15 most places where there's an increase in violent  
16 death, it's across the board. And bottom line,  
17 guns, alcohol, and infidelity, toxic mixture.

18 So what do you find? When you look at  
19 the individual risk factors, you see some related  
20 to deployment, especially as the number of  
21 deployments has gone up. Fort Leonard Wood is a  
22 recruit training station, and it was before the

1 war really started; a lot of combat intensity,  
2 family separation, legal and financial issues.  
3 And then I think more interesting than the  
4 individual issues -- which you can already tell;  
5 you know from our other data sources -- is what  
6 about the symptoms? And again, stigma is  
7 consistent; lack of access, especially for  
8 dependents in some cases. Often the risk points  
9 for soldiers are when they transition. And then  
10 problems with integration and behavioral health  
11 services and access, and then all of them  
12 standardized screening, tracking, and then  
13 leadership management.

14 Now I want you to realize that we have  
15 identified the problems, but we're also trying to  
16 fix the problems. So some of the policies that  
17 Bruce mentioned earlier in terms of signing in and  
18 out, well we're taking the lessons from the EPICON  
19 and we're saying what policies can we bring into  
20 place to try to reduce, say, the transition as  
21 being a high-risk period? We have these EPICONS  
22 available. They're not all for public release

1 because they were created for the installation,  
2 but again, in terms of good reading for you as you  
3 go west.

4 This data comes from Mike Bell and CHPPM  
5 for Fort Carson and it's looking at stigma. And  
6 the nice thing about this slide is it breaks it  
7 down into -- all stigma is not the same. Lower  
8 ranks are more concerned about what their buddies  
9 think. Higher ranks are more concerned about  
10 their careers. This won't surprise any of you who  
11 have been in the military, but they have very hard  
12 data that supports that. They did hundreds of  
13 focus groups and got this information.

14 One of the things I want to come back to  
15 is a security clearance issue. This has been my  
16 pet rock for a while. We have managed to improve  
17 it somewhat. You remember that the only question  
18 under "medical" was basically have you sought  
19 mental health counseling. Now they've changed it  
20 so you don't have to report it if your mental  
21 health counseling is a result of combat, but it  
22 still leaves other things in there. And for

1 example, going to alcohol counseling, you know,  
2 you've got to report that, and people are  
3 concerned that that's going to be the end of their  
4 clearance. So this I need your help on. I have  
5 been unable to move this rock off our plate  
6 completely. I don't know how many spies go to  
7 mental health counseling or go to AA, but I think  
8 the numbers that you'll find there are relatively  
9 few.

10 Okay. I'm going to talk a little bit  
11 about some of our resiliency programs, and then  
12 I'm going to come back to more specific suicidal  
13 data. So again, we've done a lot, we've got a lot  
14 of programs out there. We've got a lot of  
15 educational products out there. You all, I'm  
16 sure, are familiar with Battlemind. This has been  
17 our enterprise solution to focus on the strengths  
18 for the warrior. We have done all sorts of CDs  
19 for kids. These came out of the Madigan Center of  
20 Excellence that I mentioned, and you've probably  
21 seen the "Sesame Street" as well.

22 Another area we're really focused on is

1       how we bring people back home in an optimal  
2       manner. This is an example from the 3rd ID in  
3       terms of how can we reunite. Back to the Fort  
4       Bragg EPICON, one of the things we found is that  
5       the index cases were on the battlefield in  
6       Afghanistan one day, and back in the bedroom with  
7       their wife the next. And that was disconcerting;  
8       sleep deprivation, irritability, et cetera, et  
9       cetera, and then the gun in the nightstand.  
10      Warrior adventure quest is a relatively new  
11      program for us. It's really exciting I think.  
12      The idea is as you bring people back home, let's  
13      have some high-adrenaline adventures that you do  
14      with your unit. And as new people come into the  
15      unit, you integrate them there so that you can  
16      promote that feeling of cohesion and bonding. And  
17      for those of us like John and I who have been in  
18      the Army for a while, we think it's all about good  
19      unit cohesion and bonding unless you're not part  
20      of the unit. If you're the outcast, then that's a  
21      high risk. So this is not a suicide prevention  
22      program per se, but I think has a lot of potential

1 to help with integration. And so it's looking at  
2 this period here as people are coming back and  
3 looking at the array of destructive behaviors, not  
4 just suicide. So trying to increase bonding, both  
5 horizontally, vertically, and retaining the esprit  
6 décor. And again, this is a new program. I think  
7 it's too early to tell, but it's got a lot of  
8 potential to it. And again, like with everything,  
9 I let you know we can have more details as needed.

10 But I wanted to come back to suicide in  
11 the Army to close out the talk here; to give you a  
12 little bit more granularity. We think that  
13 suicide prevention -- you can get a lot of  
14 information about those who have suicided, but how  
15 does it actually lead to programs or programs on  
16 attitude which decrease suicide? I mean, I can --  
17 if Aaron suicides, I can look at his case, but  
18 it's not going to keep me from knowing how another  
19 Marine -- to prevent suicide and similarly with  
20 the other subjects.

21 A couple of things on risk factors:

22 This is a summary slide. Different than the

1 civilian world, although there is some psychiatric  
2 illness in the Army, we don't see it as a major  
3 player -- major psychiatric illness. What we do  
4 see is a lot of people are referred to mental  
5 health. Almost half of our suicides have been  
6 seen by mental health in the year before they  
7 died. That may be a referral from a PDHA or RA.  
8 It may be as a part of enlisted separation. We  
9 don't have the ability to really break that data  
10 out yet. We know we're touching mental health,  
11 but our major -- but we're not getting major  
12 psychiatric illness -- depression, bipolar,  
13 schizophrenia are small parts of it. I mentioned  
14 5 percent had a diagnosis of PTSD. Interestingly,  
15 about 5 percent have a diagnosis of personality  
16 disorder. That's lower than I would have thought.

17 Big issues are relationships  
18 consistently two-thirds to three-quarters, legal  
19 and occupational problems. A lot of people,  
20 they're both. Substance abuse -- about 16 percent  
21 of our soldiers are intoxicated at the time, which  
22 is a little lower than the civilian world, and

1 probably about 25 to 30 percent have a substance  
2 abuse problem. Pain and disability in our warrior  
3 in transition, and we're seeing trends to older,  
4 higher-ranked females. And the important part of  
5 this is traditionally, we all say it's the young  
6 white males, and our suicide prevention programs  
7 have been targeted there. So we have to have more  
8 targeted. And then firearms -- almost all  
9 suicides in theater are with the soldier's service  
10 weapon. About half of the ones back here are with  
11 their personal firearm. And you know, going back  
12 to that EPICON slide, where did you see the  
13 suicides? They're at Fort Carson, Fort Campbell,  
14 Fort Riley, Hood's not that high, and Stewart.  
15 What do all those places have in common? They've  
16 got easy access to weapons, and they're now  
17 putting gun shops into our PXs, which is something  
18 that I have some difficulty with.

19 Now, I've mentioned the CHPPM data a  
20 couple of times. This is one example of a slice  
21 of the data. So looking at all suicides from 2001  
22 to 2009, that's 817. That's a big enough body of

1 data that you can really look at it, and you can  
2 break it down any way you want, and we've done  
3 that. Look -- I've got to show you, though, this  
4 divorced, separated, or widowed -- very small  
5 number. So -- this is a joke before I say it --  
6 we are now recommending instead of marriage  
7 enrichment programs that we encourage divorce as a  
8 protective factor for suicide. That was a joke  
9 for those of you in the audience. What we do  
10 think in interpreting this is that by the time  
11 somebody gets divorced, probably the angst around  
12 the relationship has gone and the relationship is  
13 sort of over with at that point.

14 And so we can look at that by MOS, and  
15 here are your -- more of your combat soldiers and  
16 then some of the other branches of soldiers. And  
17 we can look at it by different method of death:  
18 And as I alluded to before, but graphically here,  
19 gunshot wound; and then second is either hanging  
20 or choking, any of the other asphyxiation methods.  
21 And the others are pretty much at the bottom. And  
22 for those of you in the business, you know this,

1 but just to emphasize that guns are lethal, and  
2 it's a very short flash-to-bang to use a weapon.  
3 And so if somebody has a bad day, gets a "Dear  
4 John" e-mail, it's just really easy if they've  
5 got the gun easily available.

6 I mentioned already, but I wanted to  
7 highlight it that the trends in all ages are going  
8 up, including what we historically thought of as  
9 -- is this working okay? It's not really showing  
10 up -- the green line is the older soldiers, so  
11 it's going up in that population as well, and  
12 related to that also it's going up in the rank.  
13 It's going up every where. By components, it's  
14 going up in the regular Army and then the Reserves  
15 and Guard. There was some conversation this  
16 morning about the Reserves and Guard. I'd like to  
17 emphasize again that that's been an ongoing  
18 process. Three years ago we really didn't have  
19 good information about the Reserve component.  
20 We've gotten more over time, much easier to get on  
21 those who die on active duty. And again as Bruce  
22 said this morning, those who have left active

1 duty, it's very hard to get good information on  
2 but we're hoping to track that with the VA.

3 Place of death, most in the U.S., but  
4 quite a few in theater. Now one of the good news  
5 stories about this is that the suicides have for  
6 the first time did not increase in suicide last  
7 year. Now Mr. Morales and I take great credit for  
8 this. Walt, I'm about to give you credit. Okay.

9 Walt and I went over in 2007 to a theater at the  
10 invitation of General Odierno, and we did a staff  
11 assistance visit over there. We didn't call it an  
12 EPICON. We did it in conjunction with MHAT V, and  
13 we made a number of recommendations to the command  
14 over there, which they went running with,  
15 including doing things like having a suicide  
16 review board. And basically what we'd had before  
17 that is we'd had garrison suicide programs put in  
18 theater, and so we tried to translate that. And  
19 so I don't know whether actually that made a  
20 difference or not, but as I said, Mr. Morales and  
21 I take credit whenever we can.

22 Suicides again seem to track very well

1 with mental health trends and everything's been  
2 going up. I don't have the slide with me, but I  
3 do have a slide if you want to see it on suicide  
4 attempts which have also gone up as well.

5 And if you look at the burden of injury  
6 and disease, what you see over time is the mental  
7 health keep going, and consistently we've been  
8 right after injury. Now that was true before the  
9 war started, too, that mental health -- and  
10 usually your top two reasons of hospitalizations  
11 were pregnancy and inpatient psychiatry  
12 hospitalization as well.

13 One of the things we've also been  
14 talking about, we really scaled down our inpatient  
15 psychiatry after -- or actually after the First  
16 Gulf War, and we probably don't have enough  
17 inpatient psychiatry beds. We certainly have  
18 closed at some places and shipped everybody  
19 downtown, and that's something that we are saying  
20 very hard, do we need to reopen inpatient  
21 psychiatry at Fort Carson or Fort Campbell or Fort  
22 Riley? And a lot of us would like to do that, to

1 actually get the staff to do it and the facility  
2 is a stumbling block but that's something that  
3 we're looking at.

4           So just to close because I know we're  
5 close to my witching hour, but we started a little  
6 late. What has been what we've done in the past?  
7 Well, we've done the looking at the suicides with  
8 the DODSERS and the EPICONS. We've done the  
9 screening. One other thing that I didn't talk  
10 about here is RESPECT-Mil. That's Chuck Engel's  
11 program, which is training primary care in  
12 screening, identification of depression, and PTSD.  
13 We've now got this well rolled out -- it's at 43  
14 different Army clinics -- and the data is very  
15 positive about that. And then we've done all  
16 kinds of training materials that some of you who  
17 have been around for a while will remember, like  
18 ACE -- ask, care, escort. We discussed  
19 Battlemind, an interactive video called Beyond the  
20 Front, and it's part of our stand-down training.  
21 This is your ACE card. We really started fielding  
22 these about a year ago. The thrust behind this is

1 two-fold. One is buddy aid. The other is from  
2 looking at our suicides and our data, we found  
3 that one common theme was that people were  
4 concerned so they went to get help, and by the  
5 time they came back with the Chaplain or the MPs  
6 or the command, the soldier was dead, so basic  
7 behavioral health, escort your buddy. And these  
8 cards have permeated the place. I was on the bus  
9 to Capitol Hill yesterday, and you know, people  
10 have them in their tags and everyplace else. And,  
11 of course, you guys are at the bottom of this. So  
12 we've got suicide awareness down, and we have some  
13 basic education down. The suicide prevention task  
14 force, as you heard before, it has 240 tasks.  
15 This is a little bit of a schematic of how it  
16 rolls through the different directions that Bruce  
17 told you about this morning and spins out into  
18 tasks. And there's beginning to be some headway.  
19 Is it -- you never know what's cause and effect,  
20 but there were 41 suicides was it in January and  
21 February of this year, which was a big bollix, and  
22 now our numbers are looking a little better

1       although the annual numbers are probably going to  
2       be higher than they were last year.

3               One of the areas we think we're lacking  
4       in is that we get people into the clinic, but we  
5       don't necessarily keep them from killing  
6       themselves. And so how can we as providers or as  
7       Chaplains, et cetera, do better suicide risk  
8       assessments? And under the direction of Colonel  
9       Castro from MRMC, he's held a number of different  
10      workshops to look at this. And how can we really  
11      translate this? We tend to do very well at  
12      looking for a mental health diagnosis. Having  
13      said that -- I caveat myself a lot -- one of the  
14      problems is that whether we do screening or  
15      assessment, often the person is fine then. But  
16      then it's later that they get the "Dear John"  
17      e-mail and your assessment from two weeks ago  
18      means nothing in the face of whatever catastrophic  
19      news that they have just gotten. And so we screen  
20      people intensely, but that alone is not enough.  
21      We know that we need to make sure that everybody  
22      is up to date and using evidence-based treatment.

1 And in order to do that, as you all are well  
2 aware, our workforce has been very stretched, our  
3 behavioral health workforce. Again, we've added a  
4 lot of providers in the last two years, but we're  
5 still not where we'd like to be in terms of  
6 providing enough evidence-based treatment.

7 But the final point that I want to leave  
8 you -- I've really become a convert to the public  
9 health approach. I got my MPH about four or five  
10 years ago, and it corrupted me. Because we really  
11 think that we have to move the whole risky curve  
12 back -- and let me come back to this -- so what we  
13 think we've done -- and this, again, is courtesy  
14 of Mike Bell and looking at Fort Carson -- is  
15 we've got a lot of things that have pushed our  
16 suicide prevention over this way. And what goes  
17 along with it is often criminality, alcohol or  
18 drugs. One of the things we see is that when a  
19 unit comes back, a third of its leadership changes  
20 out. The leaders say they don't know their  
21 soldiers anymore. The soldiers are coming and  
22 going -- turbulence -- there's community factors.

1 I mentioned gun control laws, but I also need to  
2 mention drugs -- the methamphetamine labs in the  
3 meadows behind Fort Carson or in the hills in  
4 Hawaii or wherever else. The installations are  
5 not pure bubbles; there's a lot of influence  
6 within the community. When we looked at Fort  
7 Bragg, we saw it's a 95, so again, the guns and  
8 the drugs coming up and down. So it's not just a  
9 community.

10 And so what we think we ought to do is  
11 push everything back to this side. And again,  
12 with all the things you heard about with the  
13 campaign plan with a lot of focuses on  
14 reintegration, however you do it, and we've got a  
15 lot of ways to do it.

16 I want to look at what I just said in a  
17 similar way. This is sort of a three- dimension  
18 strategy. There is the identification of  
19 high-risk individuals. There are looking what are  
20 common risk factors, but then there're also the  
21 population-based strategies. So we think we've  
22 got to have this approach overall.

1           So I'd like to end with this slide,  
2       which is -- again, I think we've got a pretty good  
3       sense of what the difficulties are. Again, I  
4       teased you with the data. I promise you we will  
5       give you enough data so that you can fly back and  
6       forth from the West Coast many times because I  
7       know you're hungry for more of it. And that's  
8       actually what really led to the suicide analysis  
9       cell. We were all saying, we want more  
10      granularity. We want to know. And we -- we're  
11      not all the way there, but we're probably about 80  
12      percent there.

13           Continuing problems -- I've covered most  
14      of them. What I didn't mention was Tricare, our  
15      own fatigue. Again, pain control is a big issue,  
16      and we've got a new pain management task force  
17      headed by Brigadier General Tom Thomas. And what  
18      we're trying to do is -- opioids are great, but  
19      they have a lot of problems. So what kind of  
20      complementary and alternative therapies can we  
21      use? We're using a lot of acupuncture. We're  
22      using some yoga, but we really want to standardize

1 that. Another thing that we've got a lot of  
2 emphasis now on is telebehavioral health. One of  
3 our more recent mandates was, how do we spread  
4 that in Afghanistan? Issues around bandwidth are  
5 there, but we have been given, again, very senior  
6 Army leadership support in terms of using  
7 bandwidth.

8 So I'm going to go ahead and close there  
9 and take any questions. I won't be able to stay  
10 for the panel later because I've got to leave for  
11 the airport about 3:00 p.m., so if we can have any  
12 questions now, I'd be happy to take them.

13 QUESTIONER: Thank you for that  
14 presentation. Could you go over again the numbers  
15 from the Army in terms of what kind of mental  
16 health contact has taken place for those who have  
17 died by suicide?

18 COLONEL RITCHIE: Yes, sir. The number  
19 I gave you is about 50 percent have seen some form  
20 of mental health in the year before they died.  
21 About half of those, or a total of a quarter, have  
22 seen mental health in the month before they died.

1 Next you're going to ask me how many have seen  
2 medical? And I'm not sure if I have those numbers  
3 at the front of my head; it's pretty much --  
4 pretty similar -- and I'll get those exact for  
5 you. But, again, since we're now screening  
6 everybody with a post-deployment health assessment  
7 and reassessment as they come back, a lot of those  
8 visits are occasioned by routine screens. And  
9 then, of course, we have some places where we have  
10 everybody be seen by mental health such as the  
11 program we had out at Madigan called SWAP, soldier  
12 wellness assessment program, which is now morphed  
13 into the SELF and is at Tripler as well. So by  
14 their standards, everybody coming back has seen  
15 mental health. So I don't want you to think that  
16 everybody has a mental health problem, and I say  
17 that because the Army Science Board looked at our  
18 suicides -- and you need a copy of their report,  
19 too, because they looked at this whole issue in  
20 detail last fall -- and they said, well, everybody  
21 who had been seen for PTSD, TBI, had a mental  
22 health issue, and it's really high -- you

1 shouldn't lump it all as having a diagnosis. But  
2 we also have the exact diagnoses -- adjustment  
3 disorders, depression, schizophrenia -- and I  
4 think that that's a lot more helpful. Having said  
5 that, it does mean people are coming to mental  
6 health so there's an opportunity for intervention,  
7 and that's what we're struggling with -- are we  
8 missing an opportunity for intervention?

9 QUESTIONER: Marjan Holloway. Thank you  
10 for your presentation. I had a couple of  
11 questions to ask you about slide 22, just for  
12 clarification, and this is the EPICON data that  
13 you presented. So the first question is, are  
14 these referring to individual suicides or do you  
15 have more than one suicide within each group?

16 COLONEL RITCHIE: Good question, ma'am.  
17 These usually take place in clusters of suicides;  
18 that's why we do an EPICON. Having said that,  
19 Fort Leonard Wood was two recruit suicides, and at  
20 that time, suicides among recruits were quite  
21 rare. Fort Bragg was -- we went down there to  
22 look at the index cases which were four homicides

1 -- two were suicide/homicides -- but we broadened  
2 it to look at suicide as well. Fort Riley was  
3 about 12 suicides. Fort Hood was about 12  
4 suicides. Fort Campbell was, I think, 14  
5 suicides. And Fort Carson -- they were  
6 principally looking at 14 homicides, but they  
7 looked at suicides as well. And what we do with  
8 an EPICON is we look at the index cases in great  
9 detail -- CID records and everything else -- but  
10 then there's also surveys done, focus groups done,  
11 and information and then a report is put together  
12 which goes back to that installation commander.  
13 And there're also variations of these. These have  
14 -- Fort Bragg was a public document. These others  
15 were not. Public documents -- because they were  
16 reports for the installation commander, and we  
17 wanted to be able to let them know what was going  
18 on on their installation. But at the same time we  
19 wanted to capture the information that we got.  
20 One of the reasons I'm so excited actually about  
21 the Army suicide prevention task force is we've  
22 been making recommendations for years, but without

1 a way of enforcing the recommendations and with  
2 the rapid turnover, you can make them and, you  
3 know, you leave and then they just hang there.  
4 So, but what the Army suicide task force is -- I  
5 think it's taken just about every recommendation  
6 that's in the EPICON and turned it into a task.

7 DR. HOLLOWAY: Thank you for the  
8 clarification. I think the item on the table,  
9 under individual risk factors, that really peaked  
10 my interest was what you have under previous  
11 gestures, attempts, and behavioral health contact.  
12 Now I would assume that you would agree that  
13 previous suicide behavior would be somewhat  
14 different than behavioral health contact. Do you  
15 know if -- what percentage of individuals who had  
16 suicide had previous suicide behavior based on  
17 what you had seen?

18 COLONEL RITCHIE: I do know that. Let  
19 me double check the exact figure, and let me make  
20 sure I answer the question because I've talked  
21 about -- do we have anybody from CHPPM here who  
22 can -- okay, when I break I'll pull up that exact

1 number because I've got it. You're asking a  
2 different question than behavioral health visits.  
3 You're saying previous suicide attempts?

4 DR. HOLLOWAY: Right, right, because  
5 right now I think the way you have it on the slide  
6 is all three are lumped together, and basically in  
7 my head I was thinking of gestures and attempts,  
8 focusing on possible suicide behavior.

9 COLONEL RITCHIE: Bruce is going to sift  
10 through -- I don't have my glasses on, you give --  
11 what's the number? Okay, now I'll put my glasses  
12 on. Thank you, Bruce.

13 DR. SHAHBAZ: 13 percent.

14 COLONEL RITCHIE: Okay, wait, where are  
15 we because of the self injury? History of self  
16 injury is 13 percent. Bruce, why don't you pass  
17 that around because I didn't put it all on the  
18 slide set, and I think it would be good for people  
19 -- get a copy to the people.

20 DR. SHAHBAZ: Ma'am, that 13 percent is  
21 a history within the military. We, of course,  
22 don't know if they don't self report about a

1 history prior to coming in the military. So what  
2 our focus and our data collection is a history, a  
3 documented history, within the military health  
4 system versus prior history. And allow me to add  
5 one other caveat to that. If they -- on occasion  
6 we've run into soldiers who on leave have had a  
7 suicide attempt and then not claimed a Tricare  
8 claim. Again, we don't know about it because it  
9 doesn't come back into our documentation. So we  
10 know we're missing part of that data.

11 COLONEL RITCHIE: But having said that,  
12 I want to emphasize what the data does have in it  
13 which is miles ahead of where we were even a year  
14 ago, which is the Army suicide event report, or  
15 DODSER now. It's all medical visits, it's PDHAs,  
16 and PDHRAs, it's substance abuse visits, it's got  
17 if there's any domestic violence information in  
18 there, any legal history that's recorded. So it's  
19 a very nice and, again, it's on over 800 suicides.  
20 As time has gone we've have more complete  
21 information on the later suicides because, of  
22 course, we didn't have the PDHRA before that. We

1 didn't have some of this, but it's a pretty rich  
2 data source.

3 DR. HOLLOWAY: Thank you.

4 COLONEL RITCHIE: Any other questions or  
5 should I yield to the Armed Forces Institute of  
6 Pathology? Since they're a DOD organization, I  
7 think I'll yield to my friends from AFMES, Armed  
8 Forced Medical Examiners Office, and the Armed  
9 Forces Institute of Pathology. Thank you very  
10 much.

11 MAJOR GENERAL VOLPE: Thanks, Colonel  
12 Ritchie, appreciate it. Thank you.

13 COLONEL RITCHIE: I would pull up your  
14 slides, but I'm not sure if I know where they are.

15 MAJOR GENERAL VOLPE: All right, as  
16 discussed earlier, we'll go ahead and roll instead  
17 of into a break we'll roll into the presenters  
18 from the Armed Forces Institute of Pathology and  
19 we have a team of them with us today. Captain  
20 Joyce Lapa Cantrell; Commander, is it Rosemary  
21 Malone? Okay, and then Ms. Lynne Oetjen-Gerdes.  
22 And if you would, please, we don't have bios on

1 you so if you'd just tell us a little bit about  
2 yourselves when you begin your talk.

3 CAPTAIN CANTRELL: I need one of you  
4 admin people to come up and pull slides because I  
5 don't know where they are.

6 Okay, well while we're waiting on the  
7 slides, I'll go ahead and give my bio. When  
8 Commander Feeks asked, you know, who was the one  
9 person at AFMES, Armed Forces Medical Examiners,  
10 who would be an expert on suicides -- well, if  
11 you're talking about epidemiology that would be  
12 Lynne Oetjen-Gerdes. She's been there -- she's  
13 been in the office for five or six years. I've  
14 only been there about a year now. But when I  
15 started thinking about it, I thought, well, I have  
16 a medical examiner background so I'll go ahead and  
17 start off.

18 In the first half of my career, I was in  
19 pathology and a forensic pathologist and I started  
20 out in Okinawa as the regional medical examiner  
21 for the Western Pacific. Then I came back to  
22 AFMES and spent six years there and part of that

1 time I was the chief of operations. Then I left  
2 in 2001 and did a preventive medicine residency at  
3 USUHS, went and did vaccine research for about  
4 five years. And then when this position opened up  
5 as a preventive medicine officer at the medical  
6 examiners, you know, I thought that would be a  
7 great fit for me having those two specialties.

8 Okay, so I'm going to go first. I'm  
9 Captain Cantrell. Then Lynne or Dr. Malone;  
10 she's been with us less than six months -- what  
11 was it, April or May you came in? She's a  
12 forensic psychiatrist, a great asset in addition  
13 to our mission. She's going to talk a little bit  
14 about the psychological autopsies. And Ms.  
15 Oetjen-Gerdes is going to talk about the  
16 epidemiology.

17 So we're going -- I'm going to basically  
18 tell you how we get the suicide numbers to start  
19 with. Okay, so the topics I'm going to talk about  
20 doing the autopsies on the active duty and the  
21 investigations in case of suicide, the  
22 standardization of the classification, and then

1 Dr. Malone will talk about the psych autopsies and  
2 Ms. Oetjen- Gerdes about the epidemiology.

3 Okay, these are the in-house  
4 capabilities that AFMES has. First we have  
5 operations. Those are the medical examiners and  
6 the investigative agents, and we have a CID agent  
7 right now who's the liaison staffer, DOD  
8 investigations. We also have an NCIS agent, but  
9 she's leaving, and she's basically just a freebie  
10 right now. We have other investigators that get  
11 on-the-job training, but they're not, you know,  
12 they're not like CID, OIS types. We have the DNA  
13 identification laboratory and the forensic  
14 toxicology lab, mortality surveillance which is --  
15 I'm the chief of the mortality surveillance, and  
16 that has only been around for about seven years  
17 now. And then the psychological investigations  
18 which Dr. Malone is -- she has a staff of two now,  
19 but she's working on that. So I just want to  
20 explain a little bit about -- there's some  
21 misconceptions about in doing the suicide  
22 investigations, what actually there's -- I hate to

1 break it up this way, but to understand it,  
2 there's, you know, medical examiners, they do the  
3 cases. They do have a complete medical-legal  
4 investigation, which includes the autopsy and the  
5 investigation. And they will never usually rule  
6 on a case without getting the complete  
7 investigation, but in terms of how these two are  
8 combined, I decided to break it out just to  
9 explain that there's kind of a mixed bag of what  
10 we get in terms of the quality of these  
11 investigations and the data that we can capture.  
12 So in terms of just doing the autopsy and not  
13 doing the actual scene investigation and  
14 collecting the evidence and interviewing people  
15 about what happened, that type of thing, but just  
16 in terms of the autopsies, we refer to the cases  
17 that are done by the military medical examiners as  
18 M.E. cases. And so these are going to include all  
19 the cases where the person dies or ends up  
20 somehow, the decedent ends up in exclusive federal  
21 jurisdiction. So it's going to include almost all  
22 OCONUS deaths, especially like all the theater

1 deaths, they all come through transportation, you  
2 know, through Ramstein, into the Dover Port  
3 Mortuary. And just by virtue of the fact that  
4 they end up at Dover, they are on exclusive  
5 federal jurisdiction so we have complete  
6 investigative, jurisdiction, and also the medical  
7 examiners will do all those cases. They will all  
8 get an autopsy.

9 In CONUS it's different because we don't  
10 have exclusive federal jurisdiction in a lot of  
11 places where these deaths occur. Now a lot of the  
12 military installations are so if the death occurs  
13 on Fort Riley, for example, it's exclusive  
14 federal, it will be done by an AFMES-affiliated  
15 medical examiner.

16 Then there're other cases -- if it's not  
17 an exclusive federal jurisdiction, it can go  
18 different ways. The civilian coroner or medical  
19 examiner can release the jurisdiction to us in  
20 which case we'll usually send someone. They'll  
21 have to travel usually. And they'll go do the  
22 case. They may do it at a civilian medical

1 examiner's office. They may allow them to  
2 transport the body to an MTF to do the autopsy.  
3 Sometimes it's done in a mortician's facility. So  
4 it's quite a mixed bag out there.

5           And then there are cases where the  
6 civilian medical examiner or coroner will say they  
7 want jurisdiction, they're going to do the autopsy  
8 and the investigation, and they really do not want  
9 the military trying to intervene or get involved  
10 in any way. They will usually always give us a  
11 report when they're done, but, you know, that's  
12 pretty much our involvement in those cases.

13           Also just want to mention one thing is  
14 that when I'm saying "investigations," I'm talking  
15 about from a medical examiner's standpoint, so  
16 this is kind of -- if you want in a criminal sense  
17 of investigation, even though these aren't crimes,  
18 they're going to be conducted, you know, like a  
19 police department would do an investigation. And  
20 so it's not going to include things like quality  
21 of care, you know, if there was a suicide that  
22 occurred while the person was in a hospital,

1 they're not going to look into quality-of-care  
2 issues in these investigations.

3 And then just to point out that the  
4 authority for doing the cases that we do in  
5 exclusive federal jurisdictions are derived from  
6 this federal law, 1471, and it's implemented  
7 through DOD.

8 Okay, now I'm going to talk about the  
9 investigation of the cases, not the autopsy. So  
10 if it occurs in exclusive federal jurisdiction,  
11 the death, it's going to be investigated by one of  
12 the investigative agencies, either OSI, CID, NCIS.  
13 And I can't speak to, you know, the  
14 standardization across those agencies in terms of  
15 how they investigate, but on the whole they're  
16 usually pretty complete investigations and these  
17 agents are pretty well trained to do these cases.

18 Okay, and so then there are cases like I  
19 said where the civilians will allow an  
20 AFMES-affiliated medical examiner to do the case,  
21 but they will retain jurisdiction in terms of the  
22 investigation. So they'll have a local P.D.

1 usually doing the investigation. And my  
2 understanding is, like for Army for example,  
3 they'll have a collateral investigation -- they'll  
4 open up a collateral, but basically all they're  
5 doing is saying that, you know, this step occurred  
6 and they're getting the police report from that  
7 particular jurisdiction and that'll pretty much be  
8 their involvement in the case.

9           Okay, and then just a little bit more  
10 about this -- when we have -- when I say an  
11 AFMES-affiliated M.E., I'm talking about either  
12 one of the medical examiners at our central office  
13 in Rockville -- there's about ten of them there  
14 now -- or we have scattered around the world we  
15 have medical examiners like, for example, Okinawa,  
16 Japan. I think they have always -- as far as I  
17 know, they've always had a medical examiner there  
18 so the cases, the deaths in the Western Pacific  
19 will often go there and be autopsied there.  
20 There's one in San Antonio. Right now there's one  
21 in Fort Smith. San Diego doesn't have a military  
22 M.E. there, but they do have somebody that's in

1 the Air Force Reserves that often will do these  
2 cases.

3           These examples where the civilian gives  
4 us the jurisdiction, we're going to do a complete  
5 autopsy; it's going to be a very high standard of  
6 care exam. They're going to do whatever it takes,  
7 like if it's a hanging, they're going to usually  
8 do a very detailed examination of the neck and  
9 look for any evidence that -- I mean, suicidal  
10 hangings usually don't, for example, have  
11 fractures of the bones up in the neck, so they're  
12 going to look and make sure that it wasn't  
13 fractured, you know, that type of thing. And  
14 they'll get a full set of toxicology; it'll come  
15 back to the toxicology lab at our office, and they  
16 have a very high quality of output, you know, in  
17 the forensic tox there. So from that aspect,  
18 it'll be a very good investigation, but on the  
19 investigative side, it's going to be a mixed bag.  
20 Some of them will do a very cursory investigation,  
21 you know, they go in -- hanging, doesn't look like  
22 there was anything else going on there, you know,

1 they're done with it. They don't really, you  
2 know, push on or interview anybody else, that type  
3 of thing. So I just wanted to let you know from  
4 -- I think there's -- some people assume that  
5 these cases all get the same, you know, amount of  
6 scrutiny when they're being investigated, but  
7 that's not the case.

8 We do, however, get notified about these  
9 cases through the DCIPS, the defense casualty  
10 information processing system, and pretty much in  
11 real time. I mean I think there's occasionally  
12 some that don't come to us right away, but we try  
13 to contact -- we have staff that contact these  
14 offices every morning and ask, you know, what are  
15 you going to do with this case? Some of the  
16 medical examiners, civilians, will only do an  
17 external examination. They won't do a complete  
18 autopsy, and usually if they're not going to do a  
19 complete autopsy or tox, then these staff of ours  
20 they'll go and talk to the operations officer and  
21 say, I'm concerned that, you know, they're not  
22 going to do an autopsy. And then they'll leave it

1 to, you know, our medical examiners staff to call  
2 and say, would you consider doing it or would you  
3 allow us to send one of our medical examiners to  
4 do the case?

5           Okay, so basically the bottom line is  
6 there's, you know, this, like I say, this mixed  
7 bag of the quality and the quantity of data that  
8 we get out of these autopsies. And if it's an  
9 M.E. case, you know, we don't have to go looking  
10 for the data. We -- it's, you know, it all comes  
11 through our office except for the ones where the  
12 investigation isn't done in our office. But  
13 outside of our office, sometimes this can be  
14 problematic. As been mentioned before, it can  
15 take months to, you know, even a year to get these  
16 autopsy reports from the civilians.

17           And this is just to show -- I know it's  
18 a very busy slide, but if you look really down at  
19 the bottom, the number of cases that are M.E.  
20 cases -- now it's not broken out by which ones are  
21 M.E. cases and have DOD investigations, and which  
22 ones are M.E. Cases and have civilian

1 investigations, but you can see overall the Army  
2 and the Marines have, you know, close to 50  
3 percent of the suicides being M.E. cases. And  
4 with the Air Force and Navy, it's more like -- I  
5 don't have my glasses on -- but I think it's less  
6 than 20 percent overall, averaged over the, you  
7 know, time period from 2003 on.

8           Okay, now I'm going to talk a little bit  
9 about classification because that's, you know, the  
10 basic process that, you know, underlies all this  
11 epidemiologic reporting and analyses. Before my  
12 time this was hashed out in the SPARRC committee,  
13 the suicide prevention and risk reduction  
14 committee, in collaboration with mortality  
15 surveillance division. And it came out as a memo,  
16 which I'll show you in a minute, from Under  
17 Secretary of Defense in June of 2006. And what  
18 it's going -- what it resulted in was -- well, it  
19 didn't result in -- the first full -- the M.E.  
20 cases -- in the case of the, you know, where our  
21 M.E.s do the case is basically -- they're going to  
22 rule it as a suicide and that's how it's going to

1 get counted, you know. But when we get the data  
2 on the non- M.E. cases, we have staff that review  
3 the case and if it seems that their classification  
4 is inconsistent with the way our medical examiners  
5 staff would classify the case, then there's  
6 usually a consultation will be generated and these  
7 cases are usually discussed in consensus, you  
8 know, with the medical examiners and they have  
9 meetings, you know, several meetings a week to  
10 discuss cases like this. And if you see at the  
11 bottom, this can result in some discrepancies when  
12 you look at the reporting that comes out of DCIPS  
13 versus the reporting that comes out of MSD and  
14 which is also done in collaboration with the SPPM.  
15 And that's because some civilians will call --  
16 it's mostly gunshot wounds like to the head mostly  
17 -- they'll call them accidents when we call them  
18 suicides. And, you know, I can tell you one case  
19 I saw where this person reportedly had a history  
20 previously of showing off with his gun, you know.  
21 He would pull it out and load it and unload it,  
22 and then point it at his head and, you know, click

1 it. He'd been observed to do that on previous  
2 occasions. Well, this particular time, he ended  
3 up shooting himself. That was ruled as an  
4 accident by the civilian medical examiner, but we  
5 classified it as a suicide. And that's how it got  
6 reported through the SPARRC in the official  
7 epidemiologic reporting, even though officially it  
8 will always be an accident because that civilian  
9 medical examiner ruled it that way. And this is  
10 just to show you the memo that was put out, and  
11 this particular middle area is just, you know --  
12 the whole reason this collaboration was done was  
13 to remedy inconsistencies in the reporting. And  
14 this was how it was decided; it would be an  
15 attempt to standardize the reporting back in the  
16 2006 timeframe.

17 And also just to give you the basis of  
18 what the medical examiners use to classify  
19 suicides is the National Association of Medical  
20 Examiners, which is the professional body that the  
21 medical examiners belong to. This guideline came  
22 out in 2002, and this is what they adhere to and

1 they're also -- our office is going to be carved  
2 out of AFIP with the BRAC. That's coming up  
3 probably within the next six months. We're going  
4 to be taken out from under AFIP and so we are  
5 applying for accreditation by the NAME.

6 So just to tell you what, you know, name  
7 class -- or how they define suicide results. It  
8 results from "the injury or poisoning as a result  
9 of an intentional self- inflicted act committed to  
10 do self harm and cause the death of oneself." And  
11 the whole problem with that is I think the  
12 difference between overt indicators and implied  
13 intent and not being able to get inside people's  
14 minds and really know. I mean they may have been  
15 having suicidal thoughts, but there's no overt  
16 evidence. So our medical examiners they  
17 basically, you know, say if you take a gun and  
18 point it to your head and pull it, you realize  
19 what the consequences may be even if you're just  
20 showing off or, you know, you may think that the  
21 gun isn't loaded. You still understand what will  
22 happen and how dangerous it is to, you know, put a

1 loaded weapon to your head. So they're going to  
2 basically call it a suicide. We even have  
3 differences with how Dr. Malone would call it  
4 based on looking for these overt indicators of  
5 suicide. And in discussion with the medical  
6 examiner, they don't need to have that overt  
7 indicator to call it a suicide. And that's, you  
8 know, obviously controversial, but -- and then the  
9 other thing that these -- that comes up, you know,  
10 is it a suicide versus an accident. And then  
11 sometimes the cases are called "undetermined"  
12 because there's not, you know, evidence one way or  
13 the other, like if there's more than one person in  
14 the room when the event occurs and the  
15 investigative agencies can't sort that out,  
16 they'll end up calling it undetermined.

17           And I just took these excerpts out of  
18 the main guidelines, but just to point out, you  
19 know, the manner of death certification should  
20 really be objective and based on science, you  
21 know, evidence based rather than trying to, you  
22 know, wanting to spare the family or, you know,

1 other types of reasons that you might not call it  
2 a suicide. And they talk about Russian roulette  
3 in the guideline and say that, you know, it's very  
4 reasonable to call these suicides, although a lot  
5 of civilian medical examiners will call them  
6 accidents.

7 Also the question will come in sometimes  
8 if they have a high alcohol level or they have  
9 drugs onboard. Is that really a suicide because  
10 they were under, you know, the influence of a  
11 mind-altering drug? We will -- we usually -- I  
12 mean we call it a suicide based on the other  
13 factors, not and don't consider, you know, the  
14 alcohol level or the drug levels.

15 And then there's a lot of discussion --  
16 I've read this many times and it's still confusing  
17 to me, but -- in this guideline -- I don't know  
18 the person who wrote the guideline, but they're  
19 trying to say again, you know, just by virtue of  
20 the fact that you put a gun to your head and pull  
21 it, even if it seems like it's, you know, just in  
22 fun or an accident or showing off, you know, that

1 alone can be enough, you know, to call it a  
2 suicide.

3           Okay and so, you know, we classify the  
4 deaths. And we have a database basically that has  
5 every document that classified the deaths or  
6 sometimes if it's a civilian case, the death  
7 certificate doesn't agree with the autopsy and  
8 that doesn't agree with what we called it, but we  
9 still have that all in our database so we can go  
10 back and look at that. But we do have -- we are  
11 very involved in the suicide counting. Weekly we  
12 scrub our counts with the SPPMs, and sometimes  
13 they pick up a case that we didn't get. And I  
14 don't know if it happens vice versa, but we go off  
15 of DCIPS basically for our information. And then  
16 we are involved -- we actually produce the  
17 quarterly or the counting part of the quarterly,  
18 biannual, and annual reports that go from DCOE to  
19 SECDEF. We recently instituted a weekly report to  
20 J1 on the suicide counts. That and we do ad hoc  
21 reports for the SPARRC. And the Well-Being of the  
22 Force reports -- that's not really directly, you

1 know, not confined to just suicides, but twice a  
2 year Ms. Oetjen- Gerdes gets the privilege of  
3 going to the Pentagon and standing by in case the  
4 -- it's usually -- it used to be Dr. Chu -- in  
5 case they have questions about the couple of  
6 suicide slides that are in that brief.

7 Okay, so I'm going to turn it over to  
8 Dr. Malone.

9 DR. MALONE: Good afternoon and thank  
10 you for having me. I'll just give a brief bio. I  
11 went to medical school in Charleston at the  
12 Medical University of South Carolina. I trained  
13 and did my internship and residency here at the  
14 National Capital Consortium's program. Colonel  
15 Ritchie was one of my attendings actually during  
16 my time here. I went to Sigonella, Sicily, after  
17 that and was the psychiatrist over there for two  
18 years. I returned and did the forensic fellowship  
19 through the National Capital Consortium. I then  
20 went to Bethesda where I started as a staff  
21 psychiatrist and made my way up to be assistant  
22 director and then the director. And while I was

1       there I deployed to Cuba for ten months in support  
2       of a joint medical group in the Joint Task Force.  
3       And then I finally was able to come to OAFME. I'd  
4       wanted to come here a couple of times, and finally  
5       31 March I reported there. So I've been there  
6       about six months. And Colonel Ritchie was  
7       actually instrumental in getting this position at  
8       OAFME. You know, it's to her credit that I have a  
9       job, and I appreciate that. It was actually this  
10      division -- the psychological investigations  
11      division -- was established by DOD instruction in  
12      2003, and I am charged with maintaining a  
13      psychological autopsy registry, coordinating,  
14      supervising, and conducting psychological  
15      autopsies and also the peer review of them. And I  
16      provide consultation on medical-legal  
17      investigations and related matters to Judge  
18      Advocates, CID, other organizations of the Armed  
19      Forces and federal agencies. I have a consult  
20      right now for the Department of Justice on a civil  
21      rights case. So along with the psych autopsies,  
22      I'm also a consultant in various ways.

1                   Okay, so when I talk about a  
2                   psychological autopsy, it is done to assist the  
3                   medical examiner with determining the manner of  
4                   death. That's the goal of a psychological  
5                   autopsy. So requests come to me via the medical  
6                   examiner or the investigating agency. For  
7                   example, CID will go to the medical examiner and  
8                   say, you know, our investigation is revealing  
9                   something that this death may have been a suicide.  
10                  Typically we do the manners of death that are  
11                  undetermined and where there may be a possibility  
12                  of a suicide. In very unusual circumstances, we  
13                  can do a psych autopsy if the death is known to be  
14                  a suicide, however, we also do what are called  
15                  behavioral analysis reviews and all mental health  
16                  professionals can do that. And the goal of that  
17                  review is to assist the commander by identifying  
18                  psycho-social factors, which may have contributed  
19                  to that member committing suicide, and that review  
20                  is for the purposes of intervention and  
21                  prevention. So psych autopsies, the goal is to  
22                  assist the medical examiner with the manner of

1 death. And these behavioral analysis reviews are  
2 to assist the commander with intervention and  
3 prevention techniques. They use the same  
4 methodology; they're very detailed, but they have  
5 different goals.

6 So a psych autopsy typically can take  
7 over 30 hours worth of work and sometimes over  
8 several months because you leave no stone  
9 unturned, you're trying to get collateral from  
10 commanders, family, co-workers, friends, across  
11 the board. These requests can come in within a  
12 week or two of the death or up to several years  
13 later, so then you're tracking down people, people  
14 have moved and that kind of thing, trying to get  
15 all medical records. And civilian records before  
16 they came in as well as the military records. So  
17 you have to hunt for a lot of information.  
18 There's typically about 20-25 different categories  
19 on the psych autopsy report, from their past  
20 psychiatric history, the family psychiatric  
21 history, to relationship issues, financial issues,  
22 how they were performing in the unit. We do a

1 chronology around the time of the death and also  
2 just, you know, how other people reacted to the  
3 death. So it's a pretty comprehensive evaluation  
4 which then comes down to putting it altogether,  
5 doing a suicide risk assessment, which I'm doing  
6 retrospectively, and then I opine to a reasonable  
7 degree of medical certainty. And my opinion then  
8 goes to the medical examiner, and he or she takes  
9 this report and my opinion and basically  
10 integrates it with all the other information that  
11 he or she may have, and they have the final  
12 authority. So I may opine accident, and they may  
13 leave something undetermined. We keep the psych  
14 autopsy manners of death as well separate from the  
15 physical autopsy and the death certificate, so  
16 it's another piece of information that we have  
17 data on.

18 So since I've been there in six months,  
19 11 requests for psych autopsies have come in and  
20 some of them were for soldiers. I completed four  
21 of them. One of the fellows at Water Reed who  
22 helps especially with the Army psych autopsies, he

1 completed one. And I've got a total of five  
2 pending at the Walter Reed Fellowship, and two of  
3 those are of soldiers and two are Marines. One's  
4 an Air Force and one's a Navy sailor. So things  
5 have been relatively busy. Initially -- the  
6 medical examiners knew I was coming; I was  
7 supposed to be there actually in November -- so  
8 they held on to some cases. So when I first got  
9 there, there were several Army cases and soldier  
10 cases waiting for me when I did get there.

11 The other thing that becomes an issue  
12 perhaps is what Captain Cantrell just talked  
13 about, the name guidelines which the intent is in  
14 the action. So if I'm going to point a gun at  
15 someone, you assume it's loaded and you want to  
16 kill them. That doesn't necessarily take into  
17 account just some of the, you know, the things  
18 that 18- to 24-year- olds will do even though they  
19 understand that, yes, guns are lethal weapons and  
20 death can result. So in the course of doing my  
21 psych autopsies, I had a gunshot wound to the  
22 abdomen case of a soldier. And I opined it was an

1 accident, but the medical examiner had originally  
2 said it was undetermined, and it was left as  
3 undetermined. Again, their approach to suicide is  
4 if he's got a gun, you know, he's aware that it's  
5 a lethal weapon. This gun did not misfire; I had  
6 it sent to USIS cell, so there was nothing wrong  
7 with the gun. So by virtue of the fact that he  
8 pulled the trigger, it became a -- it's listed as  
9 a suicide. And these are the discussions I have  
10 sometimes with the medical examiners. But they  
11 have their guidelines and they don't get into  
12 intent. Well, the business of what I'm doing is  
13 to get into the state of mind of that person to  
14 the best of my ability and try and see if that  
15 person was suicidal. And that's why it's a very  
16 intensive investigation to try to get all that  
17 information that you need to be able to reach an  
18 opinion regarding that. At the end of the day, if  
19 there's, you know, there's a discussion, the final  
20 arbiter in this case is the Armed Forces Medical  
21 Examiner and that's Captain Mallak. So, you know,  
22 may discuss it at a case conference and then

1 ultimately, you know, he's the final say in it.

2           If you read the instruction, each  
3 Service is actually responsible for conducting  
4 these psych autopsies. So Navy should have  
5 someone completing all the sailors, and Air Force  
6 should have someone completing all theirs, and  
7 similarly the Army should have someone doing  
8 these, or designated to do them. But CID doesn't  
9 have a psychologist assigned to them, OSI and NCIS  
10 do. So the majority of the Marine, Navy, and Air  
11 Force cases are screened through and typically  
12 handled by those psychologists. Now, they're as  
13 overwhelmed as everybody in this room is, and so  
14 they trickle to me if they can't do them. And  
15 then I either take them on depending on my  
16 caseload, or I turn to the Fellowship. The Walter  
17 Reed Fellowship has both psychologists and  
18 psychiatrists who are going through forensic  
19 training, and they have staff, and they end up  
20 doing the psych autopsy. It comes back to me, and  
21 then we get it to the medical examiner. So one of  
22 the issues is still that, you know, having a

1 psychologist assigned to CID may be helpful in  
2 reducing some of the cases that ultimately come to  
3 us; again, I know that person can't do all of  
4 them. That's why we have two Marine cases pending  
5 and one Navy case pending. And that's my job,  
6 too. I supervise. I coordinate. And I also  
7 conduct them. So I'm in the business of having  
8 visibility -- or I should have visibility -- on  
9 all the psych autopsies that are being done.

10 This billet was gapped, so when I'm  
11 trying to put this registry together that I'm  
12 tasked to do, Dr. Donovan was the first Navy  
13 forensic psychiatrist assigned to this billet. He  
14 was there from July of '03 to July of '06. This  
15 billet was gapped from July of '06 until basically  
16 March of '09. So it's not like no psych autopsies  
17 happened during that time, and I have to track  
18 them down. And I know various forensic  
19 psychiatrists did those, and one of my jobs right  
20 now is to try and get a handle on all the ones to  
21 put in this registry so then we can develop a  
22 database from those psych autopsies. I haven't

1 gathered all of them yet, but we're making  
2 progress. We're basically having to pull the  
3 files which may be in West Virginia where they're  
4 stored and get them to me so I can look through  
5 them. And my chief, Chief Saunders, we can look  
6 through them to try and find a signed psych  
7 autopsy report. So that's one of things I'm still  
8 actively doing.

9           Where we are right now and where we want  
10 to go -- I've had one quarterly meeting. I'm  
11 going to have another one with our staff, and  
12 that's Captain Mallak and myself and Chief  
13 Saunders. We get the Walter Reed Fellowship  
14 individuals, the staff over here, the NCIS  
15 psychologist, the OSI psychologist. And one of  
16 the things we have to do is standardize  
17 terminology and templates on how we do the  
18 reports, and also how we're going to do peer  
19 review, and actually they're all pretty much  
20 related. So the terms that we use so far,  
21 psychological autopsy, and NCIS and OSI have  
22 always been using this behavioral analysis review

1 terminology. Again, the goals are different; the  
2 methodology is the same. And then coming up with  
3 peer review, there are more resources in the  
4 literature for us to look at to say, okay, if  
5 you're doing a psych autopsy, minimally you should  
6 have these different paragraphs or different  
7 things that you need to include. Sometimes you  
8 don't have to include a sexual history, or you may  
9 not have to include one of the other categories,  
10 but if you're going to do a psych autopsy, you  
11 should have, you know, 1 through 19 as part of  
12 your investigation.

13           The other thing we want to do is -- or  
14 we are doing -- is the Fellowship in OAFME. We're  
15 sponsoring a symposium in May of 2010 on Death  
16 Investigations and Psychological Autopsies. This  
17 was done once before and the training issue of who  
18 can do these is related to this. It has to be a  
19 licensed mental health provider who has training  
20 specifically in psychological autopsies. So  
21 individuals who are Fellowship-trained have that  
22 training and end up doing one or several of these

1 under supervision. But there are other  
2 psychiatrists who do -- we do medical-legal  
3 investigations like sanity boards and  
4 fitness-for-duty-type things, but they may not  
5 have had specific training in a psych autopsy. So  
6 part of that training is to basically be able to  
7 produce a CD with information so individuals can  
8 look at it. And, you know, we want to develop a  
9 Website where, you know, we can coordinate psych  
10 autopsies and, you know, have questions asked.  
11 And ultimately provide ongoing training in  
12 addition to the Fellowship so that others are able  
13 to do this and do it with confidence.

14 So that's all I have. Are there any  
15 questions? Yes, sir?

16 MAJOR GENERAL VOLPE: Yeah. This is  
17 Phil Volpe. Were you saying that every suicide  
18 gets a psychological autopsy?

19 DR. MALONE: No, sir. No, sir.

20 MAJOR GENERAL VOLPE: What percentage?

21 DR. MALONE: I'll have to get back to  
22 you on the actual percentage, but if you look at

1 the ones that typically do, it's when the manner  
2 of death is equivocal and suicide may be a  
3 possibility. I've looked back at my predecessor's  
4 reports and so far I've only come across one  
5 suicide by the medical examiner that he actually  
6 did a psychological autopsy on. So we don't do  
7 them on all suicides. The better investigation to  
8 do on a known suicide to assist the command is a  
9 behavioral analysis review, which, you know, what  
10 could we have done differently? How could we have  
11 intervened? You know, what kind of things can we  
12 do to prevent this?

13 MAJOR GENERAL VOLPE: Yeah. They  
14 describe the factors surrounding it and some of  
15 the history leading up to it.

16 DR. MALONE: Yes, sir, which is part of  
17 a psych autopsy, too.

18 MAJOR GENERAL VOLPE: Right, right, but  
19 there's no -- other than the ones that go to the  
20 medical examiner's office that are indeterminate  
21 that you do, there's no standardized approach on  
22 the others that are done locally? Is that what

1       you're telling me?

2                   COLONEL RITCHIE:  The Department of  
3       Defense suicide event report has become the  
4       standardized approach that's done on all suicides,  
5       and that goes through all of the different  
6       demographics and what's happened around the time.  
7       So we'll show you one, but that's quite a  
8       collection of information.  One of the differences  
9       is that the DODSER consists in most cases of  
10      fields that you check -- what is the MOS, put in  
11      11 BRAVO -- and then has some text, but as opposed  
12      to your document which is nearly all text.  So the  
13      advantage of the DODSER, which is done on all  
14      suicides and all suicide attempts, is its ability  
15      to be quantified and rolled up into a big report.  
16      And one thing that I didn't mention earlier but I  
17      should is that the ASERs were published for three  
18      years -- 2005, 2006, 2007.  There's an annual  
19      report with all of the ASERs in them.  Is that  
20      making sense?  A DODSER on everybody, psych  
21      autopsy on about -- probably about 5 percent of  
22      cases from what you're saying, and then all of the

1 Services do some kind of command investigation as  
2 well as a risk cause analysis.

3 MAJOR GENERAL VOLPE: Okay, thank you.

4 DR. MALONE: You're welcome, sir. And  
5 basically these reports that I do go to the  
6 medical examiner. They go to CID, the  
7 investigative agency. And also the next-of-kin  
8 can request to have this as well as the physical  
9 autopsy as well as the autopsy pictures; all  
10 that's available to them through our office.

11 MAJOR GENERAL VOLPE: I guess where I'm  
12 -- I might as well just come out and should tell  
13 you what I'm thinking about which crossed my mind.  
14 I'm trying to figure out examples of which  
15 information gathered directly affected prevention,  
16 education, and policy, and programs in the  
17 Services. So I'll probably ask that question when  
18 we meet in the gathering so that the Services can  
19 answer how they've used the information that  
20 either you've gathered or we have on these  
21 standardized process of doing psychological  
22 autopsies. Because that's one of the tasks of the

1 task force here is to determine what is the best  
2 type of investigation to be done for an autopsy?  
3 What kind of information should be collected? Who  
4 should be qualified to conduct the investigations  
5 or review boards or whatever you -- whatever the  
6 term is? How is that information used to update  
7 for education and prevention programs? And how do  
8 we also maintain while we're doing that  
9 confidentiality of patient information, et cetera,  
10 et cetera?

11 DR. MALONE: Yes, sir.

12 MAJOR GENERAL VOLPE: I'll be probably  
13 asking some during the question-and- answer  
14 session. Thank you. Any other questions that  
15 anybody has specifically for this before we go on  
16 to the panel? We'll take a break and then go into  
17 the panel. Commander Feeks?

18 COMMANDER FEEKS: Sir, we still have  
19 Lynne Oetjen-Gerdes to make her presentation.

20 MAJOR GENERAL VOLPE: I'm sorry. I  
21 preempted you.

22 MS. OETJEN-GERDES: Good afternoon.

1 Thank you for having me. My name is Lynne  
2 Oetjen-Gerdes. I wear a number of hats for the  
3 mortality surveillance division. I'm the deputy  
4 chief. I'm the director of operations and  
5 research. And I'm also the senior epidemiologist  
6 for the suicide prevention and risk reduction  
7 committee. I have over fifteen years' experience  
8 in public health informatics, program evaluation  
9 and outcomes research, primarily through New York  
10 State Departments of Health and Social Services,  
11 and now currently with AFMES.

12 The mortality surveillance is basically  
13 made up of two divisions. We have a surveillance  
14 cell. We basically conduct real-time surveillance  
15 of all active-duty deaths. We receive extracts  
16 from the defense casualty information processing  
17 system, which is the reporting system for all the  
18 branches of Service, every four hours. As those  
19 reports come in, we investigate every death to  
20 determine jurisdiction, whether we have it or  
21 whether it's civilian, and whether the death is  
22 reportable. We capture cause and manner of death

1 from all sources and maintain each of these  
2 documents independently. We request relevant  
3 documentation such as death certificates,  
4 autopsies, toxicology, and investigative reports  
5 wherever possible. And we also identify emerging  
6 threats to the military and public health such as  
7 infectious disease.

8 We also have a research and analytical  
9 cell. It is staffed by MPH and higher-level  
10 epidemiologists who team with Armed Forces Medical  
11 Examiners and EASE. Unfortunately, we have a very  
12 small staff, currently only three individuals. We  
13 maintain a DOD mortality registry which was  
14 established from the DODI as the behavioral  
15 investigations division. We extract cause and  
16 manner of death from all sources and maintain them  
17 independently in a database. We develop and  
18 maintain research and analytical databases,  
19 including the SPARRC data. We have subject-matter  
20 focus and expertise on many high-visibility and  
21 high-urgency topics, including suicides, drug and  
22 alcohol, infectious diseases, and combat deaths

1 where we collaborate with many other agencies,  
2 including NGIC and JTAPIC. We also provide  
3 epidemiological support and reports to AFMES for  
4 internal operations uses, SPARRC, DCOE, and other  
5 DOD agencies.

6           Who do we count? This is particularly  
7 important in terms of looking at rates, and I  
8 think it was touched on briefly when we discussed  
9 Guard and Reserve. We count regular component:  
10 Those are all active duty. They are reportable  
11 24/7. Drilling, Guard, and Reserve: This  
12 includes weekend drills. It also includes  
13 transportation to and from the drill if they are  
14 traveling on the day that is not a drilling day,  
15 as well as their two-week advance training. We  
16 count activated and mobilized selected Reserve or  
17 Guard under Title 10 orders. We also count  
18 activated or mobilized IRR. This group is  
19 primarily those who are deployed to Iraq or  
20 Afghanistan. And we also count regular Guard and  
21 Reserve who are on temporary disability-retirement  
22 leave or permanent disability-retirement leave

1 within 120 days of retirement. So after 120 days,  
2 they are not reportable to the casualty system and  
3 so they no longer become visible to us. And we  
4 also count cadets.

5 For DOD, no surprise, the suicide rate  
6 has been increasing since 2003. This graph shows  
7 the change from 2001 to 2009 through June 30. It  
8 is important to recognize that suicides have been  
9 standardized among the SPARRC committee only back  
10 to 2001. So when you see suicide rates and  
11 trends, you will only see them back to 2001.  
12 There's some discussion to go back further to  
13 1998, but it's an extremely labor-intensive  
14 process. And sir, this is one area where unity of  
15 effort -- everyone is working together to ensure  
16 that the data are standardized and everyone is  
17 agreeing about the counts.

18 In terms of looking at the civilian  
19 rates, the civilian rate that I put up is for  
20 males, ages 17 to 60; and it's the largest group  
21 of suicides is among males in our population. It  
22 is also important to realize when comparing

1 military rates to civilian rates, that some of the  
2 literature suggests that civilian rates may be  
3 undercounted by between 15 and 20 percent, and  
4 that is because in the civilian realm, there are  
5 different pressures to meet families' expectations  
6 about cause and manner of death. There are also  
7 certain jurisdictions where if there's a drug and  
8 alcohol death -- if there is no suicide note,  
9 there is no suicide. So the power of the medical  
10 examiner system and the power of the mortality  
11 surveillance division within the medical examiners  
12 division is that we have the legal authority to go  
13 after these documents and the ability to  
14 standardize so that like-cases are always grouped  
15 and counted as one.

16           It's also important to note when we're  
17 discussing rates -- and this is becoming  
18 particularly apparent now when the chain of  
19 command wants information today that happened  
20 yesterday -- that there are some large swings in  
21 suicide counts and rates. And they occur both  
22 annually -- this is an example of active-duty Air

1 Force suicides and rates. And you can also see --  
2 I didn't point out on the other line that we also  
3 provide year-to-date, and we also do forecasting  
4 of trends. This is actually a slide that we  
5 provide weekly to J1 so they can get a sense of  
6 what the expected is versus the actual. And I'll  
7 show that again on the DOD slide. So you can see  
8 that the expected number of suicides is 122 as of  
9 June 30, and the actual is 158.

10 If we're talking about quarterly, the  
11 swings become even more apparent. This is Marine  
12 data, and this has always been one of Commander  
13 Werbel's pet peeves about the demands for having  
14 information now -- is what context should you put  
15 the information in. So these are obviously wild  
16 swings on a quarterly basis. And you can also see  
17 that the Reserves -- actually Marines and Air  
18 Force -- the suicide rate is actually declining.  
19 And in the Army and in the Navy, it's increasing  
20 slightly. And even though non-combat deaths have  
21 been decreasing -- this is one of the things that  
22 we look at in real time -- it's important to know

1       whether suicides are staying at the same  
2       proportion.  And maybe it's not that suicides are  
3       increasing in isolation, but that all non-combat  
4       deaths are increasing.  So we look at all  
5       non-combat deaths and the proportion of suicides,  
6       and you can see on the line that indeed suicides  
7       have been increasing as a proportion of all non-  
8       combat deaths at least since 2006.

9                        These are the basic suicide  
10       demographics.  The Services did a great job of  
11       presenting data at the Service level.  So this is  
12       an overview and it's pretty much in line with  
13       everything the Services reported.  You can see the  
14       percentages and in parentheses is the min and max  
15       for the time period between 2001 and 2009.  With  
16       the exception of marital status, which we had to  
17       cut at 2006, some of our data has a number of gaps  
18       in it so we didn't want to include and distort the  
19       data.  So you can see it's mostly regular  
20       component, mostly younger age groups, E-1 to E-3  
21       and E-4 to E-6, mostly white, mostly married, and  
22       mostly male.

1           Firearms have always been the preferred  
2 means for suicide. This was also clear in Colonel  
3 Ritchie's slide. One of the things that we were  
4 looking for in firearms is whether there has been  
5 an increase in firearm utilization because of the  
6 war effort. Are more people walking around with  
7 guns? And, in fact, the suicide manager before  
8 Mike Kindt, basically said, well, you know, when I  
9 asked him why there weren't as many suicides in  
10 the Air Force, he said, well, you know, the Air  
11 Force and the Navy, the reason why we don't have  
12 as many suicides is because we don't walk around  
13 with guns. And there might be some truth to that  
14 in terms of impulse, but in terms of firearms,  
15 it's the preferred means in all Services.

16           Official issues affecting suicide  
17 policy, which I think are critical for this task  
18 force as well as the Army suicide task force, one  
19 of it is in Guard-Reserve counts and rates. We  
20 have very poor visibility on what is happening in  
21 the Guard once they enter civilian status. So if  
22 they commit suicide on Wednesday, they are not

1 required -- it's not required to report them to  
2 anyone. The data are pretty much maintained at  
3 the unit level. The data may be forwarded up to  
4 centralized offices, but it certainly doesn't get  
5 passed to the casualty reporting system. And I  
6 think that's one of the things that if it was  
7 changed, it would tremendously impact our  
8 understanding of suicides in the Force as a whole.  
9 When we calculate rates, we have to calculate  
10 full-time equivalents which present a whole other  
11 tangle of problems. And the reason we have to  
12 calculate full-time equivalents is because we  
13 don't have complete capture of our numerator. If  
14 we don't have complete capture of the numerator,  
15 we can't use the denominator as it exists. And,  
16 in fact, if one calls DMDC, the Defense Manpower  
17 Data Center, and tries to get information on Guard  
18 and Reserve, they laugh and basically say, well,  
19 we can't tell you a lot because Guard and  
20 Reservists tend to fade away. So what does that  
21 mean? They just stop getting paid. And we've  
22 tried many, many ways to find alternative means to

1 calculate FTEs. We've tried to go after -- well,  
2 are these guys going to drill? Well, nobody  
3 captures drills as they went on Saturday and  
4 Sunday. You'd get points. And then you get so  
5 many points for each day. So you can't get at it  
6 that way. You can't get at it through pay files  
7 because Guard and Reserve can submit their  
8 requisitions for pay in months other than the  
9 months that they actually drilled. So there's a  
10 great need among the Guard and Reserve to somehow  
11 get a standardized data set of what's actually  
12 happening at the Guard and Reserve in terms of  
13 manpower.

14 In terms of the contingency tracking  
15 system which tells us who was deployed when, the  
16 early years of the contingency tracking system,  
17 the data are a little iffy. The early years of  
18 the tracking system, they couldn't tell  
19 definitively whether someone was in OIF or OEF,  
20 which means that's it hard to compare deployment  
21 data from the early years of the war with later  
22 years of the war.

1           It's also important to consider policy  
2 changes that alter the at-risk pool. I hear a lot  
3 about data, and I hear very little about policy  
4 and how it changes. There's a lot of research  
5 going on regarding waivers, so are we bringing in  
6 people who are more at risk for suicide? But  
7 we're also keeping in the Service a lot of people  
8 who would have been separated years ago. We now  
9 have warrior transition units. We have changes in  
10 diagnoses. I remember even as early as three  
11 years ago, maybe even before that, that people  
12 were complaining that people were getting  
13 separated out with personality disorders that  
14 actually had PTSD. So now PTSD is being diagnosed  
15 among a broader group in the Service, and because  
16 of more and more outreach, they're basically  
17 staying in the Service. So it's important to  
18 understand how all of these policies interact and  
19 increase the at-risk pool because they may be  
20 inadvertently driving up the counts of suicide and  
21 the suicide rates.

22           And the last thing I'd like to bring up

1 is that many or most of the intervention programs  
2 -- and they're all wonderful programs -- but they  
3 were not designed with program evaluation metrics  
4 in mind. I'm the chair of a new program  
5 evaluation task force on the SPARRC committee, and  
6 I've got a document that is 15 pages long with  
7 suicide prevention programs among all the Services  
8 in DOD. And to tell you the truth, I don't even  
9 know where to begin. It's a matter of  
10 understanding not only when the programs were  
11 implemented, but what the target population was,  
12 and what we're going to measure as an outcome.  
13 Are we going to measure just decreases in  
14 suicides? Does it matter whether the total mix  
15 changes? What's the impact of coming home?  
16 Changes in deployment and combat exposures which  
17 Colonel Ritchie's group is doing a great job  
18 trying to get a handle on?

19                   And then in terms of understanding risk  
20 -- and this is also the problem of database  
21 completeness and domains that I think everyone  
22 needs to keep an eye on. Many potential and

1       suspected risk factor data were not well  
2       documented in the early years of the war. We were  
3       tasked by Congress to do a study of Mefloquine to  
4       see if it was a risk for suicide? And to tell you  
5       the truth, we could not complete the study, and  
6       the reason was there was basically no data that  
7       could tell us who received Mefloquine and who did  
8       not. So it turned out that in the early years,  
9       Mefloquine was just handed out informally without  
10      any prescription data. And even if it was handed  
11      out, we know nothing about compliance because  
12      there are side effects with Mefloquine. And since  
13      it was only given out if there was a problem with  
14      drug resistance to certain types of mosquitoes in  
15      Iraq, and we had no information on where anyone  
16      was stationed. We couldn't figure out  
17      geographically whether they got it or not. So,  
18      you know, we were basically forced to look at  
19      whether they had Mefloquine onboard at the time of  
20      death, and we wound up with 11 people which  
21      certainly didn't have enough power to do an  
22      analysis. But this is the kind of thing, and the

1 development of a database has been a moving  
2 target, an evolving process, that is getting  
3 better and better all the time. But when we look  
4 at data to understand changes, we'd better be  
5 careful and know how that data has changed.  
6 Prescription data has improved. Diagnostic data  
7 has improved and changed. And the goal to build a  
8 massive integrated database is wonderful. I  
9 applaud it as long as people are clear about the  
10 differences in domains from each data set. What  
11 constitutes a CID case? If you bring in CID data  
12 and then you start making generalizations about  
13 that data, but, oh, by the way, you're only  
14 talking about the CID population. And in terms of  
15 data validation, some of the administrative  
16 databases are a nightmare. From my own  
17 experience, the contingency tracking system has  
18 gotten better over time, but I've got tons of  
19 people who have orders for deployment after death.  
20 I have people who never went, and we know they  
21 never went. I have people who died in Iraq that  
22 are not even in the database. And there also has

1 to be a commitment to correct the data when a  
2 problem has been identified, because when I  
3 originally sent my data analysis back to DMDC and  
4 said, look, these are the issues with your CTS  
5 data just based on my analysis because every case  
6 comes through Dover so we know who's died. It was  
7 turned over to all the liaisons and nothing ever  
8 came of it. So I think the quality of the data is  
9 going to be a major issue.

10 And my last comment is going to be on  
11 the limitations of policy. And I think that's  
12 going to be one of the primary questions is, what  
13 can policy do and what can't it do? How much can  
14 we legislate? How much can we mandate? It has  
15 been clear from these discussions that, well, 25  
16 percent of the people don't go for mental health.  
17 And the more distraught people become, the less  
18 likely they are to reach out. So do we mandate?  
19 Do we drag people in for counseling? And will  
20 that, if it is mandated, will that become a  
21 trigger for suicide? Will that become another  
22 stressor?

1                   Anyway, we've got tons of data. We'd  
2                   love to share it with you at the DOD level. Any  
3                   questions for me or Captain Cantrell or Dr.  
4                   Malone?

5                   QUESTIONER: I just have one quick  
6                   question, Lynne. You mentioned cadets. Were you  
7                   just talking about cadets and midshipmen at the  
8                   academies or also the ROTC cadets and midshipmen?

9                   MS. OETJEN-GERDES: Yes. Well, ROTC --  
10                  academy cadets are reportable -- I'm glad you  
11                  brought that up. The ROTC cadets are only  
12                  reportable if they're in a training cycle. So if  
13                  they're being sent from the university to a  
14                  school, then they are reportable. But if they  
15                  were to take their lives at the university in the  
16                  course of their own studies, they're not  
17                  reportable. And basically, we -- in terms of  
18                  what's reportable and what's not, we count with a  
19                  casualty offices count. So if anybody wants to  
20                  expand our mission and have us count inactive  
21                  Guard-Reserve, we would need much more staff and  
22                  money to do that. And we'd actually have to go

1 out at the state level or there would have to be  
2 changes at the DOD level to mandate reporting.  
3 And since we have no jurisdiction in the civilian,  
4 I'm not sure how that would work.

5 QUESTIONER: Thank you very much.  
6 Appreciate it. Thank you.

7 MAJOR GENERAL VOLPE: All right. I  
8 think that this would be a good time to go into  
9 the break, so let's resume here again quarter past  
10 three.

11 (Recess)

12 MAJOR GENERAL VOLPE: And let me just  
13 remind everyone once again, please silence your  
14 electronics. Alright, well, we'll be starting the  
15 panel discussion portion of our meeting and to  
16 lead that off if there were any members of the  
17 public who wanted to make a statement, I'd like to  
18 start with that. So, please come to the  
19 microphone and state your name for the  
20 transcriptionist. Thank you.

21 MR. ALTMAN: Brian Altman. Good  
22 afternoon. As many of you know, my name is Brian

1 Altman. I'm the Director of Public Policy and  
2 Program Development for the Suicide Prevention  
3 Action Network, USA, which is a division of the  
4 American Foundation for Suicide Prevention. Our  
5 two organizations officially merged in May of 2009  
6 and AFSP SPAN USA is an organization that is  
7 dedicated to reducing suicide and suicide attempts  
8 through education and awareness, providing  
9 research grants, providing survivor support,  
10 awareness as well as public policy and advocacy  
11 activities. I want to thank you for the  
12 opportunity to address the task force, General  
13 Volpe and Ms. Carroll, who is no longer here, as  
14 well as the other distinguished members of the  
15 task force. At a time when there pretty much  
  
16 nothing too little on television or the web about  
17 military suicide, one strong and courageous couple  
18 took a stand a spoke out and brought attention to  
19 the issue of suicide in the military -- both to  
20 the military itself, the suicide prevention  
21 community and the nation as a whole. And for that  
22 we are truly indebted as a nation to Major General

1 Mark Graham and his wife, Carol Graham. They have  
2 clearly done more for this cause than any others  
3 could and they have sacrificed more than any can  
4 imagine. SPAN USA AFSP has engaged in the battle  
5 to reduce suicide and suicide attempts among  
6 members of the Armed Forces in several ways. SPAN  
7 USA has partnered with TriWest Healthcare Alliance  
8 on a brochure aimed at suicide prevention for  
9 military families. It describes what you need to  
10 know and how you can get help and has been  
11 distributed to over 60,000 individuals across the  
12 nation. We have also partnered with TriWest  
13 Healthcare Alliance on supporting survivors of  
14 suicide who lost their loved ones and were members  
15 of the Armed Forces by helping them attend a  
16 Healing After Suicide Conference, which is  
17 sponsored by SPAN USA and the American Association  
18 of Suicidology. And finally, SPAN USA is  
19 currently the host of the Military Suicide  
20 Prevention Cause page on Facebook. We're taking  
21 our efforts online to Web 2.0 and you can join our  
22 cause -- Military Suicide Prevention -- and learn

1 about new developments as well as hearing other  
2 people's stories who post them on our site.  
3 There's no question that the Department of Defense  
4 has made incredible strides in its efforts to  
5 reduce suicide and suicide attempts among members  
6 of the Armed Forces. In addition to Major General  
7 Graham, the Vice Chiefs of Staff of each branch  
8 have clearly shown a dedication to addressing the  
9 problem. And programs such as resiliency  
10 training, ensuring that individuals at all ranks  
11 understand the warning signs and efforts at  
12 reducing stigma and encouraging help-seeking  
13 behavior are all areas that the military has made  
14 significant advances over the last couple years.  
15 In addition, we couldn't be more pleased at the  
16 NIMH Army, Marine Corps research project that is  
17 being undertaken at this time and we look forward  
18 to its results. However, we all know that men and  
19 women in the Armed Forces continue to struggle  
20 with mental illness and substance abuse disorders  
21 as well as find it hard to cope with their current  
22 situations involving relationships with loved ones

1 and financial hardships in today's economy. That  
2 is why the work of this task force is important  
3 and why AFSP SPAN USA has some recommendations in  
4 terms of ways to ensure that we do not lose any  
5 more of our nation's heroes to the silent killer  
6 -- suicide. These recommendations include a  
7 comprehensive, system-wide campaign to reduce  
8 stigmas surrounding mental illness and promote  
9 help-seeking behavior that includes outreach to  
10 family and friends and members of the Armed Force.  
11 As we heard, and as General Volpe discussed, each  
12 branch is continuing to do its own efforts at  
13 awareness and education and stigma reduction and  
14 help-seeking, but we need a DOD-wide unified  
15 campaign that is aimed not just a military  
16 personnel, but at their family and friends as  
17 well. We also need to provide post-deployment  
18 follow-up and assistance for family members and  
19 peers. Once again, we believe that the DOD has  
20 done an incredible effort at educating members of  
21 the military on warning signs for suicide, but not  
22 necessarily reached out to explain those warning

1 signs and what to do to seek help to the family  
2 members and friends and peers of those in the  
3 military. As referred to earlier, there needs to  
4 be more outreach and education to members of the  
5 National Guard and Reservists, their families and  
6 communities with training in both suicide  
7 prevention and community healing in response to  
8 suicide. The post-mentioned piece is incredibly  
9 important and especially with individuals in local  
10 areas that are isolated from the military bases  
11 where they have not as much access to counseling,  
12 etc. So, the post-mentioned piece for Guard and  
13 Reservists is clearly important as we've also seen  
14 from -- to help guard against contagion that may  
15 occur within the Guard and Reservists units as  
16 well. And finally we would like to see  
17 implementation of mental health screening for all  
18 members of the Armed Forces that includes  
19 insurance of follow-up and professional evaluation  
20 for those who are identified as at risk for mental  
21 illness or substance use disorders that lead to  
22 suicide. So I want to thank you for taking the

1 time to listen to the outside military voices and  
2 also offer us up as a key resource as you move  
3 forward with this task force. There is certainly  
4 much activity within the Department of Defense  
5 right now and certainly some outreach to outside  
6 organizations, but we'd love to partner with you  
7 more and help as -- in any we can. Thank you very  
8 much.

9 SPEAKER: Thank you. I appreciate it.

10 SPEAKER: Are there any other members of  
11 the public who wanted to make a statement? Okay.  
12 In that case, General, I think we can just go into  
13 the panel discussion.

14 MAJOR GENERAL VOLPE: Can we just -- the  
15 panel members, just go around -- just mention your  
16 name again and who you're representing and  
17 (inaudible) just to make sure everybody knows who  
18 they are.

19 LIEUTENANT COMMANDER CHAVEZ: Lieutenant  
20 Commander Bonnie Chavez. I'm the Navy Suicide  
21 Prevention Program Manager.

22 COMMANDER MALONE: I'm Commander

1 Rosemary Malone. I'm at the Office of the Armed  
2 Forces Medical Examiner of Forensic Psychiatrist.

3 LIEUTENANT COLONEL KINDT: Lieutenant  
4 Colonel Mike Kindt. I'm the Air Force Suicide  
5 Prevention Program Manager.

6 CAPTAIN CANTRELL: Captain Cantrell.  
7 Chief of Mortality Surveillance at the Armed  
8 Forces Medical Examiners.

9 MR. MORALES: Walter Morales, the Army  
10 Suicide Prevention Program Manager.

11 MR. SHAHBAZ: I'm Bruce Shahbaz. I'm  
12 with the Army Suicide Prevention Task Force.

13 COMMANDER WERBEL: And I'm -- I'm  
14 keeping my seat over here, but I'm one of the  
15 panelists representing the Marine Corps Suicide  
16 Prevention Program -- Aaron Werbel.

17 MS. OETJEN-GERDES: I'm Lynne  
18 Oetjen-Gerdes, Mortality Surveillance Division.

19 MAJOR GENERAL VOLPE: Okay. Great.  
20 Thank you. Questions? Any of the task force  
21 members have questions? Yes.

22 DR. KEMP: I have a couple and they are

1 somewhat related. I would like to (inaudible)  
2 from each of the branches what your sort of crisis  
3 intervention strategies are. You know, if all --  
4 if all of our good intents fail and what are the  
5 directions to people about how to get help  
6 immediately and how do you get that information  
7 out? And along with that, if you have any  
8 identified clinical guidelines or standard  
9 interventions that you use or employ for folks  
10 that you have identified as being a risk. And  
11 just brief is good.

12           COMMANDER WERBEL: Sure. I'll take that  
13 first. Now, crisis intervention means different  
14 things depending on who sees that crisis and your  
15 second part of your question, I think, gets at  
16 some of that difference -- whether it's a medical  
17 professional or it's a crisis that shows up in a  
18 unit, in a workspace somewhere or at home. But in  
19 -- just overarching, in general -- of course, all  
20 units create their own SOP for how to respond  
21 within that unit specifically, but most of them  
22 follow the procedures of notifying the chain of

1 command. If there's been -- getting the person to  
2 a Chaplain, getting the person to medical and  
3 never leaving that person alone as soon as you've  
4 identified that there's a crisis going on. A  
5 couple of nuances of that -- we're clear with  
6 Marines that if there's been -- if some behavior  
7 has taken place already -- a self-harming behavior  
8 -- then everything is skipped until you get that  
9 person to the emergency room. Then you notify,  
10 you know, other relevant individuals in the chain  
11 of command. We push the lifeline -- suicide --  
12 the Federal Suicide Prevention Hotline as the  
13 crisis hotline for all Marines and family members  
14 to call if no one else is around when they as an  
15 individual are in crisis. But we also tell them,  
16 of course, contact your chain of command, contact  
17 medical, contact the chaplains. For providers,  
18 two years ago we started training at all  
19 installations on assessing and managing suicide  
20 risks put out by SPRC and the American Association  
21 of Suicidology as a one day course for training  
22 mental health providers and better assessing and

1 managing suicide risk.

2           LIEUTENANT COMMANDER CHAVEZ: Similarly  
3 for Navy, we have asked each at the command level  
4 to develop a crisis intervention plan. And again  
5 it's somewhat different at whether that's within a  
6 medical department where there are protocols and  
7 procedures and safety on a ward or an emergency  
8 department that has one set of considerations  
9 versus an underway unit or shore command, which is  
10 why we haven't been putting out a specific  
11 template, but have asked them to consider  
12 different principles in developing that. Some  
13 things apply uniformly. As Aaron mentioned, not  
14 to leave the person alone, considerations of  
15 on-person or in-environment hazards and in an  
16 acute situation so that we don't neglect a hazard  
17 right there in the midst or a transportation  
18 hazard. So part of it's just raising that level  
19 of awareness on a crisis plan that you need to be  
20 checking pockets and that kind of stuff. The  
21 other pieces -- having thought out in advance --  
22 what are some of the resources, because I think we

1 found that often times that command -- it's  
2 getting reported to command, but via telephone  
3 call or again via somebody's text messaging and  
4 several instances of that have come up. And so  
5 they may need to access resources to get to a  
6 person that's not physically there and thinking  
7 through how to go about doing that and what  
8 resources in various locations around the world  
9 are available. There's not a standard pat answer,  
10 but they need to come up with it for their  
11 location. We also put out the lifeline as the  
12 sort of the common anywhere hotline, but ask that  
13 each location in their annual training provide,  
14 hey, this is where you can get to assistance at  
15 this location. This is how you get a hold of key  
16 members of your chain of command. This is how you  
17 get a hold of a chaplain or access preferably  
18 early support resources before someone's acutely  
19 suicidal, because it's easier to access resources  
20 at that earlier stage.

21 MR. MORALES: Okay. For the Army,  
22 basically for soldiers and family members who are

1 dispersed that don't have those resources readily  
2 available to them, we have sent out a -- what we  
3 call an ALARCT -- all activities messaging to the  
4 Army to have the soldiers or family members call  
5 Military OneSource as a crisis intervention line  
6 for them to get that immediate help or referrals  
7 in the event that person is looking for  
8 information more so than a crisis. So, the Army  
9 has decided to go with Military OneSource as well  
10 as the line from DCoE for PTSD cases and TBI. The  
11 reason for that is that DCoE launched that line  
12 just to provide that specific service to those  
13 soldiers that are suffering from PTSD or TBI to  
14 relate better to the population. So the Army has  
15 endorsed those two lines as the permanent lines  
16 for soldiers to seek help. Obviously for soldiers  
17 that are in crisis, our ACE model is in place  
18 where the soldier takes the person at risk to  
19 commanders or in the event that it needs to be  
20 taken to the hospital well that would be -- that  
21 would be the case -- to take them to the ER for  
22 immediate -- immediate care. So, basically those

1 are the models that we have in existence right  
2 now, unless, Mr. Shahbaz, you can think of  
3 something else that we're using currently in the  
4 Army.

5           COMMANDER FEEKS: Excuse me for just a  
6 second, please, Mike. I've been -- this is  
7 Commander Feeks. I've been reminded by the  
8 transcriptionist that we need to say our names at  
9 the beginning of a statement that we make so that  
10 it becomes part of the transcription. Thank you.

11           LIEUTENANT COLONEL KINDT: Lieutenant  
12 Colonel Kindt from the Air Force. In terms of  
13 crisis intervention, at each of our installations  
14 we have a Command Post. And through that Command  
15 Post, anybody calling there can access an on-call  
16 chaplain or an on-call -- on-call mental health  
17 provider. Beyond that, the next step depends, in  
18 many cases as Lt. Commander Chavez was  
19 suggesting, on where you're at. Some of our  
20 facilities have an emergency room on base and that  
21 would be your first place to escort someone to.  
22 Most of our facilities don't have a 24 hours

1 emergency department any more, so we have  
2 arrangements with a downtown facility to do  
3 emergency screenings with that mental health  
4 provider available to provide consultation to the  
5 Commander about where to go with this individual.  
6 We do use the National Suicide Prevention Hotline  
7 as our primary point of if you need help in an  
8 emergency and have no one else to call, this is  
9 where to contact. So that's kind of our crisis  
10 intervention plan and we do do more extensive  
11 education about the availability of chaplains and  
12 mental health providers and if you don't know who  
13 else to call, call your commander or first  
14 sergeant and they can tell you what to do. So  
15 those steps are in place. In terms of clinical  
16 guidelines, the Air Force has established a fairly  
17 extensive Air Force Guide for Managing Suicidal  
18 Behavior that outlines a number of procedures in  
19 terms of both assessment and management of suicide  
20 risk that we've trained throughout our clinical  
21 staff so that we believe we're providing, you  
22 know, very good standard of care to anyone that

1 comes into our mental health facilities.

2 LIEUTENANT COMMANDER CHAVEZ: I wanted  
3 to just elaborate on one piece that we had noted  
4 is that even in an acute crisis situation, it's  
5 important that the varieties of law enforcement in  
6 any given installation between the uniformed and  
7 non-uniformed law enforcement, emergency EMS  
8 responders and those other sort of gatekeepers or  
9 chaplains in medical have a coordinated system as  
10 to okay, if they're responding to a scene, who  
11 goes in when and how do they go about doing that  
12 and we're working to develop an even -- I know the  
13 VA has done some work actually in Memphis, kind of  
14 where I'm at, in training their law enforcement  
15 staff and we're heading that direction.

16 SPEAKER: Thank you.

17 DR. McKEON: Two things. I wanted to  
18 ask Mr. Morales and Mr. --

19 MAJOR GENERAL VOLPE: Can you mention  
20 your name first?

21 DR. McKEON: Oh, I'm sorry. Richard  
22 McKeon. That with the use of Military OneSource,

1       it mentioned that the Army has endorsed as a  
2       crisis service and my understanding is that they  
3       are, you know, very competent to do so. My  
4       question is does the Army promote the use of  
5       Military OneSource in terms of -- in awareness  
6       campaigns, pamphlets, brochures and other forms of  
7       communication? Does it promote awareness of  
8       Military OneSource as a crisis service or are  
  
9       there active efforts to get word out to people  
10      that Military OneSource is available for folks in  
11      the Army as a crisis resource?

12               MR. MORALES: This is Mr. Morales. The  
  
13      answer is yes. The ALARCT that went out to  
14      everyone provided that Military OneSource is to be  
15      used as a resource for awareness, but also as a  
16      resource for crisis intervention. We didn't call  
17      it suicide because we wanted to make sure that  
18      soldiers use the line for all type of crisis --  
19      not necessarily for suicide, but if a person is  
20      having a crisis -- whether it be a relationship  
21      that has failed or problems that are  
22      insurmountable, financial -- whatever the case

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1 might be, or grief. We wanted to provide that to  
2 the person as a first option.

3 DR. McKEON: But it has specifically  
4 been identified and promoted as a crisis resource.  
5 I understand you've not specifically included the  
6 word suicide, but specifically as a crisis  
7 resource.

8 MR. MORALES: Mr. Morales. Yes,  
9 correct. Yes.

10 MR. SHAHBAZ: This is Bruce Shahbaz.  
11 Let me follow on very briefly. In addition to  
12 that, a number of posters have recently been  
13 released. Every Army-level public affairs story  
14 that is related to suicide, the last paragraph of  
15 that will talk about Military OneSource. Every  
16 month when we release the suicide statistics in a  
17 public press release, the last paragraph of that  
18 will mention it. And finally, on many of our --  
19 even the leave and earning statements, the pay  
20 vouchers that come in -- there will be -- about  
21 once a quarter there's a blurb within the remarks  
22 section of that that provides that number to help

1 get that out.

2 DR. McKEON: Richard McKeon. And -- and  
3 in all of those times when Military OneSource is  
4 identified, is it that typically included that it  
5 is available in a crisis?

6 MR. SHAHBAZ: Yes, sir.

7 DR. McKEON: Thank you.

8 COMMANDER WERBEL: If I could just  
9 follow up a little bit too, I think it's  
10 interesting. We -- in one of the resource sheets  
11 we give to Marines as part of this NCO course,  
12 there's probably 10 toll-free numbers. They're  
13 for different things. We put a Vet Center number  
14 on there. We put a -- the Tricare Behavioral  
15 Health locator number on there. The three main  
16 overall numbers that we push -- and I think all  
17 the services use these three numbers, but to --  
18 you know -- in different places is the Lifeline  
19 number, the Military OneSource number and the new  
20 DCoE Outreach Call Center. And each of them have,  
21 you know, very different values. Lifeline, I  
22 think, just specifically as a crisis hotline for

1 folks in distress. Military OneSource has amazing  
2 resources, but they also -- it's a defined  
3 population that is allowed to call Military  
4 OneSource -- family members, for example, active  
5 duty service members, Reservists. And we have an  
6 SOP with Military OneSource that all of the -- all  
7 the call center personnel have that directs them  
8 that in case of a suicidal individual, here's the  
9 telephone number at every installation because  
10 they find out where that person is when the  
11 telephone call is received. Here's the telephone  
12 number of every installation of the person to  
13 contact to do a warm hand off or to get someone.  
14 You know, both the MPs could arrive at a house on  
15 the installation if someone calls OneSource  
16 suicidal and the clinic to schedule an appointment  
17 and do a warm hand off for the next day. The  
18 benefit -- in my perception of the Defense Center  
19 of Excellence Outreach Call Center -- is two fold.  
20 One that they do -- they were set up specifically  
21 for psychological health as Mr. Morales mentioned,  
22 which the others, you know, either have a more

1 narrow scope or a more broad scope, but also  
2 they're available to girlfriends and boyfriends  
3 and aunts and uncles and grandparents and not just  
4 officially recognized family members. So, we try  
5 and make use of all three because they address in  
6 some ways different needs of service members who  
7 might be looking for support.

8 MR. MORALES: This is Mr. Morales again.  
9 I want to add that even though the Army is  
10 promoting Military OneSource and DCoE, we also  
11 provide the National Suicide Prevention Lifeline  
12 as a resource. When you go to the proponent for  
13 the Army suicide prevention in the Army, which is  
14 the Army G-1, and go to that website, the Suicide  
15 Prevention Lifeline is also there so to make sure  
16 that soldiers and families they have -- they have  
17 choices. They will call whomever they feel more  
18 comfortable calling. So, my intent is not to just  
19 tell them these are the only two resources you  
20 have, but also provide all the alternative that  
21 are to their disposal.

22 DR. LITTS: David Litts. I was just --

1 what number do you have on your ace cards?

2 MR. MORALES: It's the Military

3 OneSource number.

4 DR. HOLLOWAY: Marjan Holloway. I just  
5 wanted to share an observation based on today's  
6 discussion and see if the panel members have a  
7 comment to make about this. I thought a  
8 significant portion of the day was spent talking  
9 about suicide deaths in the U.S. military and I  
10 didn't hear much about suicide attempts and  
11 suicide ideation and the tracking of military  
12 personnel who experience ideation and attempt  
13 either before coming into the military or  
14 throughout the course of their military careers.

15 And I just wanted to emphasize the importance that  
16 suicide prevention is not just about individuals  
17 who die by suicide, but also individuals who think  
18 about dying by suicide and who attempt -- who  
19 demonstrate some level of self injurious behavior.  
20 Any comments about what you have done in terms of  
21 tracking specifically surveillance for -- I know  
22 ideation is even more difficult, but what you have

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1 done to address I think the needs of these  
2 individuals.

3 LIEUTENANT COMMANDER CHAVEZ: Bonnie  
4 Chavez. We have been requiring for Navy a sit-rep  
5 or op-rep -- a message traffic report for all  
6 suicide-related behaviors. In the past, prior to  
7 April, people broke it down to ideation gestures  
8 and attempts, but really at our command level they  
9 weren't very well prepared to -- and the  
10 definitions were not very good at that point, so  
11 that category didn't really mean anything. They  
12 were really all over the map as to how they were  
13 labeled, so we've lumped them all together and  
14 asked them to say, you know, if something related  
15 to suicide -- from threat to ideation, whatever --  
16 send us this report and then we are tracking those  
17 numbers. They are to follow up then with getting  
18 the individual to a medical assessment. And at  
19 that point, the criterion for attempt that is  
20 based on again the nomenclature discussions is  
21 employed and then we're starting to collect  
22 DODSERS, which we're still at the early stage on

1 that so we're not really ready to start analyses,  
2 but we're optimistic that that will give us a lot  
3 more insights into the understanding the factors  
4 and the sequences of events that you just can't  
5 get necessarily in a death case. What we have  
6 learned -- and it's kind of premature as far as  
7 numbers tracking because as we've gotten the word  
8 out, the compliance with reporting has increased,  
9 so I can't really say what is compliance  
10 improvements and what is changes. But, in recent  
11 months, I can say that there's been about probably  
12 a hundred a month cases where individuals were  
13 either comfortable enough that they came to their  
14 command and they spoke up and they sought  
15 assistance, a family member or shipmate recognized  
16 a concern and it came to the attention. So  
17 essentially, it's something of a metric of people  
18 doing what we've trained them to do and if we're  
19 averaging maybe 100 a month doing what we trained  
20 them to do, and perhaps preventing a loss, and  
21 about four a month dying that mostly are not  
22 getting into the system, it is some sense of where

1 we're going on things.

2 MR. MORALES: For the Army. I'm sorry.  
3 Thank you, sir. Walter Morales. We track  
4 attempts and ideations two different ways. We  
5 have the DODSER and you have heard about that a  
6 lot today -- those attempts that ended up in  
7 evacuation or hospitalization. So you will see  
8 those numbers captured through that vehicle which  
9 is a DODSER and then you have the other mechanism  
10 which is through AHLTA. Perhaps soldiers that  
11 goes to the clinic -- that to a medical facility  
12 for a routine appointment and it is then  
13 demonstrated that this person has either attempt  
14 or ideated to for suicide. That is kept in the  
15 system. Nonetheless, these cases -- upon  
16 recognition -- they are either provided  
17 counseling, either provided treatment and  
18 medication or whatever that person needs to get  
19 them out of the -- out of the danger zone if you  
20 will. As for the managers, I think we do go to a  
21 great extent to provide resources for that  
22 population. If you are waiting for count the

1 numbers to do something, we're waiting too late.  
2 So we're looking at this as an iceberg where the  
3 biggest population are those that are with suicide  
4 ideations and attempts. We're trying to get to  
5 those early on -- whether it be with training,  
6 whether it be with counseling. For those that  
7 come out of theater, through the post-deployment  
8 health assessment or the post-deployment health  
9 reassessment. So that is done in theater. Right  
10 after they come back, we provide follow-up  
11 counseling and treatment and that's how we take  
12 care of other soldiers in that category.

13 LIEUTENANT COLONEL KINDT: Mike Kindt  
14 from Air Force. You're getting in a very  
15 important point in the suicide ideation and  
16 suicide attempts are very difficult for us to  
17 track. We did have within our Air Force Suicide  
18 Event Surveillance System a tracking mechanism  
19 where we attempted to collect data on suicide  
20 attempts, and what we found is that for a while  
21 that data was very good and over time we began to  
22 see some deficits and it looks like our suicide

1 attempts were decreasing. And I'm concerned that  
2 it wasn't suicide attempts that were decreasing,  
3 it was the reporting of suicide attempts that was  
4 decreasing. As we transition to the DODSER, we  
5 set a new -- what we hope is more measurable  
6 threshold and we're using what the Army is using  
7 of attempts that result in hospitalization or  
8 evacuation from theater, which is a little more  
9 measurable. We have better oversight across that  
10 through our casualty reporting system. So we can  
11 be more consistent, I think, in how we're  
12 measuring those things. We've also implemented  
13 another procedure in very early in basic training  
14 -- a new questionnaire that we're doing of all the  
15 airmen that are coming in to the service, where  
16 we're asking about past histories of suicide  
17 attempts and other dangerous behaviors. We've had  
18 some initial -- some of the initial data suggests  
19 that that questionnaire is predictive of future  
20 problems in the Air Force and we're beginning to  
21 look at how we might use that now as a screening  
22 tool for filtering some folks out of the Air Force

1 or identifying them for additional training needs  
2 much earlier in their Air Force career. But in  
3 terms of ideation, that's a very difficult thing  
4 to track. Currently, the only way we would have  
5 of getting at that is to review all the AHLTA  
6 notes or mental health notes to see which  
7 individuals have been identified as having some  
8 sort of suicidal ideation. But even within that,  
9 there are multiple levels of is it passive  
10 ideation? Is it more active ideation? Is it  
11 associated with past attempts? Many, many other  
12 issues that make it very difficult to kind of  
13 quantify where we're at with that.

14           COMMANDER WERBEL: This is Aaron Werbel  
15 from the Marine Corp. You bring up a really  
16 interesting point and I think it's fascinating as  
17 I've been thinking about my answer to that, then  
18 the realization came to me that almost all of our  
19 training efforts are focused on individuals who  
20 have ideations and some who have attempts and all  
21 of our tracking is focused on individuals who have  
22 died by suicide. So there's a real disconnect in

1 many ways between where our training is focused  
2 and what our tracking is looking at and there is  
3 debate in the field of whether that's a continuum  
4 or they're discreet populations of individuals.  
5 To answer the part of your question, there's some  
6 layers to it. I mean certainly in the  
7 intervention area, you know, our Leader's Guide  
8 for Managing Marines in Distress. And this is --  
9 this is a good example -- General Volpe, also of  
10 the question you had earlier of, you know, sharing  
11 resources. The Leader's Guide began as an Air  
12 Force initiative and all the services loved it and  
13 grabbed it and copied it and made it their own --  
14 with the permission, of course, of our friends  
15 from the Air Force. We appreciated that. But,  
16 that has, for example, sections on what to do if  
17 you suspect an individual might be at risk for  
18 suicide, what to do if there's been a suicide  
19 attempt, what to do if there's been a suicide. So  
20 the training certainly addresses attempts and  
21 ideations. Reporting -- we require in the Marine  
22 Corps and have for many, many years -- probably 10

1 or 15 years -- an administrative message for  
2 gestures, attempts and suicides. So we've been  
3 tracking those for many years. However, we've  
4 only kept track of them and we really have not  
5 done a lot to analyze the attempt data and  
6 certainly not to the degree that we analyze much  
7 more data about suicides. And that's like the  
8 other service as well. That's why we'll be  
9 starting to use as of January 1, 2010, the DODSER  
10 for all suicide attempts in addition to suicides,  
11 because there's a wealth of information to  
12 understand out there about individuals who are  
13 attempting but have not died that we've not been  
14 analyzing.

15 DR. HOLLOWAY: Marjan Holloway, and I  
16 know this might be difficult to answer, but let me  
17 kind of put the question out there. As -- so  
18 let's take the case of an example of an individual  
19 who is a military health provider. You have an  
20 individual who comes in to you who could  
21 potentially have a history of ideation, self  
22 injurious behavior with the intent to die. How

1 likely is it that you could access the medical  
2 record information that you have available to you  
3 and be able to identify that individual as high  
4 risk? So in terms of primary care physicians,  
5 behavioral health providers within the military  
6 health system, how easy is it to have access to  
7 that information for the treatment that you  
8 provide to the individual?

9           LIEUTENANT COMMANDER CHAVEZ: Bonnie  
10 Chavez. I can't speak for the last couple years  
11 of using AHLTA, because I've been doing this job,  
12 but I know that in looking back, trying to  
13 understand cause analysis in some of the cases.  
14 In some cases -- instances -- you can look in  
15 AHLTA or look in a paper copy of a medical record  
16 and see a whole bunch of information and some  
17 primary care providers and mental health providers  
18 will do or have one of their Corpsmen or medics do  
19 that review. But, there are certainly holes in  
20 that system and I can think of an example where an  
21 individual was having services at boot camp, but  
22 everything didn't get into the medical record and

1       went onto their next school and then was seeing  
2       family service center, which isn't part of the  
3       medical record system and notes got generated, but  
4       didn't make it into the paper copy and they got to  
5       a carrier, and they didn't have the connectivity  
6       to review the electronic copy and were relying on  
7       that paper copy during their preliminary screening  
8       when the individual checked on board. And so  
9       several -- a series of problems was -- kind of  
10      fell through the record system and that may have  
11      been an anomaly, but it certainly has a potential  
12      to happen. So -- and some ways that records --  
13      they're unavailable, but I would say certainly for  
14      the Navy, where we're having to kind of switch  
15      back and forth between paper and electronic  
16      because of the connectivity issues to access the  
17      electronic system that there are certainly  
18      opportunity for things to get lost. And the other  
19      key hole is that there had been a practice and  
20      there may still be the practice at medical  
21      facilities of doing a secondary medical record for  
22      behavioral health where an individual can go into

1 AHLTA perhaps, but it's going to pull a flag that  
2 says basically you really need to know this  
3 information before you can click on this note and  
4 it's kind of inhibits certain providers from going  
5 there, which -- where it might be relevant if  
6 they're about to make a prescription, it might be  
7 relevant to know that the behavioral note said  
8 this person has thought of suicide because they  
9 might consider the quantity perhaps or consult  
10 with that individual. So, while it's there, I  
11 would say that there's certainly some holes.

12           COMMANDER WERBEL: The task force may  
13 really benefit from a presentation if it's not --  
14 hasn't been considered yet from the Center of --  
15 for Telehealth and Technology at the Defense  
16 Center of Excellence where retired Army Colonel  
  
17 Greg Gahm has been pilot testing an automated  
18 behavioral health care record that addresses, I  
19 think, many of the potential gaps and has seen  
20 some really interesting initial results in trying  
21 to ensure that -- that quality of care and  
22 transition of care doesn't leave individuals

1 behind as they move from place to place.

2 LIEUTENANT COLONEL KINDT: Mike Kindt.

3 I would concur with that. I think we can -- there  
4 is room for improvement in our recordkeeping  
5 systems. As Lieutenant Command Chavez was talking  
6 about, we do keep in the Air Force separate  
7 behavioral health records from outpatient medical  
8 records. We do make brief entries to reflect that  
9 care has been provided and should be putting in  
10 those significant indicators that a primary care  
11 provider may need to know about. One of the  
12 dilemmas I think would be, you know, on the  
13 primary care side, where the majority of our  
14 suicidal folks are being seen many within a month  
15 or two prior to their suicide for completely  
16 unrelated things, the primary care providers are  
17 under an awful lot of pressure to quickly see  
18 patients to make sure they're providing access to  
19 care and depending on when that last mental health  
20 note was in the system, or when there had been  
21 reference to an attempt or an ideation in the  
22 past, they may not have time to review all of that

1 information. So I think with an automated  
2 behavioral health record, that we might do a  
3 better job of flagging some of these things and  
4 making that information more accessible. There  
5 may be some room for improvement.

6 MR. SHAHBAZ: This is Bruce Shahbaz from  
7 the Army. I concur with everyone. We are both  
8 enabled and hindered by our electronic medical  
9 record and the limitations that it has. The Army  
10 also has the limitations of maintaining -- trying  
11 to maintain the seamless transition between the  
12 deployed environment and the garrison environment  
13 and many of our small units out at forward  
14 operating bases don't have electronic medical  
15 records. So those are challenges that we're  
16 facing as well. We're facing challenges that not  
17 of all of our behavioral health clinics, which are  
18 not collocated with the -- the hospital, don't  
19 always have access to AHLTA and not all of our  
20 substance abuse have access to AHLTA, but it's  
21 something that the Army Suicide Prevention Task  
22 Force has looked at and we're developing a

1 strategy to try to standardize that and increase  
2 the access. We're also working with the  
3 telemedicine directorate folks out at Fort Lewis.  
4 So it's something we recognize and we're working  
5 towards, but by no means is it seamless at this  
6 point.

7 MAJOR GENERAL VOLPE: Phil Volpe. I'm  
8 trying to look at suicide prevention from a design  
9 standpoint and I'm thinking about -- and I'll come  
10 to the question in a second -- what's crossing my  
11 mind is my experience with the aviator community  
12 with the services when there's a bad outcome --  
13 something happens -- an accident. Okay. And  
14 there is a clear process depending on that  
15 aircraft accident -- I'll just pick helicopters or  
16 something like that for -- there's a helicopter  
17 accident. Something happens that causes damage or  
18 death or whatever. And there's a clear process to  
19 do -- and it's written in the regulation and a  
20 program on how to conduct an investigation -- what  
21 the membership is made up of that investigating  
22 body. They go out there. They have, you know,

1       whatever it is -- two weeks or three weeks -- to  
2       look at the site, ask all these questions,  
3       interview, chat, put together some things -- all  
4       for the purpose -- I mean there's nothing they can  
5       do about that accident. It happened. It's all  
6       for the purpose of affecting the future --  
7       preventing accidents in the future. And they go  
8       through this methodical process and this board  
9       meets and it's all centralized and it comes into  
10      this lessons learned center, if you will. So  
11      everything's centrally collected from these boards  
12      and what they're trying to -- what they're  
13      determining is preventable/not preventable -- and  
14      if it's preventable -- just about everything's  
15      preventable, okay. Non-preventable would be like,  
16      you know, a meteor hit the helicopter or something  
17      like that, I guess. But, if it's preventable,  
18      they go through this process of is it equipment  
19      defect? Is it -- is it training? Is it doctrine  
20      and procedure? Is it the lack of training or, you  
21      know, was it caused by the system lack of training  
22      or was it by the individual who missed training?

1 Or was it -- was it pilot error? Environmental?  
2 And they go through this methodical process to  
3 come up with those things that were related and  
4 they have what they call major findings and other  
5 contributory findings. The major findings that  
6 led to the accident, but while they were doing the  
7 investigation, they also found, you know, this  
8 didn't cause the accident, but these are also  
9 deficiencies and things that have to be looked at.  
10 And all of that is to then come back and effect  
11 and so if it's -- I mean if it's a design problem,  
12 it goes back to the manufacturer to, you know,  
13 change something in the aircraft. If it's -- or  
14 they do a workaround for an equipment defect or  
15 they'll adjust their training differently or  
16 they'll change their policy on the amount of  
17 training. The person had too insufficient  
18 training to react to the conditions of that thing.  
19 And I realize this is different. I got that part.  
20 But it's more of a process design thing of what  
21 I'm getting to and it's tied to these  
22 investigations and who -- who conducts

1 investigations and how do we conduct them? How do  
2 we determine what the factors are for that  
3 specific incident -- that specific suicide? How  
4 do we centralize that into a lessons learned and  
5 if we've determined that it's -- that training was  
6 related to it, then how do we effected changing  
7 how we train? If it was -- the person had suicide  
8 ideation, how have we changed the, you know, the  
9 awareness and suicide ideation? Or if it was a  
10 previous suicide attempt, how do we register the  
11 people to get the proper attention so that they  
12 don't, you know -- we have a follow-up procedure  
13 rather than, you know, someone just attempted  
14 suicide and, okay. They're okay. So they -- now  
15 they're back into the population and there's --  
16 there may not be any follow-up on that for  
17 sustained -- getting to the root causes of why  
18 they had the first suicide attempt that were never  
19 resolved but then led to a future suicide attempt  
20 and maybe, you know, committed suicide. But,  
21 anyway, I had that -- this design concept in my  
22 mind that if we're going to get real -- that we

1 can get real data from doing a uniform,  
2 standardized approach to investigation with the  
3 trained people to do them, with the right data  
4 points that we want to collect to then look at  
5 specific relational things related to leading to  
6 that suicide that we can then effect policy and  
7 programs. I just wanted to get your thoughts on  
8 that because some of what the members have  
9 mentioned to me -- and I'll steal a term -- this I  
10 haven't seen the translational information. In  
11 other words, how does data translate to policy,  
12 translate to procedure, translate to outcome --  
13 meaning preventing suicide -- and how come -- and  
14 how does that outcome then change the future data,  
15 you know, and that whole wheel of getting better  
16 as we go through this, I should say. You know, as  
17 we cycle through this over the years, each time  
18 tweaking and tweaking and getting better and  
19 actually changing the data. Because it appears  
20 that no data has changed very much in the  
21 demographics. Not that we can, but I'm not sure  
22 if we can or can't change it, but what I don't

1 know is if there is a system in place that if we  
2 can, I don't know if there's a system in place  
3 that we can change it. I don't know if that made  
4 any sense at all, but what are your comments?

5 COLONEL BRADLEY: Sir, if I  
6 could. I appreciate that point because depending  
7 on the person or agency completing the  
8 investigation, they have different perspectives.  
9 And so your point is well taken. When we, in the  
10 medical field, do that for a patient under our  
11 care, we call that a root cause analysis and that  
12 is designed with that intent -- to look at the  
13 proximate factors and how the holes of the Swiss  
14 cheese lined up in that particular event. When a  
15 command, however, does it from a 15-6 perspective,  
16 they're looking for what -- what systems failed or  
17 who did something wrong. And when Criminal  
18 Investigative Division or OSI or any number of the  
19 different forensic organizations do it, they have  
20 a different perspective still. So, I do believe  
21 we need to unify the different investigative  
22 perspectives so that we come up with a coherent,

1 comprehensive way of reviewing suicides.

2 MAJOR GENERAL VOLPE: Yeah, I got -- let  
3 me just mention something, too and I use the -- I  
4 threw out the term investigation -- accident  
5 investigation out there. That is not a -- a legal,  
6 actionable, attributionary event. If they find  
7 something that was criminal or something that  
8 required investigation or turnover to the command  
9 to take action for something that was improper or  
10 punishable, they can't use the data from the  
11 investigation. They actually have to conduct a  
12 separate investigation with the right authorities  
13 in order to hold someone legally accountable for  
14 this or that and everything. So they do have a  
15 separation in that process for aircraft accidents,  
16 which I think to get -- to get -- in order -- the  
17 whole purpose is so that people will reveal  
18 information. That's how you get information,  
19 without having to worry about, you know, getting  
20 punished for it because the whole goal is to  
21 prevent someone from a future event -- save a  
22 life. You know, save multiple lives. And if that

1 attitude is approached in the procedure and policy  
2 and the system, we don't know until we do it if we  
3 can make a difference in that. So, any other  
4 comments on that?

5 MR. MORALES: Yes, sir. Go ahead,  
6 ma'am.

7 CAPTAIN CANTRELL: Yes, sir. You've  
8 explained that very well. I used to participate  
9 -- oh, sorry. Captain Cantrell. I used to  
10 participate in the aircraft investigations  
11 when I was a medical examiner. And I think some  
12 of the differences are obviously if you have a  
13 crashed aircraft in your -- on your property, well  
14 that's pretty obvious to the civilians they don't  
15 want anything to do with it. Usually they're  
16 happy for you to come in and do the investigation  
17 and the engineers and the like and they usually  
18 will let the military medical examiners go ahead  
19 and do the cases, but not always. Like Orange  
20 County, they usually always retain jurisdiction of  
21 the bodies, but they do a very good autopsies.  
22 But with the suicides, it's a little different

1 because a lot of times it's not even obvious that  
2 it is a suicide initially, so we just, you know,  
3 let me get -- receive from the (inaudible) feed is  
4 found unresponsive in room. And then we find out  
5 months later when we get the autopsy report that  
6 it was ruled as a suicide, so now you've lost a  
7 lot of valuable data potentially just because of  
8 the time lag. So, that -- I mean I think that  
9 aircraft accident model is really the best we have  
10 and I just think some of these jurisdictional  
11 issues would make it a little more difficult -- a  
12 lot more difficult to do that with suicide cases.

13 MAJOR GENERAL VOLPE: One of the  
14 beauties of having this independent,  
15 autonomously-functioning task force is we can make  
16 -- recommend legislation change, so I'm not sure  
17 if you're telling me should we -- would it be  
18 helpful if we recommended legislation change and  
19 made it so that when a military member -- because  
20 this is about members of the Armed Forces --  
21 commits suicide, regardless of where it is at  
22 least in our nation, that it's under the

1 jurisdiction of the Military Medical Examiner  
2 and/or, you know, some -- I don't know if that  
3 would be helpful or not. But I think that's what  
4 we're trying to figure out. Because we could  
5 recommend legislation change to help solve that  
6 problem if that's what the problem is is you can't  
7 get good data because it's under some else's  
8 jurisdiction. We can -- we can -- we may be able  
9 to get that changed.

10 CAPTAIN CANTRELL: Well, there is a  
11 (inaudible) the 10 U.S.C. Code 1471 a provision  
12 whereby if it's believed that there's going to be  
13 inadequate investigation of a forensic case that  
14 the medical examiner can take jurisdiction, but to  
15 my knowledge that's been used very rarely and it,  
16 you know, gets into this issue of federal and  
17 states caution of (inaudible) the jurisdictions  
18 between the federal government and the state and  
19 local governments. If that could even be done  
20 eventually, it would take a lot more resources.  
21 They'd have to, you know, double or triple the  
22 medical examiner's office and those resources

1 currently were, you know, under the (inaudible).  
2 We have looming in the mix, so six months I think  
3 we're going to be carved out of AFIP, so we're  
4 going to have a different -- we're going to be on  
5 our own more or less. So that would -- you know,  
6 I'm not saying it couldn't be done, but it would  
7 involve a lot more -- take a lot more resources to  
8 do something like that. We do try our best though  
9 to contact these people up front and see what they  
10 have planned, what kind of examination they plan  
11 and what toxicology they're planning and try to  
12 help out of we can so.

13 DR. JOBES: If I might -- this is Dave  
14 Jobes. I've been consulting to various branches  
15 for the last 10 years, so as context for some of  
16 this, as eluded by the previous presentations, it  
17 was not long ago that the branches each had  
18 different ways of counting suicides and no one  
19 could agree about the numerators and denominators.  
20 And there was a task force that was created four  
21 years ago -- I can't remember how -- three or four  
22 years ago -- to change that and one of the

1 discoveries was that there were these different  
2 ways of counting, but that the Office of the  
3 Medical Examiner cuts across the branches. So  
4 there was a move to consolidate, under the Armed  
5 Forces Medical Examiner's Office, the way that all  
6 this was going to be officially handled. But,  
7 prior to that there were four different  
8 approaches. If you think of it as a metaphor in  
9 where this task force could transition things, is  
10 that is a central data gathering point and there's  
11 a forensic psychiatrist, you know, who's looking  
12 at some of those data -- but that -- but the idea  
13 that you would unify the data collection process I  
14 think logically under that office and that the --  
15 the data that's collected -- the psychological  
16 data that's relevant to suicides would be gathered  
17 in one place and it could actually be used for  
18 shaping policy I think is something that could  
19 directly come out of a task force like this I  
20 would think. It reminds me of when we first  
21 approached the OSI to do research with their death  
22 investigation data. Colonel Bradley rightly --

1 you know, they're trying to rule our foul play and  
2 we as academics went in and said well, but this is  
3 great data that could shape your program. They  
4 were like, huh? You know, oh -- like what we do  
5 in these desks could actually translate into  
6 something that could be meaningful. And after  
7 three years of hammering away at that, they said  
8 great. We'll let you in and we'll let you do  
9 research with these files and I don't think we're  
10 yet to policy implications, but we could be. So  
11 that seems to me to be absolutely at the -- at  
12 sort of the baseline one of the things that could  
13 come out of this is a unifying effort across the  
14 branches in this -- you know, through some  
15 centralized organization that -- and that could be  
16 determined. But to actually take the data to  
17 shape policy it seems to me to be something that  
18 hasn't been done in the ways that you're aspiring  
19 or describing. It should be.

20 SPEAKER: See I --

21 MAJOR GENERAL VOLPE: Phil Volpe. The  
22 resources thing, too. And don't get me -- I mean

1 we shouldn't make assumptions, too, because we're  
2 not saying all the resources for these things in  
3 order to gather the information and do the  
4 psychological autopsy has to come from the medical  
5 examiner. But, just like -- just like for say  
6 Army Aviation for a helicopter accident, it isn't  
7 Army Aviation that provides all the accident  
8 investigation board members. They tap in across  
9 the Army. You need a flight surgeon. Now they  
10 got to be certified people that understand the  
11 accident -- you know, whatever the course is they  
12 have to take to make sure they understand the  
13 procedures. A pilot. You know, different -- a  
14 maintenance person -- and they tap in around and  
15 send them out there to do this investigation, but  
16 it's all centralized under their coordination with  
17 a central body. So it would be no different than  
18 having, you know, psychiatrists and people that  
19 were trained on how to do these that you would  
20 have, you know, on a list and it would go out as a  
21 requirement to send them as part of the team and  
22 this person as part of a team and this person

1 would talk with family, talk with unit,  
2 installation, you know, look at the person's  
3 training record and -- trying to find out all the  
4 circumstances around that suicide and what we can  
5 gather and learn so it comes into this lessons  
6 learned repository where you look and see is this  
7 training. Because, clearly, the services are  
8 doing a tremendous amount of training in all the  
9 programs, but what we don't know is is that  
10 because we've identified that training is a  
11 deficiency or is it because we're doing training  
12 hope that it will make a difference? I don't  
13 know. That's what I don't know. And it's the  
14 same thing -- some of the other data, too, that  
15 I've -- another question I have is we're talking  
16 about relationship problems, okay. I'm single, so  
17 I got to be careful how I say this, which I guess  
18 means I have a relationship problem. Let me, let  
19 me -- what I, what I can't -- I'm hearing that  
20 about 60 percent or 65 percent of suicides have  
21 had relationship problems, okay. What I don't  
22 know is what's the number of Americans that have

1 relationship problems and how is that related to  
2 the relationship problem -- relationship problems  
3 that the suicide -- I don't know if it's relevant  
4 or not or how relevant or how soon it was to the  
5 -- you know what I mean? I mean it's the research  
6 that goes into that analysis is the question,  
7 because I'm not married, but my friends that I  
8 talk to have had somewhere in 10 -- the past 10  
9 years relationship challenges. They never say  
10 problems -- challenges. I'll just throw that out.

11 DR. LITTS: A couple thoughts I have --  
12 David Litts. Thank you. My sense is that as much  
13 as additional surveillance data would be  
14 interesting and potentially helpful, that that's  
15 not the weak link in the chain or the short pull  
16 in the tent in my mind and in my kind of gut  
17 feeling here. I think it's more that we -- we  
18 don't know of the constellation of things that  
19 we're doing -- 11 in the Air Force and I really  
20 get the sense that services are doing a lot of the  
21 same thing, calling it different and I think that  
22 there's a lot of similarity. But what we don't

1 know is relatively how effective are each of those  
2 things. We really don't even know it maybe that  
3 some of them are harmful, but in the Air Force's  
4 case, you know, we did 11 things at once and then  
5 found that all together there was a net reduction.  
6 So we don't know, you know, how effective each  
7 thing is and if there's maybe one or two of them  
8 that are really the difference. We also don't  
9 know really how effective we are at implementing  
10 them. You know, I mean we do something called  
11 training, but it's -- how -- shoot I'm missing the  
12 word -- is it the same training -- what's the  
13 word? Help me, someone. Done the same --

14 SPEAKER: Standardized.

15 DR. LITTS: -- standardized, but there's  
16 a --

17 SPEAKER: Fidelity.

18 DR. LITTS: -- fidelity, right. How,  
19 you know -- how good is the fidelity in that  
20 training across the system? You know, we've got  
21 trainers that are, you know, probably very -- some  
22 trainers that are very effective trainers, others

1 that are horrible. You know, so we haven't done  
2 much to assess how effective some of those things  
3 might be. So I -- and then also, I think a lot of  
4 times we haven't thought through as well as we  
5 should have what we expect to be the outcomes and  
6 I think Lynne brought this up that, you know,  
7 sometimes we're doing these interventions, but  
8 they haven't even been designed in a way that they  
9 could be evaluated. We've said we were going to  
10 train everyone and I'll go back to when the Air  
11 Force started training everyone annually. You  
12 know, we basically just put out a list of things  
13 that could be in the curriculum. We didn't know  
14 what should be there really -- what shouldn't --  
15 but, you know, gave people a menu and we never --  
16 didn't really think through exactly what we wanted  
17 the person who is getting the training to think or  
18 do differently after they had the training than  
19 they did before. So, you know, what outcome  
20 exactly were we expecting from the training. I  
21 don't know that that was ever really thought  
22 through. So -- so I guess all this is to say I

1 think that the richness of target here is really  
2 on that intervention side, trying to figure out  
3 what interventions do what. Why are we doing what  
4 we're doing? What outcome are we expecting? And  
5 let's try to, you know, learn more about that, you  
6 know, rather than investing a lot in -- in more  
7 surveillance and trying to tease out more and more  
8 specifics of each suicide case so that we can  
9 maybe get some more generalities, because the --  
10 you know, if you think about aircraft accidents --  
11 yes, there are human factors. But they're also  
12 machines and they're all kind of made the same and  
13 so if you find a part that failed on one machine  
14 -- well, let's look across all the machines that  
15 are just like it and see if we've got a bunch of  
16 parts ready to fail. In suicides, it's just  
17 almost all -- essentially all human and every  
18 single one is different and there a million  
19 different paths to a suicide and so each one looks  
20 so different than the other one that even if you  
21 find two or three that have some similar  
22 characteristics, it's hard to know how to change a

1 system based on those. So I feel like I'm, you  
2 know, it's a little bit -- 4:15 and it's kind of  
3 hard to put cogent thoughts together. But, those  
4 of some of the things that I guess I'm thinking.

5 MAJOR GENERAL VOLPE: But you bring -- I  
6 mean that's a great point because it's almost  
7 knowing that each individual is so different, even  
8 the standardized training probably ought to be  
9 ideally tailored to how each individual learns and  
10 reacts to that training, which is very difficult  
11 to do because we do standardized training the same  
12 way throughout the military, regardless of -- of  
13 the person, the individual as a person. So it'd  
14 be interesting if the -- if the programs were  
15 designed to be tailorable for the type of unit and  
16 MOS and those sorts of things. I don't know. I'm  
17 just thinking about what you said and trying to  
18 relate that to the training that we're doing.  
19 It's pretty cookie cutter training that goes  
20 across to everybody and I don't know if everybody  
21 receives it the same and reacts to it the same and  
22 learns the same from it.

1 DR. LITTS: Healthcare providers get CPR  
2 training every year -- did when I was active,  
3 right. And CPR -- it's basically a, you know, two  
4 hour refresher course to make sure you can do a  
5 skill when called upon. So we -- but we have  
6 these one hour suicide prevention trainings and  
7 they're kind of about awareness and we talk about  
8 data. But really, the -- there's one skill I  
9 think that we want most people to have or maybe --  
10 say a constellation -- and that is to recognize  
11 someone that they're working with who is  
12 distressed, be able to ask them if they're having  
13 thoughts of killing themselves and regardless of  
14 how they answer that really, also -- you're  
15 distressed. Let's see if we can figure out a way  
16 to help you out of that stress and that's kind of  
17 the core -- it seems like the core piece of --  
18 that we would want every person in the military  
19 community to be able to have. So then maybe that  
20 training ought to just be focused on those skills  
21 and when you do an annual update or whatever, you  
22 know, it's kind of like just demonstrate the

1 skill. You know, do you have it? Can you ask the  
2 question? Do you know the number to Military  
3 OneSource? Or do you know the number -- you know,  
4 how to get someone to help? That's kind of the  
5 fundamental skill.

6 COLONEL BRADLEY: John  
7 Bradley. I think that's one of the strengths of  
8 the "Beyond the Front" training, which is  
9 distinctly different from any of the other suicide  
10 prevention trainings that I've ever experienced,  
11 which are usually rote and fairly unimpressive and  
12 that's what the soldiers also tell us. The  
13 "Beyond the Front" training, however, is a  
14 skills-based training. You have a situation that  
15 you have to negotiate and you go through different  
16 courses of action that lead to different results.  
17 So I think it's certainly a wiser approach. I  
18 don't know if it's a more efficacious approach,  
19 but it seems to be more well informed and would  
20 probably ask us to get more familiar with that  
21 particular product.

22 LIEUTENANT COMMANDER CHAVEZ: Bonnie

1 Chavez. I would like to elaborate on that a  
2 little bit. We can devote more and more and more  
3 resources toward surveillance and certainly we can  
4 improve upon using all the data that's being  
5 collected in the first place and have a more  
6 systematic approach, you know, as has been  
7 established in other systems. But at the same  
8 time, what we're often seeing is the people who  
9 die are the exception to the rule. And if you  
10 look at the kind of -- the recent data in the  
11 civilian world that maybe a much as three percent  
12 of the population has serious thoughts of suicide  
13 within a 12 month period. So if we reflect that,  
14 then we have quite a number of people within our  
15 ranks seriously considering suicide, maybe even  
16 taking a plan or an action. And yet, by and  
17 large, our training is focused on if they're -- if  
18 they're showing these concerns, do something. And  
19 by and large, when they show those concerns,  
20 people are doing things. That training most of  
21 the time is working and the people that are  
22 getting into the system are getting into the

1 system because they either got the word that they  
2 should speak up or somebody recognized it. And so  
3 I know there's been EPICONS where the leaders are  
4 frustrated and they say, well, you know, these --  
5 these deaths -- none of them were showing your  
6 classic signs. The training is all messed up.  
7 You know, the Marine Corps ran into that one. And  
8 it's not necessarily that that's the case. It's  
9 that the ones that aren't showing all the classic  
10 signs or what we'll see sometimes is yes, in  
11 retrospect it's like the blind man and the  
12 elephant. You know, the spouse saw one little  
13 thing and the coworker saw another little thing.  
14 If you put them all together it paints a warning  
15 picture. But if you just saw that one little  
16 irritability or just saw that one piece, it's not  
17 going to jump and down and say oh, this person's  
18 distressed. And so digging into those sort of  
19 tragic cases isn't necessarily telling us how to  
20 be most effective in the vast major of situations  
21 where they are more classic.

22 DR. McKEON: Richard McKeon. I have one

1 quick question and then one -- if I could have  
2 each of the services respond to it would be great.  
3 The quick question is that the "Beyond the Front"  
4 training -- the simulation training that you --  
5 that you reference -- is there any kind of  
6 evaluation of that or any way of either having or  
7 instituting in the future some way of getting  
8 information because I would agree that  
9 conceptually it would seem to have a lot of  
10 potential. But is there any way to be able to  
11 find out more about what impact it's actually  
12 having in building those skills?

13 MR. MORALES: Let me go ahead and  
14 address that. Walter Morales. As mentioned  
15 before, "Beyond the Front" has been a great tool  
16 for soldiers as it really focuses on hands-on  
17 training -- making the soldier think what to do in  
18 specific cases. I think we didn't do a good job  
19 in getting a questionnaire perhaps that we could  
20 have from the field so we can evaluate how the  
21 training was conducted, the outcomes and the like.  
22 I'm happy to announce that we are in the middle of

1 getting a new contract awarded for "Homefront."  
2 "Beyond the Front" now is "Homefront." We're  
3 going to concentrate on issues that happen back  
4 home, not directly related to deployment as it was  
5 the intent of "Beyond the Front." For this one,  
6 we are planning on doing a lot better job in  
7 making sure that when that packet is launched,  
8 it's launched with a questionnaire that the  
9 trainer knows exactly how to provide it to the  
10 attendees and get that -- those answers back to  
11 Headquarters DA so they can be analyzed and see  
12 our shortcomings and the good points of the Army  
13 and what effect it's having on those attending the  
14 training.

15 DR. McKEON: Richard McKeon. And that  
16 will be using the same type of technology as from  
17 "Beyond the Front?"

18 MR. MORALES: That is correct. We're  
19 using the same technology. I have received from  
20 the SEC Army on down great comments about this  
21 product. It is intended for a small group and  
22 that's what I'm hoping the Army is doing as well

1 as other services trying to change the culture of  
2 the -- of the services -- the Army in my case --  
3 to train in small groups. Instead of taking a  
4 company or a battalion down to the local theater  
5 for training, let's stay away from that one.  
6 That's the message we are sending out. But we  
7 also know that there is value in staying away from  
8 the PowerPoint slides and involving more the  
9 soldiers in the training in the decision making.

10           COMMANDER WERBEL: There it is. Aaron  
11 Werbel. It's an excellent question. Now the  
12 discussion has shifted a little bit to program  
13 evaluation and benchmarking and, you know, how do  
14 we know that an individual resource. To the best  
15 of my knowledge, the only suicide prevention  
16 program in the military that's ever studied the  
17 whole program was the Air Force study that was  
18 done. But as -- David, as you identified, it  
19 wasn't done in a way that it could tease out each  
20 of the elements of the program. It was that the  
21 overall program was effective. I'm not aware of  
22 -- now we're doing this with the NCO course. But

1 to the best of my knowledge, that's the first time  
2 in the Marine Corps and maybe the first time in  
3 any of the services that a specific intervention  
4 tool or training tool is being studied  
5 scientifically to see if it makes a difference in  
6 behavior -- not just attitude, but also in  
7 behavior. So that's not -- and that's not just to  
8 toot our horn because I think this is the first  
9 time we've ever done it also. And I am as guilty  
10 as the rest of us I think as saying this is  
11 helpful or we know when a major failure of our  
12 programs has been we don't know. We just don't  
13 know. We're really good at developing training  
14 that we're pretty sure or we think is going to  
15 make a difference, because it makes anecdotal  
16 sense. It has face validity. But we just don't  
17 know. Before I found out I was going to be member  
18 of this task force, but when I found out the task  
19 force was going to exist and I was in my -- just  
20 my program manager hat, one of the real hopes that  
21 I had was that the task force would identify the  
22 gaps that exist in our programs. I think we've

1 got excellent programs, but for some reason our  
2 suicide numbers keep going up despite these  
3 excellent programs. Maybe some of the answer is  
4 in the gaps in our programs. What are we not  
5 seeing? And I think that we -- we get caught up  
6 in the excellence and I think we do have some  
7 great things out there. We just can't demonstrate  
8 it with data. And I think that even the standing  
9 up of this task force suffered from the  
10 nearsightedness of what the -- what the focus of  
11 the mission is in that it's just suicides by  
12 members of the Armed Forces and it's focused on  
13 investigations primarily. Because I would -- I  
14 would concur with some of the other comments that  
15 surveillance -- the investigation process is  
16 pretty good -- maybe the best in the country  
17 compared to any civilian system in terms of  
18 finding out if it's a suicide and then collecting  
19 data and now having standardized data across all  
20 of the services. But a focus on how do we change  
21 both the structure and the process interservice to  
22 ensure that we're testing and knowing whether or

1 not our interventions work and, you know, I think  
2 another failing of the service programs has been  
3 in the past -- and we're starting to do this --  
4 not reaching out to family members. The same  
5 narrowness of this -- of the task force, you know,  
6 the directed mission at least, is that we also in  
7 the service programs did not reach out to either  
8 educate or involve survivors or family members in  
9 general in our program development. And it's a  
10 huge resource out there that just has gone  
11 untapped in developing the programs and figuring  
12 out how to do it in a better way. And I would say  
13 as well with Mr. Altman here, you know, from AFSP  
14 SPAN, that public-private partnership of figuring  
15 out ways to really leverage some of the other  
16 organizations out there that are doing the same  
17 stuff and working on best practices would really  
18 help. So my hope is that we can -- and I think  
19 this -- I bring that up now because I think the  
20 talk about how do we know it's making a difference  
21 is one of the gaps -- is one of the things we've  
22 been missing in the programs over the years. And

1 I think that can really be beneficial to focus on  
2 identifying more of those and then having some  
3 recommendations for how we could fill those gaps.

4 DR. HOLLOWAY: Marjan Holloway. So I  
5 think, Aaron, what you're saying is that there's a  
6 simple solution and the solution is --

7 COMMANDER WERBEL: I would never say  
8 that.

9 DR. HOLLOWAY: -- well, I would hope  
10 that's what you're -- but let me kind of say it.  
11 Maybe you'll agree. The simple solution is that  
12 for every program that's launched within DOD, in  
13 terms of suicide prevention, there should be a  
14 program evaluation component. There's a lot of  
15 money that's being spent on these programs and I  
16 would assume it would only take a small amount of  
17 money to really add on that program evaluation  
18 component to it. So that would be my personal  
19 recommendation. But that's kind of my  
20 perspective. It is a simple solution and I think  
21 it just takes leadership to get it implemented.

22 DR. LITTS: David Litts. I agree that

1 that's an important thing we ought to be looking  
2 for. I'm not sure it's as simple because I think  
3 evaluating some of these things in real life  
4 situations are -- can be pretty -- fairly complex,  
5 but nonetheless, not undoable by any means.

6 DR. HOLLOWAY: So, David, I totally  
7 agree with you that designing the study and  
8 looking at the complexities and the outcomes --  
9 all of that -- is going to be incredibly complex.  
10 But, making sure that we -- if we notice that  
11 there's a gap -- that out of all of these  
12 programs, there's only one program that has had  
13 the program evaluation component, then the simple  
14 solution is to start doing it.

15 MS. OETJEN-GERDES: Lynne Oetjen-Gerdes.  
16 A couple of comments. One, I think we do have an  
17 accident report or the equivalent and I think  
18 that's what the DODSER is intent -- intent on  
19 being. Maybe if we focused on how to use the  
20 DODSER better and one of my thoughts surrounding  
21 that is it seems to me -- and I may be wrong,  
22 because I'm not the repository for the DODSER.

1 But it seems to me that the surveillance data is  
2 somewhere over here and the programs are somewhere  
3 else and they don't really talk to each other. So  
4 maybe if some sort of matrix could be developed  
5 for the programs to establish what they're meant  
6 to do. So let's say the ACE's program, which is  
7 Ask, Care and Escort -- for every case that has a  
8 DODSER, why isn't that case lined up with all the  
9 programs -- in a matrix for all the programs --  
10 and find out what is -- what would have -- in an  
11 ideal situation, what could have been done or  
12 should have been done? And then was it done? And  
13 is there a program that could meet that need? So  
14 then you've got the DODSER data connecting -- and,  
  
15 you know, I know it's not going to be real time  
16 because there's a lag, but there should be some  
17 sort of board or some committee, even if it's just  
18 within SPARRC or DCoE, that's evaluating these  
19 items in real time and funneling it up the chain  
20 so that it can become part of policy and lessons  
21 learned. And I would also argue that program  
22 evaluation is a worthwhile goal and certainly my

1 whole background is program evaluation, but  
2 sometimes it's very difficult to measure successes  
3 because sometimes successes are indirect. The  
4 people who went to a suicide training program and  
5 did not commit suicide because of that are not  
6 necessarily going to come back and say put me in  
7 your database. I'm one of the cases you saved.  
8 You know, it's kind of the same thing with armour.  
9 People ask us well, how many lives did armour save?  
10 Well, we deal with dead people so there's no way  
11 to know except indirectly through changes in  
12 either case mix or rates whether armour is actually  
13 saving lives. So I think we have to keep somewhat  
14 of an objective perspective on how much program  
15 evaluation can achieve, but I think connecting the  
16 data repositories with the programs in some real  
17 evaluation and I think developing some sort of a  
18 matrix for all the programs. And it will also  
19 show immediately where the overlaps are, because  
20 maybe the services are investing too much money in  
21 programs that do exactly the same thing, but maybe  
22 there aren't any programs that address the actual

1 content issues. The content issues of -- you know  
2 -- Ask Care or Escort is fine, but does it really  
3 address relationship problems and financial  
4 problems and legal problems. So how do we get to  
5 that level of granularity in our interventions as  
6 well as in our evaluations?

7 DR. McKEON: I would also like to  
8 address the issue that brought up General Volpe,  
9 the -- which has been echoed I think around the  
10 table a number of times in the connection between  
11 surveillance and -- and any kind of intervention  
12 or programmatic efforts. I would certainly agree  
13 that the primary issue is not that we do not have  
14 enough data. And I think it's -- I think it's  
15 been very common in suicide prevention nationally  
16 that surveillance data is not used to inform  
17 suicide prevention efforts. So I think much more  
18 important than improved surveillance is  
19 translating information that we have into action  
20 and how -- and there may be a number of different  
21 ways of doing that. And I'll give you one  
22 example. In a -- up in the mountains of Arizona,

1       there's a tribe called the White Mountain Apache  
2       Tribe. They're one of only a couple of places in  
3       the country that has a comprehensive -- has a  
4       surveillance system for suicide attempts. The  
5       state of Oregon has one for youth. White Mountain  
6       Apache has it. Maybe a couple of other locations  
7       that have something. But what they do in the  
8       White Mountain Apache Tribe is the -- well, the  
9       entire community is mandated by tribal leadership  
10      to do this reporting -- the emergency department  
11      at the local Indian Health Service Hospital, the  
12      ambulance squad, the police, etc., as well as  
13      community members who do in fact report -- and  
14      there's even in a supermarket to go to the folks  
15      who collect the registry. But that would be --  
16      that would not mean very much if nothing ever  
17      happened with that information. Each person who  
18      is reported to that registry gets followed up.  
19      There's an outreach visit that's made with every  
20      suicide attempter who is reported to that  
21      registry. Those who are even thinking about  
22      suicide -- if that gets reported to that registry,

1 they get followed up on. Now, that would  
2 obviously be much more difficult in -- in the  
3 military in terms of following up on something  
4 like suicidal ideation. But when we look at  
5 suicide attempts, suicide attempts are the most --  
6 are the strongest risk factor for a later death by  
7 suicide. The majority of people don't have prior  
8 suicide attempts so it's certainly in isolation  
9 not the answer, but it's -- has -- there's strong  
10 reason to think it can be a significant  
11 intervention strategy. It also seems to be, I  
12 would say, emerging evidence -- when you look at  
13 the British National Clinical Survey, when you  
14 look at the VA study, Valenstein and all looking  
15 at people -- Veterans treated for depression --  
16 thousands and thousands of cases that were  
17 analyzed, it seems pretty clear that there are  
18 risk periods. There are high risk periods --  
19 probably at least three to six months. There's  
20 probably increased risk over a longer period of  
21 time, but at least over three or six months. So  
22 that if we -- when somebody is identified as

1       having made a suicide attempt, and that  
2       surveillance data is being collected -- there are  
3       efforts, you know, being done in that direction  
4       now. The question will be what can be done to  
5       follow up with people, because it's a mistake to  
6       think that if they go to the emergency room and  
7       then they leave, they're no longer at risk. Or if  
8       they go into an inpatient unit and then they  
9       leave, they're no longer at risk. We know that's  
10      not the case. We know that there are many deaths  
11      after that. So my question would be is there  
12      anything in each of the services that is currently  
13      being done or is planned in terms of active  
14      outreach efforts for those who have made a suicide  
15      attempt with the context of that being the only  
16      two randomized controlled trials ever to show a  
17      reduction in deaths by suicide both involved some  
18      follow up methodology?

19                    COMMANDER WERBEL: I think that -- you  
20      know, it's interesting. I was going to say that  
21      we actually do -- in my impression, change policy  
22      and inform policy quite a bit based on our

1 surveillance data and I could give three or four  
2 examples of that. Here's one where I would say,  
3 for example, I don't -- I don't have the answer to  
4 that. I would suggest from the Marine Corps data,  
5 where in the last 10 years, only two of our  
6 suicides had any previous history of a suicide  
7 attempt, that we haven't looked at that because  
8 specifically it -- in the Marine Corps data -- it  
9 was not a risk factor for a future suicide event.

10 DR. LITTS: Do you think that's because  
11 -- David Litts -- that -- and I'm sorry, it would  
12 be interesting to hear it from the other services,  
13 too, but -- you know, this is really quite  
14 striking. Does that mean that these people are  
15 getting follow-up care? Or are they getting  
16 enough support from their unit? Or they're  
17 getting discharged before they kill themselves?  
18 Or how do you explain that?

19 COMMANDER WERBEL: That's a great --  
20 this is Aaron Werbel. That's a great question and  
21 the one we've started looking at is, you know,  
22 what happens after a suicide attempt. Because the

1 first thing that comes to my mind from what I just  
2 said is, you know, does that mean they're getting  
3 -- they're getting -- all getting kicked out or  
4 they're getting out after a suicide attempt and  
5 therefore you don't know whether they ended up  
6 dying by suicide. I mean I think the reality is  
7 we also have to take that into consideration of  
8 the national statistics. But I think even though  
9 that's the strongest risk factor that only about  
10 five to ten percent of individuals who make a  
11 suicide attempt go on to die by suicide, right?

12 SPEAKER: Only about five to ten percent  
13 of those who --

14 SPEAKER: Forty percent of people who  
15 die by suicide have made a previous attempt.

16 COMMANDER WERBEL: Right. But, you  
17 know, most completers die in their first attempt  
18 and most -- the vast majority of suicide  
19 attempters never try again. So it's another  
20 universal screen -- not an irrelevant one, not an  
21 unimportant one, but another universal approach to  
22 a very specific population you're trying to catch

1 and find. But we have started looking at and the  
2 initial data is that, unlike what most of us would  
3 have expected, most people don't get kicked out  
4 after a suicide attempt. But the data is not all  
5 in on that yet, but we're definitely looking at  
6 that now.

7           LIEUTENANT COMMANDER CHAVEZ: You know,  
8 we don't have a specific system in place that  
9 projects at a certain interval or requirement. We  
10 do include and it's a key portion of our  
11 operational stress control curriculum and is part  
12 of our leadership and awareness training is just  
13 how essential that follow up is, even if it's not  
14 an attempt. Because, you know, people can go  
15 through ups and downs and may be starting to get  
16 better and look like they're doing better when  
17 they've been in a difficulty and that's -- that's  
18 precisely when they end up hitting a setback or  
19 acquiring enough energy to act out their plan.  
20 And so saying hey, just because somebody went to  
21 medical and they were sent back to you, doesn't  
22 mean it stops there. Just 'cause you escorted

1       them to the door, doesn't mean that the  
2       responsibility is finished. That long term follow  
3       up is just as important and that's part of the --  
4       the sustained piece that all of the services are  
5       using on that front line supervisor is just how  
6       essential that sustainment -- whether it's dealing  
7       with the relationship issue or whatever the case  
8       may be. Just 'cause they got to a service,  
9       doesn't mean that the leadership and peer group  
10      has no more responsibility for the ongoing piece.  
11      So it's part of our sort of cultural education,  
12      but it's not -- I don't think it's formally  
13      systemized in terms of a frequency of follow up of  
14      curing letters type of program, although it's  
15      something that's been tossed around.

16                   LIEUTENANT COLONEL KINDT: Mike Kindt.  
17      In the Air Force, we've done -- we've done a  
18      number of things related to that. Certainly  
19      within our guide to managing suicidal behavior, we  
20      -- we highlight for all our clinicians the extent  
21      to which previous attempts and multiple attempts  
22      in particular are significant risk factors for

1 future attempts and outline, you know, rules of  
2 thumb for them to follow in terms of monitoring  
3 that individual's suicidal behavior and the  
4 importance of maintaining some sort of supportive  
5 care for those individuals. So we've taken steps  
6 to educate our providers in that regard. We've  
7 also made a policy change in general. These are  
8 some of the things that you were interested in.  
9 By looking at that, one of the things that we  
10 require now is that when an individual has a  
11 suicide attempt, the local medical leadership --  
12 so the mental health provider and the SGH, the  
13 chief of the medical staff -- are required to have  
14 a meeting to formally discuss whether this  
15 individual needs to have a medical evaluation  
16 board so that it comes to the -- the highlight --  
17 the attention of the senior medical officer on  
18 that base. And an evaluation of what level of  
19 care or the appropriateness of this person for  
20 continued service from a medical perspective is  
21 evaluated. It doesn't say that a medical  
22 evaluation board will occur. In some cases, this

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1 individual may already be, you know, have been  
2 diagnosed with a personality disorder, may already  
3 be leaving the service on an administration --  
4 administrative route or through some other legal  
5 channels or it may be determined that this was  
6 just a response to a very acute stressor and that  
7 the overall level of psychological health of this  
8 person is very good and that we can expect things  
9 to improve. But it does elevate that to the  
10 senior medical officer on that base to make sure  
11 they're engaged in that process. And then we can  
12 continue to do whatever else we need to do in  
13 terms of clinically -- clinical management of that  
14 high risk individual. We've also established some  
15 fairly firm procedures on patients -- particularly  
16 establishing high risk logs within each -- or high  
17 interest logs within each of our mental health  
18 clinics. So an individual who is above mild risk  
19 for suicide would be entered into this high  
20 interest log. And then we have specific  
21 procedures for if that patient fails to keep an  
22 appointment or cancels an appointment -- what

1 levels of intervention we will go to to get them  
2 back into the clinic so that each clinic has those  
3 procedures. So if I'm a high risk patient and I  
4 don't show up, we're going to call. We're going  
5 to call again. If we can't get a hold of you,  
6 we're going to call your commander and say this  
7 high risk person didn't show up and we're going to  
8 make those efforts to get you back into our  
9 facility. Maybe your kid was sick and your cell  
10 phone wasn't working and it was nothing, but we  
11 want to make sure that we've identified what's  
12 going on with that individual.

13 DR. McKEON: If I could just ask do the  
14 -- do both of you have data for your services on  
15 the proportion of those who died by suicide who  
16 had previous suicide attempts? I'm wondering  
17 whether the Navy and the Air Force and the Army  
18 are more similar or dissimilar to the Marines. I  
19 think someone had mentioned, I think, 13 percent  
20 in their data, but I don't -- that was yours.  
21 That was the Army. Do you have data that would  
22 give some sense of that?

1                   LIEUTENANT COMMANDER CHAVEZ:  Yes, sir.  
2           We have been collecting that on the -- both the  
3           DONSER and DODSER.  One of the things that we have  
4           found -- like if you look at the DONSER data, when  
5           a command member answers that, they'll go back and  
6           gather whatever kind of information they can.  
7           Often times the suicide attempts that have -- you  
8           know, the individuals with prior suicide attempts,  
9           like several that I can think of in the last few  
10          months.  The Navy was never aware of those.  One,  
11          you know, somebody drives their car into a tree.  
12          It's reported as an accident.  Somebody shows up  
13          with a knife wound and claims he'd been assaulted,  
14          but on investigation, that seems to probably have  
15          been self inflicted.  But the command wasn't aware  
16          of that until down the line.  So, most of the  
17          cases where it'll show up on the data as having a  
18          prior attempt, it wasn't a prior attempt that came  
19          to the level of awareness that got medical  
20          intervention.  I can only think of -- actually off  
21          the top of my head, in the past, I can only think  
22          of one of those.  But, we could -- we have the

1 capacity to look at that in the data. But even  
2 with that extra data, which often times people  
3 aren't aware of 'til after the fact that oh, okay,  
4 well the family member knows that this person had  
5 done this or that and didn't tell the Navy. Even  
6 with that, it was a relatively small percentage.  
7 But I can get those numbers to you all.

8 LIEUTENANT COLONEL KINDT: Mike Kindt.  
9 I'm sorry, I don't have that data with me. I have  
10 just about every other data point I can imagine,  
11 but I will certainly get that back to you.

12 MAJOR GENERAL VOLPE: I'd like to get  
13 the thoughts from the four service -- or any of  
14 you -- on any way that your thoughts are and what  
15 we can do as a task force to help reduce stigma --  
16 either through recommended legislative change or  
17 recommended policy change in DOD. If you could  
18 just -- you know, just give us your -- your  
19 thoughts on that, because that seems to be a theme  
20 that ran through the briefings is this stigma and  
21 obstacle in crisis intervention and getting help  
22 at a critical time and self -- declaring yourself

1 that you need help -- those things, because a  
2 career and a security clearance and all these  
3 other things. Is there some sort of thing that  
4 you would like this task force to take away that  
5 may be able to help -- we could do to help reduce  
6 that stigma?

7 MR. SHAHBAZ: Bruce Shahbaz from Army  
8 Suicide Prevention Task Force. First, I'd like to  
9 clarify a term. I think the stigma we should try  
10 to address is the stigma associated with  
11 help-seeking behavior. All stigma is not  
12 necessarily bad. We had a conversation right  
13 before this session began. I would like to  
14 maintain, if possibly increase, the stigma  
15 associated with self-harm behavior. That runs  
16 counter to the military ethics. We say leave  
17 nobody behind. We want to reinforce that on both  
18 sides in terms of taking care of your buddy, but  
19 also that warriors have an obligation to take care  
20 of themselves. So, stigma used in the broad  
21 sense, I think we need to be very specific with  
22 the terminology associated with it. In terms of

1 addressing the stigma associated with help-seeking  
2 behavior, we are talking about a cultural change  
3 and that is very, very difficult to achieve.  
4 We've had very limited success in our society with  
5 addressing culture shifts. Smoking campaigns and  
6 seatbelt campaigns are the two that come to mind.  
7 But aside from that, it's difficult to achieve. I  
8 think we're continuing -- what we're doing is very  
9 good -- talking about it, making it public, having  
10 officers like General Graham who come forward,  
11 having great Marine sergeants who come forward who  
12 demonstrate that what the Defense Center of  
13 Excellence is doing with the Real Warrior  
14 Campaign. All of those efforts need to be  
15 maintained. I don't know anywhere in the  
16 literature where there's a golden path for making  
17 a culture shift.

18 MAJOR GENERAL VOLPE: Okay. So you're  
19 saying that you have no recommendations for  
20 legislative or policy change to reduce stigma?

21 MR. SHAHBAZ: Sir, I have no  
22 recommendations.

1 MAJOR GENERAL VOLPE: Okay. Thanks.

2 LIEUTENANT COMMANDER CHAVEZ: Echoing in  
3 some ways to the extent that the -- the DOD as a  
4 microcosm of our general culture can support  
5 public campaigns that are changing the attitudes  
6 throughout our culture, because people's attitudes  
7 are partially formed when we require them to be  
8 important. One thin within Navy is -- or to the  
9 extent possible, even staying away from the word  
10 stigma -- there's different pieces that we all  
11 kind of throw into that Rubric, some of which are  
12 individual's attitudes and again just part in  
13 parcel of the thought process tend to increase as  
14 they're considering suicide. You know, the  
15 further down they go, the more constricted the  
16 thinking, the more inflexible, the more their  
17 attitudes change toward anything. That -- when we  
18 say well, we want to get rid of stigma it just  
19 sort of reinforces the idea every time we say the  
20 word. It's like don't think about a pink  
21 elephant, you know. It sort of just -- there's  
22 some other pieces that are barriers, that are

1 valid -- that are real barriers, you know, to  
2 certain types of policies or programs that -- or  
3 even just schedules. How feasible is it to get to  
4 that assistance in a certain operational tempo?  
5 If they speak up at a certain time right before  
6 deployment, well, you know, they probably are  
7 going to be missing a deployment to get an  
8 assessment because there's just not going to be  
9 enough time to get that done and that's going to  
10 have an impact on the mission. So there's very  
11 real barriers. They're not all necessarily all  
12 imaginary and/or just attitudes, which is kind of  
13 what falls into that stigma Rubric. The other  
14 piece is that the more people see that yes, you  
15 know, my, you know, shipmate here had an attempt  
16 or an idea and now they're sailor of the quarter  
17 this time. We actually had an instance of that in  
18 the command where I work. Then everyone can say,  
19 yes, it's possible to get reintegrated and they're  
20 probably more likely to get assistance as needed  
21 or use the support resources is just really what  
22 we're pushing, you know, in the way that world

1 class athlete will use, you know, a sport  
2 psychologist, a trainer, you name it. And that's  
3 not considered a negative. That's considered  
4 well, of course, you know. You want to be  
5 competitive. You use every resource available to  
6 you. And coaching things more along those lines  
7 because I think within the military the idea of  
8 getting help is still kind of as a counter --  
9 aversive kind of thing. So, supporting any  
10 DOD-wide reintegration processes because we don't  
11 always have ideal systems in place. For example,  
12 you know, if we have to have an individual that's  
13 not deployable for a while, can they still  
14 continue while they're getting some assistance or  
15 treatment or to have a viable career path? Or is  
16 that going to be a killer for them while they're  
17 on limited duty that they're not going to be able  
18 to advance because they're missing the key  
19 elements that they need? Do we have a viable sort  
20 of intensive outpatient programs at some of our  
21 facilities? I think it's kind of a rare -- rare  
22 piece to have a full sort of off-ramp/on-ramp when

1 somebody may need to get some more intensive work  
2 and still be able to successfully get back on. So  
3 any -- anything that can support reintegration  
4 processes isn't going to break down those barriers  
5 for everybody else because they'll see, well,  
6 yeah, that -- they did it. They did it. They're  
7 wearing stars now. I guess it's possible. So  
8 that would certainly be useful.

9           LIEUTENANT COLONEL KINDT: Mike Kindt.  
10 Sir, to answer your question, I have a couple  
11 ideas. One thing I'd ask you to look at in terms  
12 of its effect on stigma is -- that's been a  
13 concern of mine is the utilization of Military  
14 OneSource and some of the new creations that we're  
15 -- we're building that don't necessarily have  
16 military records associated with them. You can go  
17 to a chaplain and speak to somebody without any  
18 records and they're not going to talk to your  
19 commander about what's going on. In the Air  
20 Force, we have Military Family Life Counselors  
21 that are licensed professional counselors that are  
22 supposed to be doing kind of psycho education life

1 skill management issues with -- with military  
2 members and their families that also don't have  
3 records per se and don't have some of the  
4 requirements that we have within the medical  
5 system to report back to command. I think those  
6 things are great on the surface. My concern is  
7 that in the bigger picture, you can go to Military  
8 OneSource and your commander doesn't know what  
9 you're talking about, but if you come to the  
10 mental health clinic, those are the bad guys  
11 because those are the ones who can affect your  
12 career and impact your clearance and do these  
13 other things despite the evidence that we have in  
14 the Air Force that that is in the vast majority of  
15 the cases not going to happen. I think the more  
16 doors that we open for folks to seek care or  
17 intervention that doesn't have records, in some  
18 cases we may be highlighting some of the  
19 limitations of our own established systems. So as  
20 you're discussing that as a group, I'd ask you to  
21 consider that. The other issue with stigma -- one  
22 of the things that we talked about at lunch in one

1 of the other areas that the Air Force has been  
2 able to use the data to change policy, is that we  
3 do have a -- the Air Force Limited Privilege  
4 Suicide Prevention Program, which after some  
5 wrangling and Dr. Litts was involved with this  
6 with the legal folks, individuals who are believed  
7 to be at elevated risk for suicide and who are  
8 undergoing a courts martial or Article 15  
9 proceedings are allowed under policy to have  
10 privileged communications with a mental health  
11 provider that cannot be used in the  
12 characterization of their discharge or against  
13 them in court. I think that may be something in  
14 the policy that could be useful across the Air  
15 Force. One of the things we've begun to look at  
16 in the Air Force that might benefit from higher  
17 level influence is the idea of expanding that  
18 privilege to anyone who has been read their rights  
19 as part of an investigation. All of the services  
20 have talked about legal problems and  
21 administrative problems being a risk factor or  
22 increasing risk for suicide and if we can -- and I

1 think most of my colleagues would say that they've  
2 all heard stories of individuals going to their  
3 Area Defense Counsel and one of the first things  
4 the ADC tells them is don't go to mental health --  
5 or be wary of going to mental health because that  
6 might be used against you. If we could expand  
7 these programs to create greater confidence in our  
8 members, at least in some -- some subscribed --  
9 circumscribed conditions, those -- those  
10 revelations wouldn't come back to hurt them. I  
11 think that might go some distance to reducing  
12 stigma in at least some circumstances. Does that  
13 make sense, sir?

14 MAJOR GENERAL VOLPE: Yeah. Phil Volpe.  
15 Yeah, it does. That was helpful. So you're  
16 feeling is that in our response, in our  
17 activities, in our programs and initiatives that  
18 we're creating too many disparate entities that  
19 don't all communicate with each other and share  
20 information. It's almost like -- I shouldn't  
21 probably say this in public -- it's sort of like  
22 the intelligence was 10 years ago. Everybody has

1 and hoards their own intelligence in the  
2 intelligence community until some disaster  
3 happens, then we start sharing things to put  
4 patterns together and -- yeah.

5 LIEUTENANT COLONEL KINDT: Not just the  
6 -- the different pots of information that may be  
7 out there and not be -- not be being shared, but  
8 also the sense that I don't want to go see the  
9 psychologist on base or the psychiatrist on base  
10 because they are going to take a note that's going  
11 to follow me when I go for my next deployment  
12 screening or my next security clearance evaluation  
13 and if I go to Military OneSource or if I go  
14 somewhere else, that may not be as identifiable --  
15 that I might -- and by consequence, you are  
16 enhancing the stigma of our own native mental  
17 health services.

18 MAJOR GENERAL VOLPE: Yeah. So it's  
19 just almost like how do -- how do we -- how do we  
20 incentivize? Maybe that's not the word. How do  
21 we incentivize help-seeking behavior, but not at a  
22 level where -- I mean you don't want people taking

1 advantage of it either.

2 LIEUTENANT COLONEL KINDT: Yes, sir.

3 MAJOR GENERAL VOLPE: You know, how do  
4 you incentivize help-seeking behavior in people  
5 that need help seeking?

6 LIEUTENANT COLONEL KINDT: Yes, sir.

7 And I think Lieutenant Commander Chavez has -- has  
8 the right idea that we need to recast what we're  
9 doing not as correcting a deficiency, but  
10 enhancing performance. And that's one of the  
11 things that we -- we're trying to in our new  
12 suicide prevention training is create this idea  
13 that everyone has problems and dumb people let the  
14 problems overwhelm them -- their lives and get  
15 them in trouble and do those things and smart  
16 airmen address those things and look for ways to  
17 improve their effectiveness and mental health  
18 counseling could be one of those tools to enhance  
19 that effectiveness.

20 COMMANDER WERBEL: I have -- I had two.  
21 I just thought of another one, but I'll save it  
22 for another time. So I'll just stick with my

1 original two that I thought of when you asked the  
2 question, sir, or two recommendations specifically  
3 related to stigma. One, policy that at the DOD  
4 and service level that in greater detail outlines  
5 for service members what's going to happen when  
6 you end up in mental health -- what's going to  
7 happen depending on where you go, what an  
8 evaluation is. As an example, in the active duty  
9 -- in the military, we know that if we're class  
10 one, class two, class three in our dental exam,  
11 what that means. We know what it means for  
12 deployment. Maybe we're not deployable because  
13 we're class four. Maybe we, you know, we're not  
14 fully ready until we're class one in our -- I  
15 think I've got those classes right. Help me out  
16 here -- in the dental exam. I think our service  
17 members, while some of their opinions and their  
18 stigma of seeking help comes from just hearsay  
19 that's going to be out there anyway that we'll try  
20 and address in different ways, part of it is that  
21 our policy isn't clear to help them know what's  
22 going to happen -- what's going to happen and

1 what's not going to happen -- that you don't all  
2 of a sudden get the boot because you go see mental  
3 health and policy could be a little bit more clear  
4 in some details about what the possible  
5 ramifications are of going to mental health and  
6 why. And one of the elements of what I just said  
7 brings me to my second one which usually when I  
8 bring up makes people shudder. And that's in line  
9 with the dental exams, a mandatory mental health  
10 check-up -- annual -- for every service member in  
11 uniform. I say that for a couple of reasons.  
12 Primarily because in my experience which has been  
13 mostly with Marines -- sailors before the last  
14 four and a half years, but now with Marines. All  
15 they need is an opportunity to talk. When I did  
16 -- back when I did crisis response and CISM groups  
17 with a bunch of Marines in Naples, they talked  
18 about their fellow Marine who died and cried in  
19 front of me and in front of all their fellow  
20 Marines, because they had an opportunity to talk.  
21 They weren't macho, you know, men who couldn't let  
22 their emotions out. They cried. But in a safe

1 place where they knew they were amongst peers.  
2 The sergeants that I've watched become trainers in  
3 the NCO course are standing up in front of their  
4 peers talking about having sat in the bathroom the  
5 month before with a gun to their head, but didn't  
6 do it because of this. And talking about going to  
7 see -- talking about going to see mental health.  
8 They got an opportunity to do it. We did focus  
9 groups with Marines and it was fascinating to see  
10 the difference between officers and enlisted  
11 Marines and their response to their idea of  
12 mandatory, annual mental health exams. All of the  
13 officers pretty much said no way. That'll never  
14 fly. You know, it's not going to work and our  
15 Marines, you know -- forget it. With -- really  
16 from my memory, which is fallible, with no  
17 exceptions, the enlisted Marines said absolutely.  
18 Make us do it. If you make us go to see mental  
19 health every year, none of us are singled out for  
20 going to see mental health. We're all going to  
21 have to do it and once I'm sitting behind the  
22 door, maybe 80 percent of my unit still won't tell

1 about their problems, but 20 percent will just  
2 because they're behind the door and they didn't  
3 have to single themselves out to go see mental  
4 health. Everyone shudders because (a) people  
5 think, you know, well that's crazy. No one will  
6 do it and no one will talk about it anyway, but we  
7 don't need everyone to talk about their problems.  
8 We need a percentage of them to. And (b) because  
9 the resource implications of that are pretty huge.  
10 But, dental does it and when you do it and you go  
11 to your annual dental appointment, you don't only  
12 see the hygienist. You see the dentist for a  
13 brief period, too. That's it. That's it for  
14 today, sir.

15 MAJOR GENERAL VOLPE: It's -- I  
16 appreciate -- I appreciate everybody's comments  
17 and, you know, Fort Lewis is doing -- is not doing  
18 an annual thing, but what they're doing there is  
19 on redeploying troops and to not single out  
20 people, everybody goes through a mental health  
21 screening and the first two in line are the  
22 Commander and the Command Sergeant Major when the

1 unit comes back from theater to go through this  
2 process. It's pretty interesting and they're  
3 collecting data actually up there on the impact of  
4 that and stuff, but -- I appreciate that. Thank  
5 you.

6 LIEUTENANT COLONEL BRADLEY: One  
7 comment, sir. John Bradley. We have to recognize  
8 that we're struggling with a paradox of risk  
9 management and transparency and reducing stigma.  
10 Commanders want to manage risk and they want to be  
11 aware of all of the concerns that might affect  
12 their -- the troops under their command. They  
13 want to know what's going on in mental health.  
14 They want to know what's going on in substance  
15 abuse services. They want to know about the legal  
16 problems and they ask for information about that.  
17 They want a dashboard that will tell them what  
18 populations they have and what soldiers they have  
19 that are at risk. In Bradley's opinion, as long  
20 as we're catering to that need to know, that's an  
21 obstacle. It's an institutional obstacle to  
22 help-seeking behavior. So we've got to -- we've

1 got to reconcile that and try and look for some  
2 solutions to that paradox.

3 DR. KEMP: I just want to make one  
4 comment and thank all four groups here for being  
5 so transparent today and sharing with us -- you  
6 know, as a manager of a suicide program for a  
7 large organization, I know it's really, really  
8 hard sometimes to talk about what you do and you  
9 all did a great job. So, I just wanted to say  
10 thank you for that.

11 DR. McKEON: Richard McKeon again. Let  
12 me just kind of echo that because I think if you  
13 look at every community in America, you would have  
14 to say that -- that the communities that are  
15 probably focusing the most on suicide prevention  
16 currently are the Army, Navy, Air Force and  
17 Marines and along with our colleagues in the  
18 Veterans Administration. These are the  
19 communities that are paying the most systematic  
20 attention to it. And granted that none of us have  
21 found the answers yet, but the efforts are  
22 extraordinary and I know that we on this task

1 force will, you know, do our best to be a help and  
2 not a hindrance to your efforts and we look  
3 forward to working in partnership with you,  
4 because you're doing incredibly important work and  
5 you're doing it well.

6 MAJOR GENERAL VOLPE: Okay, we're going  
7 to go towards closing -- closing this session.  
8 But let me -- let me thank all the panel members  
9 here first for not only for your briefs and  
10 information -- provided very valuable information  
11 -- and echoing the comments of some of our task  
12 force members here and actually all of the task  
13 force members really greatly appreciated what --  
14 we have a feeling that we will be interacting with  
15 you again in the future, because you have so much  
16 knowledge and information that we all need to have  
17 to be helpful in this process and make a  
18 difference in the end. So, thank you all very  
19 much for being here today and being patient with  
20 us and answering our questions. I would like to  
21 turn it over to Commander Feeks for some  
22 administrative comments.

1                   COMMANDER FEEKS: This is Commander  
2                   Feeks. Thanks, General Volpe. I want first of  
3                   all to publicly honor Lisa Jarrett for all the  
4                   work that she did and the preparations and  
5                   arrangements for this meeting. It was an enormous  
6                   amount of work and she did such a good job and  
7                   then conducted such a good and gracious turnover  
8                   with Mike taking his team that we had a very  
9                   smoothly run meeting and you'd never know these  
10                  people just came aboard two days ago. So well  
11                  done, Lisa! That said -- that said, Mike, you'd  
12                  never know your team just came aboard two days  
13                  ago. You guys did a great job. I know you  
14                  probably haven't gotten much sleep in the last 60  
15                  hours, but you look pretty good and it was a good  
16                  smooth meeting. So thank you very much. The next  
17                  item is first of all, if you would please leave  
18                  your name tag on the table and you'll see it again  
19                  in a week. The next thing I want to say is this  
20                  and Bonnie Chavez knows this very well, that we  
21                  crossed that magic date of October 1. And what  
22                  that means is that money changes years and in the

1 Federal Government that's significant. What will  
2 happen is this. Reimbursement for your travel  
3 will be delayed until approximately October 15,  
4 that's if you get all your stuff in -- all your  
5 receipts in that you're supposed to turn in to the  
6 travel people to -- for them to put in your travel  
7 claim. But, don't be surprised if you're not paid  
8 before October 15, because that's how long it  
9 takes to get the accounts for the new fiscal year  
10 set up. Finally, I wanted to introduce the task  
11 force to Gail Walters if I -- did I say it right?

12 Okay. So let me have you stand up, Gail. Gail  
13 is, among other things, your media relations  
14 person. So if you're approached by a member of  
15 the media in conjunction with your work on the  
16 task force, your first thought should be Gail  
17 Walters and she's going to share her contact  
18 information with you and if you are contacted by a  
19 member of media, she'll give you some just-in-time  
20 training for how to handle that. Even if you're a  
21 seasoned pro in talking to the media, there are  
22 some rules about what you can and can't say as a

1 member of the task force. So, and in fact, I'm  
2 going to ask Gail to give us some specific media  
3 relations training during an admin session at a  
4 later meeting. But, anyway, so think of Gail if  
5 you talk to the media. And this concludes my  
6 remarks. General, back to you, sir.

7 SPEAKER: If you did have a parking  
8 voucher, please check at the front desk. We do  
9 have them for all of you.

10 MR. MORALES: Sir, I have a comment real  
11 quick. Commander Feeks, did I hear you say that  
12 you're expecting the service managers or reps at  
13 the next meeting?

14 COMMANDER FEEKS: I did not say that and  
15 they don't have -- they're not on the agenda to be  
16 present. It wouldn't surprise me if service reps  
17 came to these meetings on a pretty regular basis,  
18 although I haven't discussed that with the  
19 co-chairs, sir.

20 MR. MORALES: Okay. Just wanted to make  
21 sure.

22 MAJOR GENERAL VOLPE: Just to clarify, I

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1 mean we'll -- we'll request and ask if you need to  
2 specifically present something or we need you  
3 there, but this is -- this is an open public  
4 sessions when we have them and you're --  
5 everybody's welcome in the entire United States to  
6 come and join us at these -- at these sessions.  
7 And actually we would hope that you would choose  
8 to do that because you would be able to listen to  
9 what's going on and how we're deliberating and  
10 getting information and that might be helpful to  
11 the services at the same time. Also an avenue to  
12 share and cross pollinate information and what  
13 other things are going on in other places. So,  
14 but -- yeah. You're welcome to join us.

15 MR. MORALES: Thank you, sir.

16 MAJOR GENERAL VOLPE: With -- this  
17 concludes the public portion of our meeting and  
18 I'd like to ask Colonel Christine Bader, who is  
19 the Acting Designated Federal Official for Ms.  
20 Embry to close the meeting at this time -- adjourn  
21 the meeting.

22 COLONEL BADER: Thank you. I'd like to

1 echo comments. We really tremendously appreciate  
2 everybody's efforts in getting here today. Thanks  
3 to the task force members and to the speakers and  
4 to all of the support staff. It was a very  
5 successful first open meeting. So thanks -- thank  
6 you, everybody. With that, I call the DOD Task  
7 Force on the Prevention of Suicide by Members of  
8 the Armed Forces adjourned. Thank you.

9 (Whereupon, at 5:20 p.m., the  
10 PROCEEDINGS were adjourned.)

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