

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

**15 January 2010**

**Hyatt Regency Washington on Capitol Hill  
400 W Jersey Ave.  
Washington, DC 20001**

**1. ATTENDEES**

**PRINCIPAL MEMBERS & REPRESENTATIVES**

	<b>TITLE</b>	<b>LAST NAME</b>	<b>FIRST NAME</b>	<b>ORGANIZATION</b>
X	MG	Volpe	Philip	Joint Task Force National Capital Region Medical, Task Force Co-Chair 8901 Wisconsin Ave. Building 27 Bethesda, MD 20889
X	Ms.	Carroll	Bonnie	Tragedy Assistance Program for Survivors, Task Force Co-Chair 910 17 <sup>th</sup> Street, NW Suite 800 Washington, DC 20006
X	Dr.	Berman	Alan	American Association of Suicidology 5221 Wisconsin Ave., NW Washington, DC 20015
X	COL	Bradley	John	Walter Reed Army Medical Center 6900 Georgia Avenue, NW Washington, DC 20307
	Dr.	Certain	Robert	St. Peter & St. Paul Episcopal Church 1795 Johnson Ferry Rd Marietta, GA 30062
X	CMSgt	Gabrelcik	Jeffory	Andrews Air Force Base 1535 Command Drive Suite E302 Andrews AFB MD 20762
X	SgtMaj	Green	Ronald	Headquarters Marine Corps United States Marine Corps 1555 Southgate Road Arlington, Va. 22214
X	Dr.	Holloway	Marjan	Uniformed Services University of the Health Sciences 4301 Jones Bridge Road, B3050 Bethesda, MD 20874
X	Dr.	Jobes	David	The Catholic University of America 314 O'Boyle Hall Washington, DC 20064

X	Dr.	Kemp	Janet	VISN 2 CoE Center of Excellence Canandaigua VAMC 400 Fort Hill Ave Canandaigua, NY 14424
X	Dr.	Litts	David	Suicide Prevention Resource Center/ Education Development Center, Inc. P.O. Box 43 Macatawa, MI 49434
X	Dr.	McKeon	Richard	Suicide Prevention Substance Abuse and Mental Health Services Administration United States Department of Health and Human Services 1 Choke Cherry Road Rm.6-1105 Rockville, MD 20857
X	Col	McPherson	JoAnne	Office of the Secretary of Defense/Health Affairs Skyline 1, Suite 810 Falls Church, VA 22041
X	MGySgt	Proietto	Peter	CMC (SD) Navy Annex Washington D.C. 20360-1775
X	CDR	Werbel	Aaron	United States Marine Corps Headquarters, Marine Corps (MRS) 5820 Russell Road Quantico, VA 22134

### GUESTS & OTHER ATTENDEES

	TITLE	LAST NAME	FIRST NAME	ORGANIZATION
X	CDR	Feeks	Edmond	DHB Executive Secretary
X	LTC	Ueoka	Alan	JTF CAPMED
X	CDR	Malone	Rosemary	Office of the Armed Forces Medical Examiner
X	Ms.	Oetjen-Gerdes	Lynne	Armed Forces Medical Examiner System, AFIP
X	Dr.	Rake	Geoffrey	DoD Patient Safety Analysis Center
X	Dr.	Campos	Rene	Military Officers Association of America
X	Ms.	Cosley	Kim	US Coast Guard
X	Dr.	Ramchand	Rajeev	RAND Corporation
X	Mr.	Taylor	Eric	CNO Staff
X	Ms.	Ruocco	Kim	TAPS

X	Ms.	Heuer	Kathy	Integrity One Partners
X	Ms.	Greene	Fairah	USUHS
X	Ms.	Mandry	Sue	HealthNet
X	Mr.	Szeto	Edwin	USUHS
X	Ms.	Cantrell	Joyce	AFIP
X	Ms.	Hall	Joan	HQ, USAMRMC
X	COL	Castro	Carl	HQ, USAMRMC
X	Mr.	Jenning	Keith	The Catholic University of America
X	MAJ	Hall	Jeffery	WTB, Fort Riley
X	Mrs.	Hall	Sherry	Army Spouse
X	MAJ	Thomas	Jeff	WRAIR
X	Ms.	Julie	Hughes	BAH Contract Support to DCoE

**2. ADMINISTRATIVE SESSION (closed)**

**3. OPENING REMARKS AND INTRODUCTIONS**

**4. DoD PATIENT SUICIDE RCA PROCESS**

Dr. Geoffrey Rake presented, “DoD Patient Safety Analysis Center: DoD Patient Suicide RCA Process”. (Briefing attached)

**SUMMARY OF PRESENTATION:**

The Department of Defense Patient Safety Analysis Center serves as the Root Cause Analysis (RCA) repository. The center receives between 60-100 RCAs a year. The Department of Defense Patient Safety Analysis Center performs data analysis of adverse events and generates reports, reviews, alerts and advisories.

**Root Cause Analysis (RCA)**

An RCA is a process used to review specific events, verify why the event happened and develop recommendations to prevent the event from happening. The RCA process is an in-depth analysis that takes about 50-100 hours of staff time. The decision to complete a RCA is based on the severity of the event or the potential that the event may occur. The Joint Commission has standards that specify what events need RCAs and what kind of RCAs need to be produced. DoD Service Headquarters also have polices which determine when RCAs are required. For example, in the past the Air Force made a determination that ambulatory events that had substantive behavioral health involvement should have a

RCA. Other Service branches may have other criteria for RCAs. Organizations that submit their RCAs to the Joint Commission and Higher Headquarters are Joint Commission accredited.

The DoD Patient Safety Analysis Center only receives RCAs that were selectively submitted to the Joint Commission and Higher Headquarters. Not all RCAs are submitted to the Higher Headquarters because some organizations who complete RCAs are not Joint Commission accredited. Those RCA's are not submitted to either the Joint Commission or The DoD Patient Safety Analysis Center.

The RCAs that are sent to the Patient Safety Data Analysis Center are usually reviewable sentinel events. Sentinel events are an unexpected occurrence or variance involving death or serious physical or psychological injury or risk thereof. The Joint Commission states that if a suicide occurs in an inpatient status or within 72 hours of discharged it is a reviewable sentinel event. Typically, the DoD Patient Safety Analysis Center does not see suicides within an inpatient setting.

### **The Joint Commission Minimum Scope of Root Cause Analysis**

The Joint Commission defines 14 elements in the minimum scope of a RCA. Each of the following elements are viewed and documented in the RCA process.

1. Behavioral Assessment Process
2. Physical Assessment Process
3. Patient Observation Procedures
4. Care Planning Process
5. Continuum of Care
6. Staffing Levels
7. Orientation & Training of Staff
8. Competency Assessment/Credentialing
9. Supervision of Staff
10. Communication with Patient/Family
11. Communication Among Staff Members
12. Availability of Information
13. Physical Environment
14. Security Systems and Processes

### **The RCA Process**

An RCA process is initiated in the event of a suicide, suicide attempt, and the initial response to the event. After the event occurs, an event report summarizing the event is immediately completed. The event report is used to determine whether or not an RCA is needed. The decision to complete an RCA is made generally in coordination with the Joint Commission, in the case of accredited facilities, and with Higher Headquarters. If an RCA is needed, an RCA team is formed. The RCA team is a multidisciplinary team of 5-10 individuals formally chartered by organization leadership. The individuals on the team will be people with similar specialties or skills sets of the individuals involved in the event.

The RCA team reviews medical records, evaluate perishable documents, complete interviews and research. After gathering information the RCA team conducts an analysis and generates the RCA report. The RCA report can be retained within the facility or sent though Higher Headquarter and submitted to the Joint Commission for their review. Once the report is sent to the Joint Commission it is ultimately submitted to the Patient Safety Data Analysis Center.

### **Constituting a Credible RCA**

A credible RCA report must be thorough and plausible. The report must include a summary of the event, identification of causal factors, development of an action plan, outcome measures (which looks at the implementation of the particular action plan), and the development of a flow chart called a “snap chart”, which illustrates the temporal flow from the earliest aspects of an event to the conclusion of an event.

### **Using Data from the RCA**

The RCA team completes annual and mid-year summaries, builds focus reviews, takes the lessons learned from their investigation and disseminates it through a Patient Safety Program newsletter. The DoD Patient Safety Analysis Center also collaborates with the DoD and VA to share RCA data.

### **Dr. Rake’s Recommendations:**

1. RCAs related to suicide are underutilized. More RCAs should be done in terms of looking at ambulatory suicides, particularly where there is substantive behavioral health involvement.
2. Any RCA involving suicide should be submitted to the Patient Safety Data Analysis Center even if they don’t have a requirement to be submitted to the Joint Commission.
3. Additional elements such as branch of Service should be added to the RCA data collection tool. Adding that element will enable data to align with various data streams.

## **SUMMARY OF QUESTIONS AND DISCUSSION**

- Dr. McKeon asked Dr. Rake to clarify his first recommendation. Dr. Rake reiterated that his recommendations were:
  1. More RCAs should be done in terms of looking at suicides that have a substantive behavioral health involvement.
  2. All RCA’s should be submitted to the Department of Defense Patient Safety Analysis Center.
  3. The branches of Service should be included as an important element of the RCA, so data can be compared to understand the provision of care, the environment and demographic context of the individual.
- Dr. Litts asked how many RCAs Dr. Rake had on file and whether he had recommendations or lessons learned for improvements. Dr. Rake stated that he had 28 RCAs and explained that it is hard to generalize lessons learned due to the limited amount of data that he receives.
- Dr. Litts asked how much data is needed to make a recommendation of improvement. Dr. Rake stated that it may differ if a statistical perspective is being used. Dr. Rake explained that he can start seeing patterns and trends that occur earlier on with a lesser number of RCAs. The DoD Patient Safety Analysis Center is currently collaborating with the VA to leverage some lessons learned.
- Dr. Kemp asked Dr. Rake to talk about patient safety initiatives that he have implemented in the area of suicide prevention and whether there are any patient plans such as checklists or rules. Dr. Rake answered that he did not generate anything specific and is not aware of anything at the

patient safety level that looked at suicide systemically. Dr. Kemp asked whether there were patient safety officers at each one of the installations. Dr. Rake replied yes, patient safety officers are at each installation.

- Dr. Berman asked Dr. Rake to explain why there are only 28 RCAs. Dr. Berman asked whether there were any barriers to getting more. Dr. Rake explained that 15 of the 28 were reviewable sentinel events, which would be inpatient and/or within 72 hours of discharge.
- Dr. Berman asked whether the budget has limited Dr. Rake's ability to do more and whether the process of RCA is expensive. Dr. Rake does not think the budget has limited the number of RCAs. When a facility makes a determination to do a RCA they have to balance the risks associated with a particular event that occurred and decide whether it is effective to bring together an RCA team. Higher Headquarters such as the Joint Commission makes those decisions in certain instances.
- Dr. Kemp stated that there becomes a saturation point when RCA after RCA has been completed. The VA is currently looking at alternative ways to look at events.
- Dr. McKeon stated that within his experience with RCAs, he always found something to learn. He understood that there could be a saturation point but felt that the RCA process is untapped in terms of what could be learned. Dr. McKeon stated that the behavioral health care system is an important area to make stronger due to the significant amount of deaths from suicide that has touched behavioral health care system.
- Ms. Carroll asked whether family members are consulted and part of the analysis. Dr. Rake stated that there are challenges associated with consulting the family members and including them in the analysis such as, quality assurance rules. However, family members have been consulted in the past.
- Chief Gabrelcik asked whether it would be beneficial to include the family members to the RCA to see if there are trends with the family or with the member themselves. Dr. Rake replied although he doesn't feel he is the appropriate person to answer that question, he feels that family members would be valuable in terms of the process of collecting information and interviews at a minimum. There are also suggestions to involve chaplains as members of the RCA team.
- Dr. Kemp stated that one of the lessons that the VA learned is that the RCA process with inpatient safety is very quality management oriented. Dr. Kemp asked whether moving the RCA process into a type of psychological autopsy review would be more effective to get better information. Dr. Rake agreed that there would be better information.
- Dr. Berman stated that the American Association of Suicidology is currently completing a study of suicides on railways using a combination of psychological autopsy and RCA. Dr. Berman strongly suggested involving family members in the RCA process.

- Dr. Holloway asked whether RCAs have been done historically for suicides in deployed settings. Dr. Rake answered no. Generally RCAs were done in support of Joint Commission accreditation and deployed facilities are not Joint Commission accredited. Dr. Rake also mentioned that the resources needed to conduct an effective RCA in a deployed setting may not always be available.
- Dr. Litts asked whether the Joint Commission’s minimum standards includes communication with the patient and family. Dr. Rake answered yes; family members are an element that is included in the RCA in terms of communication issues. Dr. Rake could not recall the percentage of RCAs that have data from family members.
- Dr. Jobs asked whether the RCAs or psychological autopsies could fit together with postvention or support for staff members. Dr. Rake agreed that this was possible.
- CDR Werbel asked how Dr. Rake felt about using the Tap Root process in a RCA for a suicide investigation. Dr. Rake replied that he felt it could be used because the RCA process is an industrial model that is not developed for a health care environment. It is adaptable to any organizational structure and can be used at an operational unit.

## **5. OFFICE OF THE ARMED FORCES MEDICAL EXAMINER (AFME) ARMED FORCES INSTITUTE OF PATHOLOGY**

CDR Rosemary Malone presented, “AFME Psychological Autopsy”. (Briefing attached)

### **SUMMARY OF PRESENTATION:**

#### **Policy**

The DoDI 5154.30 March 18, 2003, Armed Forces Institute of Pathology (AFIP) Operations instruction is the governing policy that supersedes any other service-specific regulation. The DoDI 51543.30 policy established a division for psychological investigations (PI). The primary purpose of the policy is to clarify psychological autopsies and to assist the Medical Examiner (ME) in ascertaining the Manner of Death (MOD).

The DoDI 5154.30 instruction allows AFME to delegate authority regarding psychological autopsies (PA) to the Chief Deputy ME within the PI division. According to DoDI 5154.30 instruction CDR Malone is tasked to maintain a PA registry, and to coordinate and supervise the PAs.

Military Services are responsible for PAs of their Service members. If a PA request is made and approved by the Chief Deputy ME the appropriate military service is notified and the case is assigned. A Mental Health professional who has an active unrestricted license and received specific forensic training (Forensic Psychologist or Psychiatrist) is authorized to conduct a PA and submit a report of findings. The PA report is provided to the ME with a copy to the Military Criminal Investigative Organization and if requested to the Next-of-Kin (NOK).

#### **History: Civilian**

In 1958, the Los Angeles (LA) ME consulted the LA Suicide Prevention Center for further classification of equivocal death findings. The LA Suicide Prevention Center’s Co-founder and Co-

Director, Dr. Edwin Shneidman, was a psychologist who coined the term psychological autopsy while working in the field of suicidology.

### **Military History: Army**

The Army has worked with PAs as early as the 1980s. The Army has published both pamphlets and regulations regarding PAs. The Department of Army (DA) Pamphlet 600-24, "Suicide Prevention and Psychological Autopsy" 1988 is informational and states that a Commander or Special Agent In Charge (SAIC) could request a PA. This authority enabled the Army to develop prevention programs, lessons learned and promoted epidemiological studies. It also permitted mental health officers who were conducting investigations to have contact with family members to facilitate bereavement counseling. Army Regulation (AR) 195-2; "Criminal Investigation Activities", states that a PA is required.

AR 600-63, "Army Health Promotion", 17 November 1987 and 28 April 1996 clarified the nature of death, focusing on psychological aspects of a dead person. AR 195-2 is cited within AR 600-63, which states a mental health officer will conduct a PA. According to AR 600-63 a report of the PA is included in the Criminal Investigation Command (CID) Report of Investigation and sent by the preparing officer through the Major Army Command (MACOM) to the Headquarters, Department of the Army (HQDA) and to the Commander at Walter Reed Army Institute of Research for deaths that are confirmed or suspected suicides, single car motor vehicle accidents (MVA) with no survivors, when requested by the Commander of the local CID office, accidents involving unusual or suspicious circumstances, all cases in which the MOD is equivocal and other cases when requested by the Commander or SAIC of the local office.

AR 600-63 was updated in September 2009. Commands from all components are required to conduct investigations as directed in AR 15-6 for every suicide or equivocal death that is a possible suicide. PAs will be initiated only at the request of the involved ME or CID. A Senior Commander may request a PA through CID. The PA results are made available for review to the Deputy Chief of Staff (DCS), G-1 Army Suicide Prevention Program (ASPP), the local Suicide Prevention Task Force (SPTF) and the USA Center for Health Prevention and Prevention Medicine (CHPPM). The report is made available to these organizations to assist with determining trends, data points and documenting lessons learned.

Pamphlet 600-24, "Health Promotion, Risk Reduction, and Suicide Prevention", 24 November 2009, served to increase the accuracy of the reports. The pamphlet includes information on Fatality Review Board reviews the PA to identify possible causes, evaluate prevention efforts and make recommendations to the Commander.

### **Military History: Navy and Air Force**

Only 5 to 10 percent of all cases in the Navy and Air Force are selected for a PA. The cases that are selected are equivocal deaths or high-profile cases. The PAs are conducted by highly trained psychologists on staff at Naval Criminal Investigative Service (NCIS) and Office of Special Investigations (OSI).

### **Military History**

The explosion on the USS Iowa led to the Federal Bureau of Investigation (FBI) to begin conducting their version of a PA. The USS Iowa 1989 FBI Equivocal Death Analysis report was very controversial and led individuals to begin questioning how PAs are conducted, who should conduct them and what purpose a PA served. An additional report was completed titled, DoD IG Report 1996: Review of DoD Policies & Procedures for Death Investigations, which stated DoD is to expedite the issuance of an overall policy for conducting and using the results of a PA. In addition, the report recommended

Military Departments to develop implementing procedures, quality assurance and a disclaimer on the front cover of the results.

There was a delay in developing a DoD-wide policy and non-concurrence from the Services. The Health Affairs Policy Letter 2001 was signed by the Acting Assistant Secretary of Defense and sent to all Secretaries of the Services. The letter clarified that the primary purpose of a PA is to assist in ascertaining the MOD where the manner of death has not been determined or in other unusual circumstances. In addition, the PA may be performed when approved by the AFME to amplify information or help explain circumstances relating to a suicide.

### **PA Investigations and Report**

A PA investigation and report can take up to 20 - 50 hours of work, two to four months and over 10 pages. The content is not standardized; however, there are some important areas to investigate and include in a report.

The following are important factors to capture in the PA investigation and report:

- Source/Reason for Request
- Demographics
- Sources of Information
- Records & Documents
  - Medical records
  - Toxicology reports
- Death Scene Evidence
- Personality & Lifestyle
- Recent Stressors
- Significant relationship
- Developmental & Social History
- Educational, Financial, Legal, Medical (Family), Military, Occupational and Psychiatric(Family) histories
- Spirituality
- Reactions to death
- Timeline
- Analysis of Manner of Death
- Forensic Opinion

### **PA Versus Other Investigations**

A PA is also referred to as an Equivocal Death Psychological Autopsy (EDPA). The purpose of an EDPA is to assist the ME in determining the MOD. A forensically-trained psychiatrist or psychologist conducts the EDPA. The typical deaths that undergo an EDPA are drug-related or staged death scenes.

Another investigation commonly referred to as a Behavior Analysis Review (BAR) is also called a Suicide Psychological Autopsy (SPA). The BAR is used to understand which psychological factors contributed to suicide for the purposes of intervention and risk mitigation. Service psychologist conduct BARs. Commanders often request for a BAR to get an overview of what occurred, identify if something was not investigated and how to improve the process.

## **6. MILITARY OPERATIONAL MEDICINE RESEARCH PROGRAM**

COL Castro presented, "Research Efforts Toward Reducing Suicide Behavior among Military Service members and Veterans". (Briefing attached)

### **SUMMARY OF PRESENTATION:**

#### **Role of a Research Area Director (RAD)**

RADs are responsible for problem solving within their assigned mission space, overseeing the development and execution of a research program and coordinating with medical RDTE Program Managers of other DoD Components. COL Castro is responsible for 4 main lines of research areas that include injury prevention and reduction, psychological health and resilience, physiological health, and environmental health and promotion.

#### **Evidence-based Military Public Health Suicide Prevention Model**

A good evidence-based model has to validate suicide screening instruments used by all Service members, obtain information from surveillance programs and conduct an analysis of the data retrieved. Executive management or the Board of Directors would review the data to develop policies. After policies are developed, suicide prevention training, suicide assessments, treatment and management would be validated.

#### **Levels of Scientific Evidence**

The lowest level of scientific research is level one which is an expert's opinion. The second level of scientific research is simple case studies or series. The third level of scientific research is comparison studies, followed by randomized trials, then a series of randomized trials.

#### **Suicide Prevention RDT&E 2007-2009**

In 2007, the Army established a five year study with the National Institute of Mental Health (NIMH). The Navy is not currently funding any suicide research studies. The Air Force is in the process of developing suicide research studies.

#### **Suicide Research**

There are currently five studies directed toward epidemiological research. The goals for the studies are to analyze how to manage suicides and to review the risk screening instruments. In comparison to Post Traumatic Stress Disorder (PTSD) studies the epidemiology cases are underfunded. Four current studies are directed toward managing suicide behavior and one study is validating a risk screening instrument to predict suicide related outcomes among Army recruiters in-training.

#### **Unfilled Research Gaps**

There are several gaps in suicide research. These gaps include:

- Universal prevention
- Psychometrically sound, theory-driven screening measure(s)
- Basic science to validate underlying psychological and bio-psychological theories of suicide
- Theory-driven evidence-based treatment studies (in-patient and outpatient)  
(i.e., CBT, CT, DBT, Interpersonal Therapy [IPT])
- Other evidenced based indicated interventions to prevent and manage suicide behavior (e.g., caring outreach, collaborative assessment and management, safety planning, collaborative care models, etc.)
- Combined psychotherapy and pharmacotherapy treatment studies

- Research to examine the effects of brief interventions to reduce problem drinking on suicide behavior and other outcomes (e.g., accidents, homicide, intimate partner violence, etc.)
- A research approach that integrates a brief evidence-based intervention to reduce problem alcohol or drug use in the primary care setting (e.g., enhanced RESPECT-MIL)
- Evidence-based systems of care

#### **SUMMARY OF QUESTIONS AND ANSWERS:**

- Dr. McKeon asked if there is an oversight on funding for training on suicide prevention. COL Castro replied that there are plans in the future to fund training on suicide prevention.
- Dr. Kemp asked if there is a mechanism to report a trend in autopsies to the field. Dr. Rake replied there are several mechanisms such as newsletters, VA alerts and advisories. Dr. Rake also commented that the Patient Safety Program is also helpful in disseminating information to Military Health System (MHS) personnel.
- CDR Werbel asked for clarification on the PA process and procedure. CDR Malone replied when the request for a PA is made her office determines if a PA should be initiated based on DoDI instruction.
- Dr. Berman asked if there are any barriers within the DoD and Military Services to gather archived documents and records for completing PAs. He also asked about the cost for completing a PA. CDR Malone replied there is some difficulty in retrieving civilian records. In addition, she stated a PA costs about two hundred and fifty dollars an hour.
- Dr. Holloway asked what percentages of suicides receive a PA. CDR Malone replied that she did not have a definite number but estimated from 2003 through 2006 half of all suicide cases received a PA. Dr. Holloway also asked CDR Malone to explain the process for sharing the PA with family members. CDR Malone stated that when a NOK requests a PA, a cover letter is sent to the family member stating that it may be helpful to have a chaplain present when reviewing the PA. In addition, CDR Malone mentioned that the PA report includes forensic and medical terminology that may require clarification by her office.
- COL Bradley asked if families provide feedback on the types of behavioral health or spiritual support available at the time of death. CDR Malone replied family members receive support through the Command.
- Dr. Berman asked if there is a data set that could be aggregated and could provide information from the last 30 days of a series of suicide cases. CDR Malone replied that a PA would provide the best information.
- Dr. Jobs asked if there are recommendations to go forward to standardize the PA. CDR Malone replied that currently there is a peer review process with NCIS, OIS and members from a fellowship program (military and civilian) to review literature to come to a consensus as to what minimally needs to be included in a PA report. Dr. Jobs also asked for the timeline on rewriting the PA instruction. CDR Malone stated the revision could happen within the next 12 to 15 months.

- Dr. Holloway asked whether any suicides occurred within an inpatient military setting and what were the conclusions from those cases. Dr. Rake replied yes, there are suicide cases that occurred within an inpatient military setting and the conclusion identified is a lack of communication.

## 7. MHAT 6

Jeffrey Thomas presented the “Mental Health Advisory Team (MHAT) 6 Study Results”.  
(Briefing Attached)

### SUMMARY OF PRESENTATION:

The MHAT 6 study had a three-fold mission:

1. To provide a theater-wide assessment, both in Afghanistan and Iraq, over the past six or seven years of soldier mental health and well being;
2. To examine the delivery of behavioral health care on the battlefield;
3. To collect data, write the report, and make recommendations for sustainment and improvement.

Data was collected from Iraq between February to March 2009. Data was collected from Afghanistan from May to June 2009. The MHAT 6 study was the first to employ random sample of pre-selected platoons outside of the large Forward Operating Bases (FOB). Separate samples were obtained for maneuver and support/sustainment units.

Key OEF findings included:

- Psychological problems: 14.4% of maneuver Soldiers met criteria for depression, anxiety, and/or acute stress—higher than 2005 but similar to 2007. Support/sustainment rate similar to maneuver rate.
- Combat exposure: Higher than previous MHATs
- Barriers to care and Stigma: Maneuver unit barriers higher than previous MHATs. Increase may reflect change in sampling. Stigma rates held constant.
- Multiple deployments: Higher rates of mental health problems and marital problems for multiple deployers.
- Behavioral health assets: Understaffed IAW Combat and Operational Stress Control Planning Models of 1:700 to 1:1000 staffing ratio.

Key OIF findings included:

- Psychological problems: Rate of 11.9% in maneuver units: significantly lower than every year except 2004. Support/sustainment rate is similar.
- Combat exposure: Combat exposure levels lower than every year except 2004. Support/sustainment units significantly lower than maneuver units.

- Barriers to care and stigma: Maneuver units reported high barriers. Support /sustainment sample report low barriers. Stigma held constant.
- Dwell-time: Related to mental health rates in maneuver units. Rates nearly return to garrison rates at 24 months dwell-time. Full return in 30 to 36 months.
- Marital problems: Divorce/separation intent steadily increasing.
- Resilience: Positive officer leadership key factor producing resilient platoons.
- Suicide: 2008 rate 21.5 per 100k are similar to 2007. This is the first time since 2004 that the OIF theater rate (all Services) has not increased.

The key finding with regard to Psychological Problems for OEF troops was that roughly 14% of the maneuver soldiers met criteria for depression, anxiety and/or acute stress, and that this was higher than rates in 2005 (10.4%) and similar in 2007. The MHAT 6 study found that support and sustainment units had very similar rates as compared to the maneuver (15% vs. 14.4%, respectively). With regard to OIF troops, the rates of mental health problems (depression, anxiety and/or acute stress) were significantly lower than every year except for 2004 (16%).

The key finding for Combat Exposure for OEF forces was that reported levels of combat exposure in maneuver units was significantly *higher* than 2005 (10.7%). Rates for support/sustainment units were significantly *lower* than maneuver unit rates (6.2% vs. 10%, respectively). Reported levels of combat exposure for OIF forces in maneuver units were lower than every year except 2004 (10.3%). Rates for support/sustainment rates were significantly lower than for maneuver rates (3.9% vs. 9.3%, respectively).

With respect to Multiple Deployment for OEF forces, soldiers on their second or third deployment more likely to meet screening criteria for psychological problems. Soldiers on their third deployment were nearly two times more likely to report marital problems than soldiers on first deployment (30.8% vs. 14.3%, respectively).

The key finding for Barriers to Care and Stigma for OEF forces were that maneuver soldiers reported significantly more barriers to care when compared to either 2005 or 2007. There were no significant changes in stigma across OEF forces for 2005, 2007, and 2009. Stigma about receiving mental health care remains a concern. There was more stigma concern in maneuver units compared to support and sustainment units (Note: no specific data was provided for this assertion.)

With respect to OIF forces and Barriers to Care and Stigma, maneuver soldiers reported significantly more barriers to care than every previous year except for 2003 (26.3%). This was likely due to the sampling design that surveyed more soldiers outside of the FOBs, a group that has difficulty accessing care. Overall, stigma issues for OIF forces had the same pattern of data as in OEF forces. The overall trend for stigma had not changed over time and maneuver unit stigma was higher than that for support/sustainment units.

The MHAT 6 study reported that the OIF theater rate for suicides for all Services and the individual Army rate in 2008 were not significantly different from 2007 (24.6 and 25.6, respectively for OIF Army and 20.2 and 19.2 respectively, OIF theater). This was the first year (2008) since 2004 that the theater rate had not increased. The MHAT 6 study also found that there were fewer providers per Service member for OEF forces compared to OEF 2007 and OIF 2009. Specifically, as of 31 May 2009 the staffing ratio was 1:1,123 personnel, which is fewer than the 1:700 recommended staffing level.

Dwell Time for OIF forces was significantly related to mental health problems. Based on the 2004 Hoge et al study, a 10% rate of mental health problems for garrison troops would be considered normal. The study showed that OIF forces required 24 months dwell time to accomplish a near return to garrison mental health rates and 30-36 months of dwell time to achieve a full return.

The MHAT 6 study reported that Marital Relationships had declined particularly for junior enlisted with young soldiers being the most vulnerable. Reports of intent to get divorced or seek a separation significantly increased (21.9% in 2009 vs.12.3% in 2003).

One of the favorable results was the impact of officer leadership on increases in resiliency. The study evaluated acute stress scores for soldiers with high levels of combat and found that good officer leadership was a main factor leading to resilience.

The MHAT 6 study made the following recommendations:

- Delivery of behavioral health care in theater
  - Implement a dual-provider model within BCTs
  - Create an NCO 68X30 position in Brigade Behavioral Health Section
  - Establish organic behavioral health requirement on the National Guard BCT Table of Organization & Equipment (TO&E)
  - Recommend assigning a Behavioral Health Advocate per battalion who has been trained in the basics of behavioral health
  - OEF Specific: Add BH personnel in order to meet the 1:700 ratio
  - OEF Specific: Maintain 1:700 ratio through the surge in forces
  - OEF Specific: Appoint a senior theater-wide BH consultant (appointed June 2009) and a senior Behavioral Health NCO for USFOR-A
- Training
  - Develop and validate new resiliency training for at risk groups
  - Continue to emphasize leaders' roles in creating resilient units through leadership training

MAJ Thomas also reported on the status of the MHAT 5 OEF recommendations:

- Time off and Down-Time Policies
  - Access to R&R, sleep hygiene and re-set time
  - Directed at soldiers in remote/outlying locations
  - Implementation not being systematically accomplished.
- Delivery of Behavioral Health Care in Theater
  - Theater BH oversight, improving outreach, conducting psychological debriefings and travel throughout the ATO.
  - Overall, improvements have been made.
- Training
  - Develop training for at risk groups (e.g. units that experienced high levels of combat), implement BH training for medics, families, redeploying Soldiers and develop training targeted at stigma and suicide.

- Overall, training developed and implemented to meet the intent of recommendations.

MAJ Thomas stated that the next MHAT study (MHAT 7) was being directed by the Vice Chief of Staff of the Army and is set to begin in the spring of 2010 as a joint survey. Development and coordination of the survey tool was currently underway.

## **SUMMARY OF QUESTIONS AND ANSWERS**

- With regard to the leadership issue, CDR Werbel cautioned that troops with higher levels of resiliency might attribute their lack of acute stress to officer leadership, but that was a conclusion that should not necessarily be drawn. MAJ Thomas agreed that it was an observational finding and might be an ingredient although not the main ingredient.
- Dr. Berman asked why the marital relationship problem seemed to appear at the third deployment and not the first or second. MAJ Thomas stated that soldiers and their families may feel that that can survive a first deployment and even a second one, but the third one was too much of a stressor.
- Dr. McKeon asked about in-theater suicides and whether a risk assessment had been completed prior to deployment or whether the suicide was a “surprise” when it occurred. MAJ Thomas stated that he did not have that data but possibly the Services’ Surgeons General Offices could assist.
- Dr. Holloway asked MAJ Thomas to identify the two most commonly reported stressors. MAJ Thomas stated that separation from family and the length of the deployment were the two most commonly mentioned. MAJ Thomas acknowledged that researching single soldiers’ relationship problems was a challenge and needed closer data analysis.

## **8. RAND STUDY**

Dr. Ramchand presented, “Preventing Suicide Among Military Personnel, Overview of the RAND Study”. (Briefing attached)

### **SUMMARY OF PRESENTATION:**

The DoD patterns of suicide are similar to those in the civilian population. Specifically, the national suicide rate is 4 to 5 times higher for males than females and that the national suicide rate among non-Hispanic whites and Native Americans is double the rate for other ethnic minorities. These similarities suggested that suicide prevention programs that are effective in the civilian sector would also work for the DoD.

RAND’s preliminary review of the literature looked at correlations and risk factors in suicide as well as differences. Literature reviews lump suicidal behaviors together and RAND believes this to be valid. RAND looked to differentiate factors that are correlated with completed suicides, with suicide attempts, as well as suicide ideation. RAND found the strongest evidence suggesting prior suicide attempts, mental illness and substance use disorders to be associated with completed suicides. However, they all lack a strong predictive power, meaning that while many of those who complete suicides have

some of these risk factors, very few of those with these risk factors will prospectively go on to die by suicide.

Emerging evidence in other areas is also noteworthy. Psychological correlates, are the most widely studied with the strongest evidence related to the feeling of hopelessness. RAND found evidence of a genetic component to suicide, such as neuro-biologic factors and external factors, which are sometimes called life events or triggering events. There is emerging evidence about those factors, but it remains unknown whether those are independent risk factors or whether they're mediated or moderated by an underlying vulnerability such as a mental illness. Dr. Ramchand discussed social factors such as firearm availability, clustering among teens, suicide clusters, and imitative suicides following media coverage as also being part of the report.

The RAND report focused on four areas:

1. What current initiatives already existed within the DoD to prevent suicides.
  - a. RAND collected detailed information about those initiatives and conducted key informant interviews with stakeholders in the DoD and each of their Services.
2. Whether the current initiatives in the DoD and the Services reflected “state-of-the-art” for suicide prevention.
  - a. Identified characteristics of what seemed comprehensive, effective programs and looked at the DoD programs for presence of these characteristics.
3. What are the best practices regarding suicide prevention programs.
  - a. Best practices were driven by the public health approach, which looks at the primary prevention or campaigns targeted towards the general population.
4. What distinguished an individual who is in need of selected prevention versus individual prevention
  - a. There is no clear guidance.
  - b. Postvention, a prevention technique, is the response to a completed suicide within this society in general.

## **SUMMARY OF QUESTIONS AND ANSWERS**

- CDR Werbel asked if there is a there's been no statistically significant difference across race. Dr. Ramchand stated that there were some differences among the races in the reported data although the Navy and Marine Corps data did not break out Native American data separately.
- Dr. Berman stated that his understanding is that the majority of suicides have never made a prior attempt, but once there's attempt, multiple attempts increase risk. Dr. Ramchand commented that the statistic was based on international data on suicides from older studies.

## **AFTERNOON PANEL QUESTIONS AND DISCUSSION:**

- Dr. Holloway asked about the coping skills and coping strategies commonly used by Service Members. MAJ Thomas answered that the MHAT 6 study adapted a brief cope scale, where

soldiers engaged in acceptance coping and positive appraisal were illustrated. Dr. Ramchand stated that there are elements of self care, promising approaches, and therapeutic approaches for people who are suicidal or attempted suicide. Skills are taught about taking care of themselves and knowing when to ask for help. MAJ Thomas emphasized the extent to which people utilize care and the effectiveness and usefulness of some of the training.

- MAJ Thomas stated that his group published a study in the Journal of Clinical Accounts and Psychology, formerly known as the Battlemind Training Program, that showed the efficacy in the Army reducing acute stress or PTSD scores months after combat. MAJ Thomas stated that some of his training is in conjunction with Comprehensive Soldier Fitness.
- Dr. Jobes stated that the suicide prevention needs of a pre-deployed soldier will be different from the suicide prevention needs of a deployed soldier and a post deployed soldier.
- Dr. Jobes asked whether the MHAT 6 accounts for pre deployment, never deployed, pre-deployed, deployed, post deployed and multiply post deployed. MAJ Thomas replied that the needs of everyone are different and the way to assess that in MHAT is to be more comprehensive. MAJ Thomas stated that there is not a pre-deployment group in the maneuver units aside from those that are new to the military.
- Dr. Ramchand stated that there are a few studies that have compared the pre-deployed, deployed, and post deployed such as the Hoge 2004 study. Only 2 or 3 studies have tracked individuals prior to deployment and assess them pre-deployment and post deployment; there is also a study from the UK and a study of Dutch infantrymen.
- MAJ Thomas mentioned Tyler Smith's group with the Millennium Cohort, which is the largest prospective health project in military history. The project is designed to evaluate the long-term health effects of Military Service, including deployments.
- Dr. Holloway asked whether an individual had the experience of trying to come out and ask for help. MAJ Thomas answered that stigma is a huge barrier to care. It is also difficult to get a provider while on battlefield. Stigma is not the only barrier in the deployed environment.
- Dr. Kemp explained that Service Members call the VA suicide prevention hotline or make other actions when their fellow soldiers or comrades turn against them. MAJ Thomas replied that the data he collected supports the role of climate and individual morale.
- Chief Gabrelcik asked whether the MHAT study asked junior leaders if they had recommendations on how to lower the stigma on seeking care. MAJ Thomas answered that there is a qualitative aspect of survey that touches on it.
- Dr. Jobes asked about the effect of dwell time on multiple exposures to combat. MAJ Thomas answered that the MHAT6 research concludes that many Service Members spent a lot of their time video gaming and searching the internet, which can be the cause of isolation behavior.

## **9. REAL WARRIORS CAMPAIGN**

Ms. Hughes presented, “Real Warriors Campaign Briefing”. (Briefing attached)

### **SUMMARY OF PRESENTATION:**

The Real Warrior Campaign’s goal is to create awareness, understanding, and investment in the concepts of resiliency and combating stigma for psychological health care. The program campaign uses the health belief model. The campaign attempts to communicate, convince Service Members, as well as reinforce positive outcomes from possible actions. The campaign also demonstrates that only treatment works and that it is available.

Real Warriors has completed about 15 studies that deal with stigma and psychological health.

Observations and conclusions within focus group studies:

- Service members expressed feeling guilt.
- Service members felt the severity of their psychological wounds was not equal to the physical wounds that they saw others dealing with.
- Service members expressed stigma and wanted proof regarding Service members who have received treatment and are maintaining successful military or veteran careers.
- Flag officers felt it was easier for the enlisted to seek help and the enlisted felt it was easier for the officers to seek help.

The Real Warriors Campaign maintains an active website and social media presence. There are eight profiles on the Real Warriors website that reaches out to individuals who are going through hard times. The profiles include different ranks. The site offers 24 hour, seven day a week access to live chat function to DCOE. There is also an active page where treated Service members who have thought of suicide provide advice and counsel to others.

Ms. Hughes presented MAJ Hall’s public service announcement (PSA) and introduced him to the Task Force members.

## **10. SERVICE MEMBER PANEL**

MAJ Hall stated that his multiple deployments and long periods away from his family were not the reason for his suicidal ideations. He believes the things he saw and experienced during his deployments may have been a contributing factor.

### **SUMMARY OF QUESTIONS AND DISCUSSION:**

- MAJ Hall mentioned that the cheerleading and motivation of soldiers in the war is not helping several of the service members in continuing their Service.
- Ms. Carroll asked Mrs. Hall whether there were marital difficulties. Mrs. Hall answered that she never had domestic issues or marital issues but she lacked stronger communication with her husband.

- Ms. Carroll asked Mrs. Hall if she was aware of the resources given to her and her husband. Mrs. Hall replied that she did not know what to do, who to go to or how to get in contact with anyone to help her. She contacted a mental health provider, who was a clinical psychologist at a hospital but the psychologist did not help.
- SgtMaj Green asked MAJ Hall to speak about stigma. MAJ Hall stated that stigma in combat is hard to deal with. When someone is falling behind the formation there is no encouragement, but rather berating. However, some in leadership positions are trying to change that.
- Dr. Litts asked about the effectiveness of treatment that MAJ Hall received. MAJ Hall stated that he did not get treatment for his physical pain for about 3 years. He was hurt in Iraq in Aug 2003 and he just got into the TBI clinic about six months ago.
- MAJ Hall explained that he went to a psychiatrist and was given prescription pills after a 15 minute interview. He tried going to a different psychiatrist and spoke about the things he saw while in war and found that the psychiatrist didn't know how to help him.
- MAJ Hall stated that Deployment Health Clinical Center (DHCC) at Walter Reed has helped him greatly overcome his suicidal thoughts because they did not look at him from the mental health aspect. There was a holistic approach, such as looking at one's physical body and trying to repair their inner spirit.
- The pain management clinic also helped MAJ Hall deal with his PTSD. It allowed him to function normally.
- COL Bradley asked MAJ Hall what kept him from going seeking help. MAJ Hall answered that stigma stopped him from seeking help. He broke his foot and did not let anyone know. He did not want to get fired, look weak or lose his clearance. MAJ Hall mentioned that he rather die an honorable death. MAJ Hall received mental health care when he realized that he could not uphold the standard that he had put on himself.
- SgtMaj Green asked Mrs. Hall how we could make the resources that are given to spouses more effective. Mrs. Hall answered that many of the community sessions on base were a way for wives to have a gossip session and that was detouring people from attending. However creating clubs for smaller groups of people or making sessions more attractive by adding activities such as trips to the mall may help draw people to come to the sessions and help them get the information that they need.

## 11. PUBLIC COMMENT

Ms. Lynne Oetjen-Gerdes, Deputy Chief of Morality Surveillance introduced herself and stated that there is not going to be one model or approach to prevent suicide. There needs to be a tool for those who attempted suicide or thinking of committing suicide, to tell their stories, and provide assessments and evaluations. There is no single root cause of suicide. What should be found are the controllable causes.

The intervention point such as isolation is a controllable cause. Ms. Oetjen-Gerdes would like to start a process, to find evaluation forms that combine RCAs with some of the information that's on the DODSER. She would also like to do a simulation model that's going to help identify some of the areas.

Col McPherson thanked Ms. Oetjen-Gerdes for her comment and asked CDR Feeks to adjourn the meeting.

CDR Feeks thanked everyone for attending and adjourned the meeting

**\*\*\*MEETING ADJOURNED\*\*\***