MEETING of the DEPARTMENT OF DEFENSE
TASK FORCE ON THE PREVENTION OF SUICIDE
BY MEMBERS OF THE ARMED FORCES

11 March 2010

The Omni La Mansion Del Rio
112 College Street
San Antonio, Texas 78205 USA

ATTENDEES

PRINCIPAL MEMBERS & REPRESENTATIVES

	TITLE	LAST NAME	FIRST NAME	ORGANIZATION
	MG	Volpe	Philip	Commanding General, Task Force Co-Chair Western Regional Medical Command Box 339500, MS 109 JBLM WA 98433
X	Ms.	Carroll	Bonnie	Tragedy Assistance Program for Survivors, Task Force Co-Chair 910 17th Street, NW Suite 800 Washington, DC 20006
	CDR	Feeks	Edmond	Executive Secretary, Defense Health Board
	Ms.	Bader	Christine	Director, Defense Health Board
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
X	Dr.	Certain	Robert	St. Peter & St. Paul Episcopal Church 1795 Johnson Ferry Rd Marietta, GA 30062
X	CMSgt	Gabrelcik	Jeffery	Andrews Air Force Base 1535 Command Drive Suite E302 Andrews AFB MD 20762
	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
	Dr.	Jobes	David	The Catholic University of America 314 O'Boyle Hall Washington, DC 20064

	TITLE	LAST NAME	FIRST NAME	ORGANIZATION
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
	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	MAJ	Barnes	Reggie	Army National Guard
X	Mr.	Mojica	Jose	US Army Reserve
X	Dr.	Bryan	Craig	Department of Psychiatry, University of Texas Health Science Center, San Antonio, TX
X	Dr.	Crow	Bruce	Southern Regional Medical Command Warrior Resiliency Program, Fort Sam Houston, TX
X	Dr.	Talcott	Wayne	Department of Behavioral Medicine, Wilford Hall Medical Center, San Antonio, TX
X	LtGen	Roadman	Charles	Retired, USAF Surgeon General
X	COL	Keesee	Nicole	US Army Task Force on Suicide Prevention
X	Mr.	Lewis	Steve	AMEDD C&S, Ft Sam Houston, TX
X	Mr.	Shabaz	Bruce	Army Suicide Prevention Task Force
X	LTC	Kindt	Michael	USAF, San Antonio, TX
X	Mr.	Orman	David	USA MEDCOM, San Antonio, TX

	TITLE	LAST NAME	FIRST NAME	ORGANIZATION
X	Mr.	Grill	Dennis	Southern Regional Medical Command Warrior Resiliency Program, Fort Sam Houston, TX
X	Mr.	Biskell	Graem	Ft Sam Houston, TX
X.	Mr.	Mason	Shawn	Lincoln Center, San Antonio, TX

OPENING REMARKS AND INTRODUCTIONS

The meeting was called to order by Col Joanne McPherson. All attendees were welcomed and general housekeeping instructions were presented. All guests were asked to sign in at the registration desk, where copies of all presentations were available for guests. Col McPherson reported that written statements could be submitted to the Task Force and that the next meeting of the Task Force would be 14-15 April in Colorado Springs.

Ms. Bonnie Carroll welcomed the Task Force and other attendees and asked for introductions of Task Force and specifically pointed out LtGen (ret) Charles "Chip" Roadman, former USAF Surgeon General (1996-1999) in the audience who did early work in Suicide Prevention in the Air Force. She then asked the other guests to introduce themselves.

SUICIDE PREVENTION IN THE DEPARTMENT OF VETERANS AFFAIRS—DR. JANET KEMP

Dr. Kemp reported that 18 veterans who received care within the VA system kill themselves every day. At least 60% of these suicides also have a known mental health diagnosis. VA statistics estimated that 1,000 veterans attempt suicide monthly and 8% of these will reattempt within a month. Because data from the CDC is received three years from occurrence, national data is always behind the "curve". There is a great deal of variation across the VA from data collected monthly

The VA is beginning a comprehensive program to include both public health and a clinical program because improved mental health care lowers the suicide rate. The new campaign "It Takes the Courage and Strength of a Warrior to ask for Help" has new posters out. Most of the success of the program is probably related to the phone number listed on the poster. The call line/number has been an extremely important tool for the VA. They have received 3,000 calls from AD personnel and want to remind everyone that this service is also available for National Guard and Reserve personnel. Calls from family members of deployed service members are transferred to active duty chaplains.

Two areas of concern for the VA are young veterans from Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) and Vietnam veterans. Preliminary data suggests that younger veterans (18-29) have lower rates of suicide if they are actively receiving care in the

VA. It is too early to tell if a difference is really being made, because of the 3-year lag from the CDC, but it appears that current programs are having a positive impact.

VA has a number of resources dedicated to suicide, such as the National Hot Line, Chatline, and Operation Save. Operation Save is a program specific to the VA where all employees get suicide prevention training within 30 days of hire. This program has generated many referrals to the VA Suicide Prevention Coordinators.

The Advanced Care Program is another resource for those identified to be at higher risk for suicide. The program includes:

- Chart flagged
- Safety Plan
- Weekly visits for 30 days
- Safety Plan Revision
- Medication Review
- 90 Review
- Maintain or reactivate the plan

QUESTIONS:

Dr. McKeon asked Dr. Kemp what more is needed?
Dr. Kemp responded that better contact for urgent intervention. There could be a national access number for all veterans. Also, follow-up from referrals or the hotline. They need a person to do this. Finally, someone (such as the Suicide Prevention Coordinator) needs to be able to meet the person in distress and take them at least to initial intervention services.

Dr. McKeon: Are there any recommendations you have for next steps for accessibility?
Dr. Kemp: We need to improve points of contact for active duty. Every base across the country needs a 24/7 hot line to call. There is a gap. The national number should stay the national number; it's already out there.

Dr McKeon: Should the services have the Suicide prevention coordinators that the VA has?
Dr. Kemp: Yes, it's immeasurable. We broke all the rules, they can see clients anywhere.

Bonnie Carroll: What is the protocol when an AD member calls the VA number?
Dr. Kemp: Each service has a different protocol. The best contact seems to be the chaplains. If the service member is off base, we work with the local community, sometimes Military One Source, which doesn't seem to be much help.

Dr. Berman: Since only 1/3 of the VA suicides are in the VA system, what actions are being taken to get more veterans into the system?
Dr. Kemp: We need to get past the idea that veterans aren't registered and enrolled in our system before we can treat them particularly when they have called the mental health hotline.

The VA has expanded their outreach programs into the community to make it more visible. The AV is also making greater use of its Vet Centers within the communities.

Dr. Berman: Is there anything being done in the AV to address the problem of chronic pain within the veteran community?
Dr. Kemp: The VA has set up some work groups to look at chronic pain similar to the TBI and PTSD work. Often the last point of contact with the VA was a specialty clinic like orthopedics or podiatry, so we're starting to work more with the primary care community.

US ARMY RESERVE COMPONENT BRIEFING—MR. JOSE MOJICA AND DR. NICOLE KEESEE

Mr. Mojica began his briefing with The Four Pillars of the USAR Suicide Prevention Program:

1. Educating the entire force
2. Reducing stigma associated with asking for help with behavioral/mental health issues
3. Providing/accessing resources to AR soldiers, families and civilians.
4. Involving Families.

Suicides predominantly stem from relationship issues. Strong Bonds is a training program that is chaplain-led for spouses, children and significant others. Other programs include the Yellow Ribbon Program, Suicide Prevention Training and the Family Program Academy curriculum. The Army Reserve had 35 suicides for Calendar Year 2009. The average age was 31, with 29 suicides by male and 2 by females. The Reserve unit does not always know when a member has committed suicide until the service member does not show up for drill or if a family member calls and reports the death. Once the unit is informed, a Serious Incident Report (SIR) is initiated. The death is in a pending status until the unit receives a death certificate at which time it is forwarded up the chain of command.

COL Keesee continued the presentation by stating that one of the new requirements for Reserve units is that if the unit deploys together, then the units returning from deployments will stay together for 90 days upon their return. Another improvement is the Concept Plan which provides structure to include 91 new civilian positions, of which 38 will be full time suicide prevention program managers. The USAR will also be adding Family Advocacy and substance abuse staff.

The transition from Active Duty to Reserve status is not seamless. The transfer of information and an IT system interface is lacking. Although the Army Reserve is the smallest component of the Army, soldiers in the reserve are unaware of the services available and how to access them. Access to services is a big challenge for the Army Reserve. Health Navigators are needed, but this is further complicated by the fact that some reservists have multiple insurance benefits and some have none.

Three big challenges exist for the Army Reserve:

- Employment
- Dispersed population
- Getting the right information to the right people.

The Army Reserve recently joined with the VA to produce a new suicide prevention video and training similar to "Beyond the Front" and "Shoulder to Shoulder" that target unit level leaders. Unit-level leaders are often in the best position to help soldiers in need that are on the ground. The Army Suicide Prevention Awareness program is now available for Army Reserve families and VA civilians and is being pushed down to every major Subordinate Command.

QUESTIONS:

COL Bradley: Is a DoD suicide event report filed for a reserve member's suicide?
Mr. Mojica: It is hit-or-miss proposition within the USAR. Their regulations call for a report to be submitted through the medical treatment facility commander, but that is not always happening.

Dr. Certain: Has any consideration be given to having family members fill out the reassessment form?
Mr. Mojica: They are not aware of family members filling out the reassessment form. The USAR has begun reaching out to the families to make sure they know who to contact. There is also a rear detachment structure that can assist.

Dr. McKeon: So then the Army suicide numbers could be underreported?
Mr. Mojica: Yes, it is possible.

Dr. McKeon: Could you clarify what types of new suicide prevention and training videos the USAR is producing?
Mr. Mojica: The new videos will focus on the soldier when he's back home and adjusting to family situations. Family members are being included in the videos.

Dr. Kemp: Are the NG and USAR doing any work with the local judicial systems to find out when veterans are getting in trouble with the law?
Mr. Mojica: No, the local commanders are not engaged with the local court systems.

Dr. Berman: What might be done to improve the quality of the suicide data that you collect?
COL Keesee: The USAR uses the Serious Incident Report which is initiated by the unit commander. We do not have access to the DODSER system. There is a big disconnect between the Active duty and Reserve component computer systems.

ARMY NATIONAL GUARD BRIEFING – MAJ (P) REGGIE BARNES

MAJ Barnes identified numerous challenges and successes that have occurred in the Army National Guard. The identifying risk factors are white males, between the ages 20-24, enlisted, and, to their surprise, over half of those soldiers that committed suicide had not deployed. The common stressors that were identified were financial problems, typically a huge debt and a failed or failing relationship.

The challenges include:

- Overcoming stigma-"You're only as strong as your weakest link"
- Increased number of suicides
- Lack of a substance abuse treatment program for the National Guard.
- Medical information rarely follows when the service member is released from active duty back to his/her NG unit, leaving the soldier with the responsibility to identify medical issues for care that is needed beyond the 90 day reintegration period.

The successes include:

- The Comprehensive Soldier Fitness Program-a resilience program.
- ARNG Soldier and Family Support Division services complete with personnel.

There are actually 54 separate National Guard units, one for each state and territory. Different states have different programs and have created programs to help with financial issues, as well as Peer to Peer and Buddy to Buddy. We are working with the Air National Guard to have "purple" suicide prevention, family advocacy, and substance abuse programs. We also want to create a Risk Reduction Team.

QUESTIONS:

Bonnie Carroll: When a guardsman kills himself and is not in a duty status, there are no benefits for the surviving family. What can we do to fix this problem?
MAJ Barnes: We're trying to work with the Director of the ANG to talk with the state Adjutant Generals to make sure they are aware of the processes that have been mandated by the Vice Chief of Staff of the Army. Families can call my office and I will assist them. I will update the slides with my information.

MAJ Barnes also stated that he was unaware of the Tragedy Assistance Program for Survivors until a recent magazine article and requested more information from Ms. Carroll on TAPS.

PANEL DISCUSSION: Mr. Mojica, COL Keesee, Dr. Kemp and MAJ Barnes

Dr. Litts to Dr. Kemp: How much training is required to develop a good safety plan?
Dr. Kemp: Suicide Prevention Coordinators are responsible for training others through video vignettes and manuals. Facilities have found ways to shorten the process. We need a longitudinal focus on looking when someone received a safety plan and their continued success. Basically, there is not enough data to know what kind of safety plan training works best. We have a wide range of people out there doing these and doing them in a variety of way, ie, groups being

discharged from inpatient status. The most critical element seems to be the phone number - they always have a phone number they know they can call.

Dr. Berman to Dr. Kemp**:** What is the impact of using the term "weakest link" and saying it takes a "Warrior to Ask for Help" Does it create a paradox?
Dr. Kemp: The slogan doesn't seem to matter. The veterans wanted the picture right and the uniforms right, but most importantly they wanted a number to call. What we don't know is how long of a message is meaningful.
MAJ(P) Barnes: The ANG is also working on its messaging so that it addresses the needs of "current" service members, instead of just "active duty" service members.
COL Keesee: The change has come from leadership from the top all the way down to the unit level.

CMSgt Gabrelcik to the panel: In relation to Line of Duty determinations, could access to care change if TRICARE Prime was an option?
COL Keesee: Making soldiers prove that their injuries are duty connected is difficult, and is not the same in the Active component. This is really a problematic situation. The Reserves have a process called the Active Duty Medical Extension Order. Over 50% of applications by soldiers have been denied; that is a challenge for the USAR. TRICARE Reserve Select is an option, but while many soldiers can afford it, others cannot.
Mr. Mojica: The Army Reserve has had a problem with incomplete LOD determinations and will continue to have problems until commanders are educated about the importance of the document.

CMSgt Gabrelcik to panel: If TRICARE Reserve Select costs were lowered for this group, would that help?
MAJ Barnes: Probably not, because the lack of Line of Duty (LOD) determination is a problem, therefore the soldier has to prove the injury happened as a result of his/her service.

Dr. Certain to panel: What kind of partnerships do you have with Faith Communities and 501c3s, etc to help these folks, or barter for cheaper rates or partnering? We can't get the National Guard or Reserves to even return a phone call to offer help from our 501(c)3.
MAJ Barnes: We're working with the Suicide Prevention Program Managers in the field to find the necessary resources.
COL Keesee: The Reserves have no funds, the National Guard has access to funds that the reserves do not.

Dr. McKeon: If National Guard or USAR do not deploy, are they not eligible for medical care?
Dr. Kemp: If a service member gets sick while still state-side they would be eligible for care. Eligibility for care is determined by the DD Form 214. However, if a service member has been deployed, the determination of benefits is easier.

Dr. Holloway to Mr. Mojica: In 2004 there were 8 suicides. In 2009 there were 35. Was this data due to a better tracking system? What is the rate of suicides?

Mr. Mojica: The increase in numbers is due to better tracking. I do not have the actual rates. The USAR has seen a much higher number of soldiers who are now reaching out to their commanders for information and assistance.

Dr. Holloway to Dr. Kemp: What happens in the VA after a suicide attempt is made?
Dr. Kemp: After an attempt or flagged high-risk, the veteran falls into the Enhanced Care Program package. Their record is flagged, a safety plan is initiated, weekly visits are scheduled for the first 30 days, and a medication review. After 90 days the care plan is reviewed and adjusted as needed. Parts of the enhanced package of care could be used by DoD.

Dr. Holloway to Mr Mojica: Is the Reserve cross-checking SGLI for payments to family members when suicides that are occur during the week?
Mr. Mojica: Human resources Command handles SGLI information and we seldom get feedback from them concerning SGLI payment information.

Dr. Berman to Dr. Kemp: What about service connection? Can there be an incentive for being or staying sick?
Dr. Kemp: Highly service connected means monetary compensation. The VA considers this therapeutic and does not "quibble". Some compensation can be part of the treatment plan. If you take away award compensation, then some patients may stop seeking care.
COL Keesee: veterans know that a 30% disability rating is the golden number because it means more benefits.

SUICIDE PREVENTION IN PRIMARY CARE- DR. CRAIG BRYAN

Traditional mental health culture is contradictory to Warrior Culture. Dr. Bryan pointed out how we are stuck in the illness model of mental health and stated that we need to transition from the traditional mental health culture to the Warrior Culture. Using Cognitive Behavioral Therapy (CBT), traditional clinical language only reinforces illness. The delivery of mental health services needs to be fundamentally changed. The focus should not be on changing the warrior; rather, focus on sustaining optimal performance and maintaining wellness. The Defenders Edge (DEFED) Program was developed to work with security forces that were having difficulty but would not go to mental health. The basic tenets of the DEFED Program are:

- Teach Core Mental Health Resilience skills; a security forces (SF) program not a mental health program
- Assumption that Warriors are inherently strong
- Airmen already had the skills, just needed a coach to use these skills in new ways
- Less emphasis on trauma and more emphasis on "benign stressors"
- Taught/coached in SF terms; i.e. diaphragmatic breathing (arms training concept)
    - How does fear make you better at your job?
- Conducted on SF compound

- Non clinical intervention; “I had a fight with my wife yesterday, what do I do? Response: “Let’s talk about it.”
- Conducted like a conversation and eventually the service member figured out our identity but still sought “care”

These principles were also applied in the Kelly Family Medicine longitudinal study. Do patients actually get better? All groups got better, even the severely stressed get better after four appointments. When outpatient mental health visits are compared to primary care-based the results are the same. When a Combat Writing and Impact Statement approach used, decreases in PTSD are noted. Preliminary data shows favorable results. Patients tend to be more honest using paper and pencil than by direct questioning.

Dr. Bryan stated that MH providers need to get out of the mental health clinics. MH providers need to change their frame of reference, doing more of what is currently being done is not eradicating associated stigma. Physician Assistants and Physicians love this type of integration; Psychiatrists and Psychologists do not. The value of “encounters” (RVUs) done in this type of approach needs to be weighted to give the provider credit for the work that is being done. The system is not designed to give credit for nontraditional service delivery. Patients tend to be more honest using paper and pencil than by direct questioning, so questionnaires are used.

QUESTIONS:

Dr. Berman- Regarding questionnaire screening, did the provider ask a direct question about suicidal ideation?
Dr. Bryan: We cannot be sure. Provider documentation patterns indicate that longer notes that included information about suicidal condition seemed to correlate positively with primary care providers who asked the question.

Dr. Berman-Were the service members asked or did they volunteer the information?
Dr. Bryan: Some of both.

Dr. Berman-What is the length of time between the previous medical appointment and the screening?
Dr. Bryan: On average it occurred within 48 hours of the appointment.

CMSgt Gabrelcik: Did you feel that service members were more likely to tell you their problems without repercussions when you were imbedded with them in the field?
Dr. Bryan: Yes, they were more willing to share their experience even while they were outside the wire before they had returned to their base camp.

Bonnie Carroll: This sounds similar to what is going on in DCoE. Are you working with them?
Dr. Bryan: No, we are working with the AF Security Forces to develop resiliency programs, but we have lots of requests for our program.

THE COMMUNITY HEALTH APPROACH - Col WAYNE TALCOTT

As early as 1996, suicide prevention was identified as a community problem and not a medical problem. Leadership involvement is essential for the success of a suicide prevention program. Two key elements are early detection and early prevention. The AF community health approach focuses on the 11 elements of the Air Force Suicide Prevention Program. The backbone of the Air Force program is the Integrated Delivery System (IDS). The IDS is comprised of installation helping services, mental health, family advocacy, drug and alcohol program, legal services, chaplain, and the family support center. The IDS reports to the Community Action Information Board (CAIB), which is comprised of senior leadership on the installation.

Once the program was in place, suicide rates dropped, but then slowly returned to pre-program rates. The question then became how to sustain the program. The Air Force surveyed everyone in the Air Force, with the survey pushed from top leadership down the chain of command. Leaders had to identify problems and report how they were going to fix them. During the time the survey document was in the field the suicide rate actually fell.

QUESTIONS:

Dr. Holloway: What was the rationale for conducting suicide prevention training online?
Col Talcott: The Air Force has so much required training and given the rhythm of deployments, the decision was made to put as much as possible online. It was not a clinical or programmatic decision.

Chief Gabrelcik: Does Professional Military Education training frequency matter?
Col Talcott: The answer seems to be repetition in a variety of venues as training time is finite.

Dr. Berman: What can you do to further decrease suicide rate, understanding that it will never be completely eradicated?
Col Talcott: The Air Force seems struggle at the 10 per 100,000 line, knowing there will always be some suicides despite their best efforts.

Dr. Litts: When the program started in the program in Fiscal Year 1999 the message went out to commanders to check up on their troops. As a result the suicide rate went down. A community-wide commitment does seem to make a difference. The model is not necessarily about suicide prevention but rather a public health approach to decreasing stress.

Dr. Holloway: How did you get the community to commit to it? What are the factors that support sustainment**?**
Col Talcott: The Chief of Staff of the Air Force made it his priority, asking his direct reports about what's going on with suicide. The same focus existed on the senior enlisted side.

Sustainment was assisted with the establishment of the Office of Primary Responsibility within the Chief of Staff's office. This office helps to guide the decision making process.

Dr. Litts (comment): In 1995/1996, if a suicide occurred in a unit, there was a briefing to the Major Command (MAJCOM) commander. Five MAJCOMs still do this today in the form of an Aircraft Accident Format review.

WARRIOR RESILIENCY PROGRAM - COL BRUCE CROW

COL Crow provided a history of the Warrior Resiliency program. Congress awarded the Department of Defense over $900 million in Fiscal Years 2007 and 2008 for transformation to increase psychological resilience and to decrease stigma. The funding was distributed to the Services through the Defense Center of Excellence. The Army Warrior Resiliency Program originally began at Brooke Army Medical Center with Army Medical Command (MEDCOM) award of $7 million. The Warrior Resiliency Program (WRP) is organized into three divisions:

1. Clinical Services Division
2. Training Division
3. Clinical Outcome/Program Evaluation.

There are currently four funded studies and four proposals in evaluation. The on-going Suicide Reduction Initiatives (SRI) are:

- Clinical Risk Mitigation Study at Fort Carson
- Recruiter Risk Assessment Study. Identify risks among Army recruiters, conducted at Fort Jackson Recruiter School.
- Risk Management Process Improvement at Fort Sam Houston, TX
  Implement clinical practices based on published evidence for efficacy
- Early Identification of Adolescent Suicide Risk

COL Crow also identified four additional projects for which proposals have been submitted or are in the process of being submitted. They include:

- Military suicide research consortium
- Suicide prevention efforts in primary care study
- Assessment of risk behaviors study
- Post-Deployment Health Reassessment (PDHRA) timed suicide risk assessment

QUESTIONS:

Dr. McKeon: Could you clarify the $30 million proposal for a suicide research consortium?

COL Crow: The proposal identifies high priority projects that did not receive funding through other funding sources. Some of the funding would be used for administrative overhead.

Dr. Berman: Are these proposals all in response to RFPs or unsolicited proposals?
COL Crow: Three were solicited and one is simply a process improvement project. We are not in the role of directing individuals to research funding sources.

Dr. Berman: If I knew a researcher who wanted to conduct research on a relevant military problem, could this body make recommendations on courses of action for funding?
COL Crow: We could help make connections on potential research collaborators.

Chief Gabrelcik: What comes out of the research? Are there recommendations for specific courses of action?
COL Crow: In the Fort Carson study, we encouraged the Primary Investigator (PI) to disseminate what has been learned at a mid-point in the study as opposed to waiting until the end of the study. Otherwise, we do not judge the projects on their potential scientific merit when making the initial award.

PANEL DISCUSSION-COL CROW, DR. BRYAN AND COL TALCOTT

Dr. Holloway: How do you employ change to get research studies off the ground?
Dr. Bryan: There is very slow process in getting studies off the ground as the various approval layers must be navigated. We need to streamline the process to start treating patients as soon as possible.

Dr. Holloway: Has it been your experience that most Institutional Review Boards do not how much experience with suicide related research?
Dr. Bryan: It has been my experience that once you show an organization that you understand their system and know their people that they are more willing to partner with you.

Dr. Kemp: Do the Army and Air Force have clinical treatment plans or guidelines when someone is exhibiting suicidal ideation or behaviors?
COL Crow: The process for any kind of guideline is decentralized; what may be used at one base may not be used at another. A root cause analysis is conducted within the Army with a suicide when a patient has seen a mental health provider. Also, a DODSER report is initiated.
Col Talcott: One of the things we discovered when we conduct a medical incident investigations is that it is very different in every facility. Most AF mental health professionals are very young and do not stay in the service very long. We have developed a guide for managing suicidal behavior. A team will visit a base and take a one-week look at everything.

Dr. Kemp: Are there any studies on contagion clusters?
Dr. Bryan: There is not much relevance to the civilian community. Dr. Bryan stated that in his Air Force experience it was about a system that contributed to the cluster and not necessarily about the way individuals were impacting each other.
Dr. Crow: It may be associated more with youth. Some epidemiological studies have been accomplished with no real contagion cluster identified.

Dr. Berman: What happens to the data that's collected? Is it aggregated and used to improve treatment or training?
Col Talcott: The AF looks at the suicide from the perspective of the 11 initiatives to determine if they were properly followed. Interviews are also conducted. The information is collected, sanitized, and submitted up the chain of command.

Dr. McKeon: Where can the Task Force get the best information that demonstrates how servicemembers have accessed the behavioral health system and what has been learned?
COL Crowe: Most of the information is anecdotal. We work hard to reduce the stigma associated with seeking mental health treatment. We can probably do a better job in challenging ourselves in the management of suicidal patients. A root cause analysis is also conducted for suicides within 30 days of a behavioral health visit.
Col Talcott: The information is located at our Risk Management office and at the Air Staff. Once an investigation team completes its one-week investigation the information is shared with the appropriate base commanders, taking privacy rules into account. The investigation is briefed all the way up through the MAJCOM up to the Air Force. We also send information back down the chain in the form of NOTAMs – Notice to Airmen.

Dr. Berman: Do the Critical Incident reviews serve as a psychological autopsy?
Col Talcott: Not really looking at the decedent. Rather, we looked at whether policies and procedures were followed and, basically, making a complete picture of the incident.

Bonnie Carroll: Are you incorporating family input into the investigation? Family members want to provide information during the investigation.
COL Crow: It is part of DoDSER but not sure to what extent family input is solicited. It is up to individual inputting the information into DoDSER.
Col Talcott: OSI is not necessarily inclined to gather family input.

Chief Gabrelcik to Dr. Bryan: Were there any quality of life issues associated with SFS work in Balad?
Dr. Bryan: Yes, there were complaints about life in the desert, i.e. phones don't work, having to drink so much water with crystal light, and other benign stressors. When soldiers failed to follow instructions outside the wire that could put them at risk they lost privileges which affected their morale. The command had to balance morale and appropriate discipline to accomplish the mission.

COMMENTS FROM THE PUBLIC - LTGEN CHIP ROADMAN

LTGEN (ret) Chip Roadman made a public comment stating that early successes in suicide prevention were more about public health and did not involve the pathology of PTSD and TBI. Quality of care is not Service or venue specific**.** Suicide rates among populations are the only numbers that are generalizable across the Services and the continuum of care. The Services bring in young healthy men, and women, break them [via war]-- denying them benefits--and then returns them from where they came, but they are not the same person they were when they entered the military. The Services are losing more service men and women to suicide than to hostile fire. Research and improvements in care delivery are important, but the problem at hand is taking care of the men and women currently at risk.