

UNITED STATES DEPARTMENT OF DEFENSE

DEFENSE HEALTH BOARD

CORE BOARD MEETING

Bethesda, Maryland

Wednesday, July 14, 2010

PARTICIPANTS:

Core Board Members:

WAYNE LEDNAR, M.D., Ph.D., Co-Vice President

GREGORY POLAND, M.D., Co-Vice President

CHRISTINE BADER, Director and Designated Federal
Official

COLONEL (Ret.) ROBERT CERTAIN

JOHN CLEMENTS, Ph.D.

FRANCIS A. ENNIS, M.D.

EDWARD KAPLAN, M.D.

JAMES LOCKEY, M.D.

DENNIS O'LEARY, M.D.

GENERAL (Ret.) RICHARD MYERS

MICHAEL OXMAN, M.D.

MICHAEL PARKINSON, M.D.

JOSEPH SILVA, M.D.

DAVID WALKER, M.D.

Task Force Members:

MAJOR GENERAL PHILIP VOLPE, Co-Chair

MS. BONNIE CARROLL, Co-Chair

COLONEL JOANNE McPHERSON, Executive Secretary

LANNY BERMAN, Ph.D.

COLONEL JOHN BRADLEY, M.D.

PARTICIPANTS (CONT'D):

Task Force Members (Cont'd):

CHIEF MASTER SERGEANT JEFFORY GABRELCIK

SERGEANT MAJOR RONALD GREEN

MARJAN HOLLOWAY, Ph.D.

DAVID JOBES, Ph.D.

DAVID LITTS, O.D.

RICHARD McKEON, Ph.D.

MASTER SERGEANT PETER PROIETTO

COMMANDER AARON WERBEL, Ph.D.

Other Attendees:

ERICA AUERBACH

MARK BATES

SEVERINE BENNETT

ROSS BULLOCK, M.D.

FRANK BUTLER, M.D.

CAPTAIN JOYCE CANTRELL

MARIANNE COATES

COLONEL GEORGE COSTANZO

KENNETH COX

WALTER DOWDLE, M.D.

LIEUTENANT COMMANDER ERIC DEUSSING

VINDHYA EKANAYAKE

RICK ERDTMANN

DEIRDRE FARRELL

CHARLES FOGELMAN, Ph.D.

PARTICIPANTS (CONT'D):

Other Attendees (Cont'd):

TRACY FELTON

DEBORAH FUNK

PIERCE GARDNER, M.D.

ANNE GIESE

DONALD GINTZIG

LIEUTENANT GENERAL CHARLES GREEN

ROY GRINKER

COLONEL WAYNE HACHEY

STEVE HOLTON

BOB IRELAND

LIEUTENANT COLONEL MICHAEL KINDT

CREE KINNEBREW

MATT KLEIMAN

COLONEL MICHAEL KRUKAR

JOHN KRYSTAL, M.D.

COLONEL TIM LAMB

CAPTAIN ROGER LEE

GEORGE LUDWIG

PERRY MALCOLM, MD

COMMANDER ROSEMARY MALONE

COLONEL BOB MONHAM

COLONEL SCOTT MARRS

JOHN McMANIGLE

ELLEN MILHISER

COLONEL ROBERT MOTT

CAPTAIN NEAL NAITO

COLONEL DAVID NIEBUHR

PARTICIPANTS (CONT'D):

Other Attendees (Cont'd):

LYNN OETJEN-GERDES

COMMANDER BILL PADGETT

LISA PEARSE

ROSIE PHAN

REBECCA PIETSCH

LIEUTENANT COLONEL KATHY PONDER

DANNY PUMMILL

JAMES CAMPBELL QUICK, Ph.D.

RIDGE RABOLD

CHARLES RICE, M.D.

MICHELLE RODRIGUEZ

KIM RUOCCO

COMMANDER ERICA SCHWARTZ

MICHAEL SCHOENBAUM

COMMANDER CINDY SIKORSKI

JACK SMITH

SHERRICA STEELE

RAMYA SUNDARARAMAN, M.D.

MICHAEL TATE

THOMAS UHDE, M.D.

GAIL WALTERS

EILEEN ZELLER

Staff:

CHRISTINA CAIN

ELIZABETH GRAHAM

LISA JARRETT

OLIVERA JOVANOVIC

JEN KLEVENOW

KAREN TRIPLETT

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1 P R O C E E D I N G S

2 (9:10 a.m.)

3 DR. POLAND: I want to welcome everyone
4 to this meeting of the Defense Health Board.
5 We've got a number of important topics on our
6 agenda, so I do want to get started here. Before
7 we do, I just want to embarrass our Executive
8 Secretary a little bit. You'll notice she's
9 wearing blue. She is the proud mother of Nolan
10 Bader, who just finished First Basic at the Air
11 Force Academy. So congratulations --

12 (Applause)

13 DR. POLAND: -- soon to be part for the
14 long blue line.

15 MS. BADER: That's right. Thank you.
16 As the Designated Federal Officer for the Defense
17 Health Board, the Federal Advisory Committee, and
18 a continuing independent scientific advisory body
19 to the Secretary of Defense via the Assistant
20 Secretary of Defense for Health Affairs, and the
21 Surgeons General of the Military Departments, I
22 hereby call this meeting of the Defense Health

1 Board to order.

2 DR. POLAND: Thank you, Ms. Bader. And
3 now following the tradition that was initiated
4 some four or five years ago, I'd ask that
5 everybody stand for a moment of silence as we
6 think about and honor the men and women who serve
7 in our Armed Forces.

8 (Moment of silence)

9 DR. POLAND: Thank you all very much.
10 Since this is an open session, I'd like to go
11 around the table and have the Board and
12 distinguished guests, and any members of the
13 public introduce themselves, as well as the new
14 Core Board and Subcommittee members, if any are
15 present, to tell us a little bit about themselves.

16 So if I can, I'll start to my left with
17 Dr. Lednar.

18 DR. LEDNAR: Wayne Lednar, Global Chief
19 Medical Officer of the DuPont Company.

20 MS. BADER: Good morning. Christine
21 Bader, Director, Defense Health Board.

22 MG VOLPE: Good morning. Phil Volpe.

1 I'm the current Commanding General of the Western
2 Region Medical Command and the Army's Regional
3 Medical Command, and I'm the Co-Chair on the DoD
4 Task Force on the Prevention of Suicide.

5 MS. CARROLL: I'm Bonnie Carroll. I'm
6 the Co-Chair of the Task Force. I'm the Director
7 of the Tragedy Assistance Program for Survivors,
8 the national organization supporting surviving
9 family members who've died in the Armed Forces,
10 including over 1,000 who have died by suicide.

11 I'm an Army surviving spouse and an Air
12 Force Reserve officer.

13 Col MCPHERSON: I'm Colonel Joanne
14 McPherson. I am the Executive Secretary for the
15 DoD Task Force on the Prevention of Suicide.

16 DR. SILVA: Joe Silva, Professor of
17 Internal Medicine and Dean Emeritus at the
18 University of California, Davis School of
19 Medicine.

20 DR. BERMAN: Good morning. I'm Lanny
21 Berman and I'm Executive Director of the American
22 Association of Suicidology and President of the

1 International Association for Suicide Prevention
2 and a member of the Task Force.

3 DR. OXMAN: Mike Oxman, Professor of
4 Medicine at Pathology of the University of
5 California, San Diego, and a Core Board member, an
6 infectious disease doctor and virologist. Thank
7 you.

8 CDR WERBEL: Good morning. Aaron
9 Werbel. I'm a Navy clinical psychologist and the
10 Suicide Prevention Program Manager for the Marine
11 Corps and a member of the Task Force.

12 DR. KAPLAN: Good morning. Ed Kaplan,
13 Professor of Pediatrics at the University of
14 Minnesota, Medical School, and a Core Board
15 member.

16 DR. JOBES: Good morning. I'm Dr. David
17 Jobes and a Professor of Psychology at Catholic
18 University here in town and a member of the Task
19 Force.

20 DR. PARKINSON: Mike Parkinson. I'm a
21 Core Board member and immediate Past President of
22 the American College of Preventive Medicine.

1 DR. LITTS: Good morning. I'm David
2 Litts, the Director of Science and Policy at the
3 National Suicide Prevention Resource Center and a
4 member of the Task Force.

5 DR. FOGELMAN: Good morning. I'm
6 Charles Fogelman. I'm Chair of the Psychological
7 Health Subcommittee of the Board, and I operate as
8 an independent consultant.

9 SgtMaj GREEN: Good morning. Sergeant
10 Major Green, Sea Enlisted Advisor of Headquarters,
11 Battalion Headquarters of the Marine Corp, and a
12 member of the Task Force.

13 DR. BULLOCK: Good morning. I'm Russ
14 Bullock, Professor of Neurosurgery at the
15 University of Miami and head of the Subcommittee
16 on Traumatic Brain Injury.

17 DR. LOCKEY: Good morning. James
18 Lockey, Professor of Environmental Health and
19 (inaudible) Medicine at the University of
20 Cincinnati, and Core Board member.

21 CMSgt GABRELCIK: Good morning. Chief
22 Master Sergeant Jeff Gabrelcik, former Chief of

1 the Air Force Review Boards, now Chief Sustainment
2 Policy for the Air Force Reserve and Task Force
3 member.

4 DR. O'LEARY: Good morning. Dennis
5 O'Leary, President Emeritus of the Joint
6 Commission and a Core Board member.

7 DR. MCKEON: Hi. I'm Richard McKeon.
8 I'm a clinical psychologist and Acting Branch
9 Chief for Suicide Prevention at the Substance
10 Abuse and Mental Health Services Administration,
11 and Co-Chair of the Federal Working Group on
12 Suicide Prevention, and a member of the Task
13 Force.

14 DR. WALKER: David Walker, Professor and
15 Chair of the Department of Pathology, University
16 of Texas, Medical Branch at Galveston, and a
17 member of the Defense Health Board.

18 DR. HOLLOWAY: Good morning. Marjan
19 Holloway, faculty member at Uniform Services
20 University, Department of Medical and Clinical
21 Psychology as well as Psychiatry, and a member of
22 the Task Force.

1 DR. CLEMENTS: I'm John Clements, the
2 Chair of Microbiology and Immunology at Tulane
3 University, School of Medicine in New Orleans, and
4 a member of the Core Board.

5 DR. CERTAIN: Robert Certain, retired
6 Air Force Chaplain serving an Episcopal Church in
7 Marietta at the present time, and a member of the
8 Core Board and the Task Force.

9 Lt Gen GREEN: Good morning. I am Bruce
10 Green, the Air Force Surgeon General.

11 GEN (ret) MYERS: And I'm Dick Myers, Core
12 Board member, Retired Military.

13 DR. RICE: I'm Charles Rice, the
14 President of the Uniform Services University and
15 currently performing the duties of the Assistant
16 Secretary of Defense for Health Affairs.

17 DR. POLAND: And I'm Greg Poland,
18 Professor of Medicine and Infectious Diseases at
19 the Mayo Clinic in Rochester, Minnesota, and one
20 of the Board Co-Vice Presidents.

21 I think Ms. Bader has administrative
22 remarks before we begin the morning session.

1 MS. BADER: Thank you, Dr. Poland. I'd
2 like to welcome everyone to this meeting of the
3 Defense Health Board and to thank the staff of the
4 Bethesda Marriott Hotel for helping with the
5 arrangements for this meeting as well as the Task
6 Force, and the briefers for this afternoon's
7 session who have all worked very hard to prepare
8 for this meeting of the Defense Health Board.

9 In addition, I'd like to thank my staff,
10 Jen Klevenow, Lisa Jarrett, Elizabeth Graham,
11 Olivera Jovanovic, Christina Cain, and Jean Ward
12 for their assistance in arranging this meeting.

13 I would like to remind everyone to
14 please sign the general attendance roster on the
15 table outside, if you have not already done so.
16 Additionally, for those who are not seated at the
17 table, handouts are provided in the back of the
18 room on a separate table.

19 Restrooms are located in the hallway
20 just outside the meeting room, and for telephone,
21 fax, copies or messages, please see Jen Klevenow
22 or Lisa Jarrett -- Lisa Jarrett's standing in the

1 back of the room -- and they can assist you.

2 Because the open session is being
3 transcribed, please make sure that you state your
4 name before speaking and use the microphones so
5 that our transcriber can accurately report your
6 questions. Copies of the report from the Task
7 Force on the Prevention of Suicide by Members of
8 the Armed Forces have been provided to the voting
9 Defense Health Board members. We have assigned a
10 numbered copy to each voting Defense Health Board member
11 to ensure all copies are collected
12 following the report presentation.

13 Prior to lunch, please hand carry your
14 Task Force reports to either Lisa Jarrett or
15 Elizabeth Graham, and they can account for all
16 copies at that time.

17 Refreshments will be available for the
18 morning session, and we have a catered working
19 lunch here for Board members, Task Force members,
20 Ex-Officio members, Service liaisons, and DHB staff.
21 Lunch will also be provided for our distinguished
22 guests and our speakers.

1 For others looking for lunch options,
2 the hotel restaurant will be open. In addition,
3 there are several alternatives located in nearby
4 shopping centers. You can obtain maps and
5 directions for these local establishments from the
6 front desk.

7 The next meeting will be held on August
8 18th and 19th at the United States Military
9 Academy at West Point. And I must put in a plug
10 since Dr. Poland mentioned my youngest son, who's
11 at the Air Force Academy; my eldest son is at the
12 United States Military Academy. So I don't want
13 to leave him out. We're a joint family.

14 DR. POLAND: What do you do when it's
15 Army versus --

16 MS. BADER: And, lastly, I ask that you
17 please put all portable electronic devices in a
18 silent mode. I did receive an update from Colonel
19 McPherson, the Executive Secretary for the Task
20 Force. Additional blue folders have been placed
21 in front of everyone's seat here at the U-shaped
22 table, and within those blue folders you'll find

1 the 13 foundational recommendations, an updated
2 exec sum, graphs and charts for the report, and a
3 copy of the slides.

4 And I would be remiss -- routinely, we
5 introduce folks in the audience because we want to
6 get them captured, so I'd like to ask Lisa Jarrett
7 to please pass the mic so that we can introduce
8 some of the folks in the public. Thank you.

9 MS.PONDER: Lieutenant Colonel Kathy
10 Ponder, OSD Accession Policy, Assistant
11 Director of Reserve and Medical Manpower.

12 DR. LUDWIG: George Ludwig. I'm the
13 Deputy Principal Assistant for Research and
14 Technology at the Army Medical Research and
15 Materiel Command.

16 MS. RUOCCO: Kim Ruocco. I'm the
17 Director of Suicide Education and Support for the
18 Tragedy Assistance Program for Survivors. I'm
19 also a survivor. My husband died by suicide five
20 years ago. He was a Marine major.

21 MR. HOLTON: Steve Holton, a retired
22 Force Master Chief in the Navy now working for

1 OPNAV in 135, Suicide Prevention for the Navy, and
2 a survivor. My brother and sister have both taken
3 their lives.

4 MR. SMITH: Jack Smith, Acting Deputy
5 Assistant Secretary for Clinical and Program
6 Policy.

7 CDR PADGETT: Good morning. Commander
8 Bill Padgett, Headquarters, Marine Corps Health
9 Services.

10 CDR SCHWARTZ: Hi. Commander Schwartz.
11 I'm from the Coast Guard, Preventive Medicine
12 Division.

13 DR. ERDTMANN: Good morning. My name is
14 Rick Erdtmann. I'm a staff member at the Institute
15 of Medicine and an Ex-Officio member of the
16 Defense Health Board.

17 COL KRUKAR: Good morning. Michael
18 Krukar, Director of the Military Vaccine Agency.

19 CAPT NAITO: Good morning. Neil Naito,
20 Director of Clinical Care and Public Health,
21 BUMED.

22 MR. GINSIG: Donald Gintzig, Deputy

1 Chief, Bureau of Medicine and Surgery.

2 COL HACHEY: Wayne Hachey, Director of
3 Preventive Medicine, OSD Health Affairs, Force
4 Health Protection and Readiness.

5 CDR SIKORSKI: Good morning.
6 Commander Cindy Sikorski, Preventive Medicine
7 resident, Uniformed Services University.

8 LCDR DEUSSING: Good morning.
9 Lieutenant Commander Eric Deussing, Preventive
10 Medicine resident, Uniformed Services University.

11 COLONEL MONHAM: Good morning. Colonel
12 Bob Monham with the Preventive Medicine, Army
13 Surgeon General's Office.

14 DR. UHDE: Tom Uhde, Professor and Chair
15 of the Department of Psychiatry and Behavioral
16 Sciences, and Co-Director of Psychiatry
17 Institute at the Medical University of South
18 Carolina, and a member of the Psychological Health
19 Subcommittee at the Defense Health Board.

20 DR. QUICK: Jim Quick, Air Force,
21 retired, and Psychological Health Subcommittee
22 member.

1 DR. KRYSTAL: John Krystal, Professor
2 and Chair of Psychiatry, Yale University, and
3 Chief of the Clinical Neurosciences Division of
4 the V.A. National Center for Posttraumatic Stress
5 Disorder, and a member of the Psychological Health
6 Subcommittee.

7 MS. RODRIGUEZ: Good morning. Michelle
8 Rodriguez. I'm the Director of Business
9 Development for our Health Portfolio at SRI
10 International.

11 MR. PUMMILL: Dan Pummill, Director of
12 Policy and Procedure at the V.A.

13 MS. ZELLER: Eileen Zeller, Public
14 Health Advisor and Substance Abuse Mental Health
15 Services Administration in the Suicide Prevention
16 Branch.

17 MR. COX: Kenneth Cox, a Special
18 Consultant to the U.S. Army Public Health Command,
19 and a liaison with the Army STARRS Project.

20 MR. SCHOENBAUM: I'm Michael Schoenbaum. I'm
21 a Senior Advisor to the Director of the National
22 Institute of Mental Health, and I'm one of NIMH's

1 principal scientists in the Army NIMH Study
2 Kenneth Cox just referred to, the Army STARRS, Study
3 of Risk and Protective Factors for Suicide in U.S.
4 Army Soldiers.

5 MR. KLEIMAN: Matt Kleiman. I'm the
6 Chief of the Individual and Family Support
7 Programs at Coast Guard Headquarters.

8 MS. MILHISER: Ellen Milhiser,
9 Editor of Synopsis Newsletter.

10 MS. FARRELL: Hi. Deirdre Farrell. I
11 provide research support for the Task Force on
12 Suicide Prevention of the Armed Forces.

13 MS. AUERBACH: Hi. Erica Auerbach. I
14 work for Booz Allen Hamilton. I support the Task
15 Force for the Prevention of Suicide by Members of
16 the Armed Services.

17 DR. BUTLER: Good morning. Frank Butler
18 from the Committee on Tactical Combat Casualty
19 Care and member of the Trauma and Injury
20 Subcommittee.

21 COL COSTANZO: Good morning. George
22 Costanzo. I'm the Director of the Joint Theater

1 Trauma System at Fort Sam Houston in San Antonio.

2 MS. GIESE: Anne Giese. I work at the
3 Defense Centers of Excellence for Psychological
4 Health and Traumatic Brain Injury.

5 Lt Col Kindt: Lieutenant Colonel
6 Michael Kindt, Air Force Suicide Prevention Program
7 Manager.

8 Col MARRS: I'm Scott Marrs. I'm the Air
9 Force Psychology Consultant.

10 MS. OETJEN-GERDES: Lynn Oetjen-Gerdes. I'm
11 the Deputy Chief of the Mortality Surveillance
12 Division and the Armed Forces Medical Examiner
13 Representative to the SPARRC Committee.

14 CDR MALONE: Good morning. Rosemary
15 Malone. I'm a forensic psychiatrist in the
16 Psychological Investigations Division at the
17 Office of the Armed Forces Medical Examiner.

18 CAPTAIN CANTRELL: Good morning.
19 Captain Cantrell from the Chief of Mortality
20 Surveillance at the Armed Forces Medical Examiner.

21 MS. PEARSE: Lisa Pearse. I'm the
22 Associate Program Director for Preventive Medicine

1 at the Uniformed Services University.

2 COL NIEBUHR: David Niebuhr. I'm the
3 Director of Preventive Medicine at Walter Reed
4 Army Institute of Research.

5 MS. PHAN: Rosie Phan, contract support
6 for the Defense Center of Excellence for
7 Psychological Health and Traumatic Brain Injury.

8 DR. BATES: Good morning. Mark Bates,
9 Director of Resilience and Prevention, DCoE.

10 DR. MALCOLM: I'm Perry Malcolm. I'm a
11 Reserve Physician working with in OSD DDR&E.

12 COL LAMB: Good morning. Colonel Tim
13 Lamb, Joint Staff, Joint Staff Surgeon's Office.

14 DR. KINNEBREW: Cree Kinnebrew,
15 supporting Booz Allen Hamilton and also supporting
16 the Task Force.

17 DR. SUNDARARAMAN: Ramya Sundararaman, in a
18 public health position, Subject Matter Expert for
19 DCoE through Booz Allen.

20 MR. MCMANIGLE: John McManigle, Vice
21 Dean, Uniformed Services University, School of
22 Medicine.

1 MS. PIETSCH: Rebecca Pietsch, Contract
2 Support for DCoE.

3 MS. CAIN: Christina Cain, DHB Support
4 Staff.

5 MS. JOVANOVIC: Good morning. Olivera
6 Jovanovic, DHB Support Staff, CCSI
7 Contractor.

8 MR. RABOLD: Good morning. Ridge Rabold,
9 Program Manager, Armed Forces Institute of
10 Pathology.

11 MS. COATES: Marianne Coates,
12 Communications Advisor to the Defense Health
13 Board, CCI -- CCSI Contract.

14 DR. GRINKER: Hi. Roy Grinker,
15 Professor of Anthropology and Human Sciences
16 at the George Washington University, writing a
17 book on the history of military psychiatry.

18 MS. EKANAYAKE: Hi. Vindhya Ekanayake,
19 Ph.D. candidate in clinical psychology at Purdue
20 University.

21 DR. Ireland: Bob Ireland, retired, Air
22 Force, Psychiatrist Consultant to DCoE.

1 MR. Tate: Mike Tate, Project Manager,
2 working for Booz Allen.

3 MS. WALTERS: Gail Walters, Public
4 Affairs Support to the Task Force on the
5 Prevention of Suicide among Members of the Armed
6 Forces, and also a surviving family member of
7 suicide.

8 MS. GRAHAM: Hi, Elizabeth Graham, DHB
9 Support Staff.

10 CPT Noe Muniz: Hi. Noe Muniz, Aide to
11 General Volpe.

12 MS. JARRETT: Lisa Jarrett, Defense
13 Health Board Staff.

14 DR. POLAND: Okay. Let's see. Let's
15 get started. Our first presentation will be
16 delivered by the Co-Chairs of the Department of
17 Defense Task Force on Suicide Prevention by
18 Members of the Armed Forces, Major General Philip
19 Volpe and Ms. Bonnie Carroll.

20 Major General Volpe serves as the
21 Commanding General of the Western Regional Medical
22 Command and Senior Marketing Executive for

1 TRICARE, Puget Sound. He's a board-certified
2 family medicine physician and a Fellow of the
3 American Academy of Family Physicians, and a
4 Diplomat of the American Board of Family Medicine.

5 Major General Volpe recently served as
6 the Deputy Commander, Joint Task Force, National
7 Capital Region Medical. His numerous awards and
8 decorations include the Defense Superior Service
9 Medal, the Legion of Merit, the Bronze Star, the
10 Purple Heart, the Defense Meritorious Service
11 Medal -- Meritorious Service Medals -- the Army
12 Commendation Medal with "V" Device, and, in
13 addition, Major General Volpe possesses the
14 Surgeon General's "A" Proficiency Designator in
15 the field of Family Medicine.

16 I guess following him will be Ms.
17 Carroll, who serves as the National Director of
18 the Tragedy Assistance Program for Survivors, or
19 TAPS. TAPS is the National Nonprofit Veterans
20 Service Organization addressing the emotional,
21 psychological, and administrative problems that
22 arise from the loss of a loved one in military

1 service to America.

2 Previously, Ms. Carroll served as the
3 Deputy Senior Advisor for Programs, Ministry of
4 Communications Coalition Provisional Authority in
5 Baghdad, Iraq, and Deputy White House Liaison,
6 Department of Veterans Affairs.

7 Her military experience includes Chief
8 Casualty Operation in the United States Air Force
9 Reserve and the Air and Space Operations, Air
10 Reserve Component Advisor at the Pentagon.

11 She also assisted with the publications
12 Living With Grief After Sudden Loss; (inaudible)
13 Living With Grief: Children and Adolescence; and
14 Living With Grief: Who We Are and How We Grieve.
15 So welcome.

16 MG VOLPE: Great. Thank you very much,
17 sir. It's an honor and pleasure for the members
18 of the Task Force to be here and to present to our
19 distinguished members of the Defense Health Board
20 and distinguished guests that are in the audience,
21 and folks that are very interested in this topic,
22 because it is an important topic, and this is a

1 call to action and is an urgent matter that needs
2 to be addressed within the Department of Defense.

3 As the Co-Chair for the Department of
4 Defense Task Force for the Prevention of Suicide
5 by Members of the Armed Forces, we have the final
6 draft, but it is pre-decisional. It's
7 pre-decisional because we wanted to make sure we
8 included the advice and guidance of the members of
9 the Defense Health Board into the report. And so
10 I wanted to make sure everybody was aware of that.

11 Could I go on to the next slide, please?
12 So why? Why a task force, why are we here?

13 Besides the more recent last several
14 years increases in the number and rate of Service
15 member suicides, there has been an ongoing rate
16 for a number of years and in decades. And
17 Services have had programs throughout, but this is
18 pretty alarming with the current War on Terrorism,
19 the all-volunteer Force, and the missions that
20 need to be done by Service members.

21 The other reason is, is that this Task
22 Force was put together because it is a complex

1 field. It lacks a certain amount of
2 evidence-based research that needs to go forward
3 and conducted, and it requires a lot of expert
4 opinion and consensus in order to figure out the
5 way ahead.

6 There is no silver bullet solution to
7 suicide prevention, and there really is no gold
8 standard program that's without a doubt that will
9 be able to prevent suicide that we were able to
10 find on the Task Force. So this was pretty
11 complex, and that's why we've gathered these
12 experts together to form this Task Force and to
13 deliberate over the past year.

14 And then every single life is valuable
15 and every loss is deeply tragic. And this affects
16 all the Services, Army, Navy, Air Force, and
17 Marine Corps. And, like I said, each one of these
18 suicides is very tragic indeed, and we need to
19 remember that this is a human dilemma, and it's
20 about human beings and people, and men and women
21 serving their country who have taken the same oath
22 that all of us in uniform have taken. And we owe

1 it to them to prevent every suicide that we can.

2 The members of the Task Force also want
3 to express right up front our appreciation,
4 sincere appreciation, for not only the Services
5 and DoD and folks briefing us on best practices,
6 which I'll talk about in a second, but all those
7 who participated and provided information to the
8 Task Force.

9 It has been an enormous, enormously
10 valuable information that has come forward to us.
11 And we also want to thank people that have also
12 come forward to us privately, as well as during our
13 sessions, to provide information and share
14 information, even personal stories with us about
15 suicide. And the Task Force did indeed take all
16 of that into account.

17 May I have the next slide, please?
18 Here's an overview of what I will cover. It's
19 very important, the creation of the Task Force,
20 specifically, the Congressional Charter specifics
21 that we were tasked to make sure we addressed or
22 answered somewhere in the report about our

1 membership, meetings, briefings, and site visits
2 that we made; and then we'll go into the general
3 observations with respect to the report, ongoing
4 suicide prevention efforts.

5 Four focus areas that we have put
6 together and defined which we consider. Any
7 comprehensive suicide prevention program needs to
8 have multiple initiatives in each of these focus
9 areas in order to be comprehensive, but there are
10 also lines of defense for suicide because again,
11 this is multi-factorial and it's a very complex
12 area. And this blanket of defense has to be
13 attacked from multiple fronts.

14 And we have 16 strategies that are
15 specific to the Department of Defense that we are
16 hoping that the Department of Defense will adopt
17 as strategies because we believe that these will
18 make a difference in saving lives. And then we
19 have some foundational recommendations. The
20 report, in it will have a number of findings and
21 recommendations. There's dozens and dozens of
22 recommendations in there, and we wanted to make

1 sure that everybody understood, while every
2 recommendation is important, there needs to be
3 some foundation in there from which this
4 foundation needs to be solid and not crack at all
5 for the whole structure of suicide prevention to
6 remain standing up.

7 So I'll talk a little bit about those
8 foundational recommendations, and then we'll go
9 into some question and answer period. And, of
10 course, any recommendations that the Defense
11 Health Board could provide to us in finalizing
12 this report and going forward to the Secretary of
13 Defense would be very important and valuable for
14 us.

15 Next slide. Creation of the Task Force
16 clearly, Section 733 of the National Defense
17 Authorization Act 2009, and these are the words,
18 line by line: "Secretary of Defense shall
19 establish within the Department of Defense a Task
20 Force," which is this particular Task Force here
21 and the members are here, "to examine matters
22 relating to the prevention of suicide by members

1 of the Armed Forces." So this is a task force set
2 up to look at uniformed Service members and
3 Defense Department Service members.

4 But I will mention that we also were
5 able to include and speak with and look at
6 programs in the Coast Guard and some other areas
7 that we thought were important, not only to learn
8 from, but they also serve in uniform and in a way
9 are also members of the Armed Forces, although not
10 in the Defense Department, but the Department of
11 Homeland Security.

12 And I also wanted to mention that we
13 also have talked extensively and worked with the
14 Veterans Affairs, because this is not just Service
15 members while they're on active duty; this is a
16 continuum in life even after serving on active
17 duty and in the years that follow.

18 Next slide. The purpose of this Task
19 Force was really clear, as stated in the Section
20 722, "a submitted report to the Secretary of
21 Defense, make recommendations for a comprehensive
22 suicide prevention policy," and the purpose, of

1 course, was to prevent suicides and save lives.
2 And that's what we focused on as a suicide
3 prevention, and I don't think there was a meeting
4 or a session we had where we didn't come back and
5 back ourselves up and say it is about saving
6 lives. And that was our focus the entire time and
7 sense of importance in the way I feel that the
8 Task Force members went about doing their
9 deliberations and work.

10 Next slide. This is the charter from
11 Congress, the specific questions that Congress
12 asked us to address, and you could read through
13 these pretty clearly: Identify methods to --
14 excuse me -- methods to identify trends and common
15 causal factors in suicides; methods to establish
16 and update suicide education and prevention
17 programs; do an assessment of current suicide
18 prevention education programs at each military
19 department; assessment of suicide incidence by
20 military occupation.

21 And then there's a whole bunch of
22 recommendations -- excuse me, a whole bunch of

1 directives to us to look at type and method of
2 investigation, because there is no standardized
3 type and method of investigation that goes across
4 all of DoD. While there may be standardized
5 within a particular Service, each Service does
6 investigations and looks at suicide from various
7 aspects and different informational data points
8 now, as they go.

9 Next slide. And then this all has to do
10 with the investigation process, the qualifications
11 of the individual to conduct an investigation,
12 what would be the required information to be
13 determined by the investigation, what are the
14 reporting requirements for it, what's the
15 appropriate official it will be reported to, the
16 use of the information gathered in these
17 investigations, but also, how do you protect the
18 confidentiality because this is very personal and
19 emotional.

20 And there's privacy and confidentiality
21 aspects that we need to make sure that we keep in
22 mind as we are reporting information about

1 suicides or investigation suicides.

2 Now, all of these are -- the whole
3 report answers these questions when taken
4 collectively. And then in the front of the report
5 on the Introduction section, we have these stated,
6 and we have some reference sections in the report,
7 multiple reference sections which, collectively,
8 answer the question. And then we've created an
9 Annex A, which is summarized answers to each of
10 these specific things in the report. So it's in
11 multiple places in the report. We wanted to make
12 sure that we answered the specific questions as we
13 went about our duties.

14 Next slide. Let me talk about the Task
15 Force membership really quick. As stated in
16 Section 733, there will be 14 members appointed by
17 the Secretary of Defense, at least one from each
18 military Service of the four military Services,
19 and no more than half can be DoD members. And
20 indeed, we have eight non-DoD and six DoD members.

21 The non-DoD members have to have
22 experience in the following areas: national

1 suicide prevention policy, military personnel
2 policy, research in the field of suicide
3 prevention, clinical care, mental health, military
4 chaplaincy, pastoral care, and at least one family
5 member, members of the Armed Forces with
6 experience working with families.

7 Next slide. These are the members of
8 the Task Force. Most are here, and many
9 introduced themselves during the initial
10 introductory section here. I think what's
11 important to say is they're listed in the front of
12 the report in the Introduction section, and then
13 there are bios in Annex B of the report for each
14 member of the Task Force.

15 Next slide. Meetings and briefings.
16 The Task Force collected information from a number
17 of -- there was meetings, briefings, and also some
18 site visits that were made on all the
19 installations. And I want to get into this a
20 little bit and speak to this.

21 The original organizational meeting, I
22 should say a preparatory session that we had, was

1 on August 7, 2009. That was the first session
2 where the members came together just to organize
3 and look at methodology and our way ahead, way
4 forward, and our strategy for coming up with how
5 we were going to develop a report at the end of
6 this process. And meetings were held monthly and
7 twice monthly, face-to-face meetings since then.
8 It's been a pretty extensive amount of time placed
9 on members of the Task Force to come together
10 because this is very complex, as I had mentioned.

11 We had open and preparatory sessions in
12 there, and there is a number of information
13 briefings and panel discussions. Now, the
14 information briefings, the meetings are listed in
15 Annex D, and all of the briefings and briefing
16 topics and speakers and stuff are listed in Annex
17 E on there. But they covered a whole host.

18 This isn't all inclusive; there were
19 other aspects and other topics that were in here,
20 but the majority of the briefings and panel
21 discussions that we had during our open sessions
22 covered a lot of these areas, and this gave us a

1 broad breadth of understanding suicide and
2 understanding the various Services' approach to
3 suicide, their suicide prevention programs, and be
4 able to do some gap analysis and look at
5 strategies based on best practices that we could
6 make recommendations for our -- for the Secretary
7 of Defense.

8 Next slide. These are the site visits
9 we made, and you could see we made site visits to
10 all four of the military Services, a sampling of
11 installations that were chosen by the Task Force,
12 again Army, Marine Corps, Navy, and Air Force. And
13 I got to thank right up front the Services for
14 assisting the members of the Task Force to make
15 these formal visits, because we do know that
16 there's a great burden on each of these
17 installations when you have a task -- you know, a
18 group of folks coming in and asking for some
19 specific things. Because during these sessions,
20 we were able to meet with various groups of
21 individuals of which the Task Force gained some
22 significant information from that helped with

1 developing the report.

2 We were able to meet with junior
3 enlisted Service members, noncommissioned
4 officers, officers, leadership at different levels
5 in and around an installation and units, family
6 members, talk with behavioral health individuals,
7 as well as community service individuals on
8 installations and stuff, and support service
9 individuals, of course.

10 So we gained a tremendous lot by these
11 visits, and they, a lot of it, confirmed or
12 emphasized many of the other findings that we were
13 already coming up with, with briefings and
14 information from the Services, but we felt it was
15 very important to put eyes on and get out and
16 speak with people out there to get the full feel
17 of the environment and the surroundings that have
18 to do with suicide and suicide prevention.

19 There were some other individual visits,
20 informal visits, that were made on various
21 installations as members traveled about and
22 especially those that are in DoD that travel about

1 the various installations, too.

2 Next slide. Okay, here's some general
3 observations that I think are very important to
4 mention up front. A lot of credit needs to go out
5 to the Services. The Services are engaged. All
6 four military Services are engaged in suicide
7 prevention. Leadership is involved at all levels,
8 especially at the strategic level, and I got to
9 tell you, of our four focus areas which I'll
10 describe in a moment, the Services have programs
11 in all of those focus areas. So they have some
12 pretty extensive programs that are out there. But
13 we believe that a lot of those programs are not
14 optimized or don't benefit from standardization,
15 data collection, surveillance and all those other
16 things. So that's where we focused a lot of our
17 recommendation on, and I'll discuss those in the
18 foundational recommendations when I get to those.

19 But I want to make sure that it's clear
20 that there is -- there is no lack of effort, and
21 there's no lack of energy going into suicide
22 prevention in the various Services right now.

1 Bullet No. 3, you could see there, and I
2 wanted to mention this because, you know, there
3 are saves going on. There are saves going on. We
4 -- there's no way to mention how many saves are
5 actually occurring, but we got to witness and see
6 and hear about and share information throughout
7 the year where we saw people taking action, or
8 leaders taking action, that actually saved a life.
9 They intervened whether it was a family member or
10 a buddy, or was self-care or a behavioral health
11 provider.

12 Now, we also feel that we're not
13 leveraging the strategic communications enough on
14 those positive aspects which would help in the
15 strategic communications, if you will, or positive
16 psychology for suicide prevention; that we seem to
17 be focused on the negative side and all the things
18 that go wrong. But that will be a recommendation
19 that you'll see that comes up later on, on there.
20 But I wanted to mention that there are people
21 being saved, and there's no way to really
22 calculate how much of that really occurs.

1 There is a relationship between the
2 increased operation tempo, including deployments,
3 but not whether you've just deployed. I mean,
4 deployment in itself is a stress with separations
5 on families, a lot of the causal factors that are
6 involved in suicide. But even those that don't
7 deploy, there's just a general OPTEMPO increase
8 and stress on the Force right now. And I believe
9 this was emphasized the greatest when we went and
10 made site visits.

11 I mean, I could clearly say the Force
12 overall appears to be fatigued. And I think that
13 was pretty unanimous by the members of the Task
14 Force that we believe that there is some fatigue
15 going on, and I'll discuss that some more when we
16 get to our recommendations where we believe there
17 are solutions or strategies to address that as we
18 go. But there is a relationship there.

19 Suicide is multi-factorial and suicide
20 prevention must be multi-solutional. I know
21 "multi-solutional" is not a word, but I tend to
22 make up words as I go and put them on a chart.

1 But the bottom line is multiple factors, complex
2 factors, go into suicide, and there's no single
3 silver bullet program or one thing you could do
4 that is going to save lives. It is a conglomerate
5 of multiple things that have to come together.

6 It's sort of like multiple layers of
7 Swiss cheese, and there's openings in there, and
8 multiple pathways for people to go based on their
9 unique situation individualized, their emotional
10 state, their resiliency, whether they have
11 behavioral health problems or no behavioral
12 health problems, stresses on them, relationships
13 and/or changing relationships, significant events
14 in their lives, tragedies, all of these kinds of
15 things.

16 And then folks, individuals that
17 recognize, get people intervention, make the right
18 action, get them to -- helping individuals, be they
19 behavioral help or other community or installation
20 services and, at the same time, those individuals
21 who are trained specifically for suicide - -
22 suicide prevention, suicidal behaviors, that can

1 modify behaviors and actually be very effective in
2 prevention and preventing people from committing
3 suicide.

4 But it's multiple fronts, multiple
5 avenues, and you'll see that when we come up with
6 our focus areas and our strategies on the way
7 ahead, as well as many of our recommendations that
8 are made in the report.

9 Next slide. Okay, these are the four
10 focus areas, and let me take a moment to speak
11 about these. These are the four focus areas that
12 we believe are, if you will -- I'll use the word
13 "domain" -- a lot of folks don't like when I use
14 that word but these are focus areas in
15 comprehensive suicide prevention programs that we
16 believe need to have initiatives in each of these
17 areas. These are lines of defense for suicide.

18 Let's look at the first one:
19 organization of leadership. We strongly believe
20 that if you're going to function in, if you're
21 going to be successful in suicide prevention, you
22 got to organize for suicide prevention. It's got

1 to be organized, structured for suicide prevention
2 where there is some sort of centralized planning,
3 decentralized execution or centralized policy,
4 decentralized programs, but there is some rigor
5 into policy guidance and also to allow
6 standardization for surveillance, because this is
7 a public health problem. And without being
8 organized for success, it is hard to optimize all
9 of the impacts and effects that we want of our
10 programs out there.

11 The other portion of that first one is
12 leadership. Leadership has to be involved in all.
13 This is a leadership issue. This is not a
14 health care, a medical issue per se. While medical
15 care and health care is an important portion of any
16 suicide prevention program, I say medical care and
17 behavioral health care, things like pain control,
18 things like multiple medications that people are
19 being managed on, especially if they are
20 mind-altering medications or psychotropic
21 medications.

22 While all of that is important, also on

1 that same note behavioral health care is important,
2 behavioral health diagnosis where you have anxiety
3 reactions, adjustment disorders, posttraumatic
4 stress disorder, depression, the management of
5 those things are very important. But that, in and
6 of itself, will not prevent suicide. Suicide goes
7 well beyond that.

8 There are so many primary prevention
9 things that are very important: well-being,
10 quality of life, life skills for handling stress,
11 building resiliency. And again I could go on and
12 on. Trained buddies and family members who are
13 people that will first get the indicators of an
14 altered behavior of an individual, that may give
15 them the first sign in getting and knowing where
16 to go in getting those people help. Reliable
17 crisis intervention, hot lines standardized, you
18 know. The 911 equivalent for suicide prevention
19 is what we're basically -- or crisis intervention
20 is what we're speaking about.

21 This is all leadership stuff.
22 Leadership is vital, absolutely vital to suicide

1 prevention, and it needs to remain in the
2 leadership lane.

3 Wellness enhancement and training, I
4 mean this is, you know, this -- this is the bread
5 and butter of public health issue. This is the
6 primary prevention site, you know. While we can
7 pour acids on the behavioral health side, and,
8 yes, we have to make sure we have the right number
9 and configuration of behavioral health people to
10 handle behavioral health problems and to
11 intervene. We really need to push this curve, you
12 know, more to the left on the prevention side and
13 making sure people are resilient and don't need
14 the intervention to begin with, and have the life
15 skills of dealing with the tragedies and
16 disruptions that happen in every human's life,
17 anyone who lives long enough: the ups and downs of
18 human life and changing relationships, especially
19 with the added changing relationships with
20 military members having multiple separations and
21 then reacquaintances, and, you know, reconfiguring
22 relationships once folks are coming back from

1 deployment and stuff. But wellness enhancement is
2 very key to prevention. And it really is, it gets
3 us to a point where we're shooting ahead of the
4 duck and not just at the duck or behind the duck
5 for those that know what I'm understanding here.

6 And then a portion of that is training.
7 Training is vital to this whole process. And I
8 mention training because we think the Service
9 programs in our evaluation of them have very
10 excellent awareness and education programs. But
11 we're talking about skills training. And while we
12 believe the Services do have some skill training
13 programs, skill development programs, it's
14 probably not enough at this point whether it's a
15 time factor in the OPTEMPO -- and I'll get into
16 that in a second, tool on that -- but actually we
17 need the training where people have to demonstrate
18 that they've learned the skills that are important
19 to preventing suicide, whether it's buddy aid or
20 family members.

21 And there is a lack of training of
22 family members. That I could tell you pretty

1 unanimously from the board when we went out, and
2 family members are asking for training. Many
3 family members have shared on Service members
4 that have committed suicide or died by suicide.
5 You know, "I knew there was something wrong. I
6 didn't quite know what it was, and I didn't know
7 who to ask or who to...," you know.

8 And there's a certain guilt feeling that
9 goes with that with survivors, too, on that. But
10 it also, as we went around, we realized that
11 families aren't included a lot in unit-level
12 training. Some immediate family members are
13 spouses, but moms and dads of single soldiers are
14 not all that included in training and development
15 of skills on what to do and what to look for in
16 those kinds of things. So that's another whole
17 area.

18 The third focus area, or the third line
19 of defense, is access to and delivery of quality
20 care. That has to be in place. And I think
21 what's important here is making sure that our
22 behavioral health people and the first responders,

1 if you will, or the first line of helping people
2 -- chaplains, community service individuals, as
3 well as behavioral health personnel -- they need
4 some specific competencies in training in suicide.
5 Just having a degree in psychology or psychiatry
6 or whatever it is, is not enough for suicide
7 prevention. There needs to be some specific
8 training programs, and we'll talk about that
9 recommendation in a second.

10 But this is a vital area of defense,
11 too, because while wellness enhancement and
12 training, and building resiliency and life skills
13 is important, some people are still going to be
14 affected and will end up in our hands on the
15 intervention side. And we have to have quality
16 intervention. We have to have access to the
17 intervention, and they have to have quality
18 intervention that will change the behavior and/or
19 get them out of this pathway that they're
20 currently on towards suicide.

21 And then overall, because this is a
22 public health issue, is surveillance: surveillance

1 and investigations. This is the only way we
2 really learn, the only way we really learned from
3 a public health standpoint and could consolidate
4 information is to collect data. That's how you
5 learn about causal factors and trends. That's
6 how you identify epidemics or thread areas, or
7 changing constellation of signs and symptoms
8 and/or demographics or those kinds of things. But
9 you need to have a system of a pretty rigorous
10 surveillance system.

11 Public health sort of prides itself on
12 unity of effort. Centralized planning,
13 decentralized execution, or a disciplined
14 reporting process of standardized information and
15 surveillance is a part of that.

16 And in the area of investigations, we
17 also believe -- and this was a particular task
18 that was asked to us, or directed to us, by
19 members of Congress in the National Defense
20 Authorization Act is to look at investigations,
21 how the Services are investigating suicides and
22 how -- really, investigations from the aspect of

1 preventing future suicides, not investigations to
2 hold people accountable for this or that, or
3 whatever it is.

4 And then we found a pretty significant
5 gap in that area, but we believe this is
6 important. The reason why we have this on here as
7 part of the focus area as surveillance is 'cause
8 it's about learning. We have to be a continuous
9 learning organization to be, to really inform
10 suicide prevention programs as time goes by. And
11 the only way you do that is through surveillance
12 and investigations.

13 And what investigations give you that
14 surveillance does not is those unique dynamic
15 relationships and interactions that happened in
16 the last few hours, last few days, last few weeks
17 of a suicide. What are we really learning from
18 those things? And if that information isn't
19 collected, investigated, if you will, and
20 someone's not looking at all the aspects, those
21 dynamic aspects that aren't in surveillance data,
22 we're not learning as much as we could be that can

1 inform programs. So we believe that there needs
2 to be a standardized way to conduct
3 investigations.

4 This is -- and we also believe -- and
5 I'll get into that in the recommendations -- but
6 this, is we think, the models are out there already
7 on which to model this after. And that has to do
8 with, like, aircraft accident investigations, and
9 where their sole purpose is to prevent the future
10 aircraft accident, or serious incident or death
11 accident investigations, safety accident
12 investigations and those things where they're
13 focused on prevention, okay, not accountability
14 for the immediate situation but for future
15 prevention. And that's what we're talking about
16 there.

17 So this is very important to us. The
18 Services have programs in each of these areas, but
19 we believe that they can be further optimized in
20 benefit. And we think they need to do that very
21 soon. The sense of urgency is important to get on
22 with this business, and we'll have some specific

1 recommendations in that area, those areas.

2 Next slide. Sixteen strategies. We
3 came up with 16 strategies specific for the
4 Department of Defense that we want the Department
5 to adopt. And these strategies are focused, the
6 strategies under each of the focus areas, I should
7 say. And there's five in the first focus area,
8 organization and leadership, that are strategies.
9 And one of the strategies for the Defense
10 Department is to restructure and organize for
11 unity of effort in suicide prevention.

12 Okay, now we're not saying that a
13 (inaudible) way of speaking, you know, every
14 program and every Service program needs to be
15 centralized at the DoD level. And now there are
16 Service programs, and it's important that Services
17 have their programs based on their culture and
18 that their leaders in the Service are running
19 their programs and responsible for their programs.
20 But they could certainly benefit from some
21 centralized policy and standard reporting
22 requirements that come up from which we can learn

1 from. So this is a very important strategy.

2 Another important strategy is to equip,
3 empower leaders at all levels. This is talking
4 about not only developing tools for leaders which
5 has to come through some of the research in the
6 area: What are the best tools for identifying
7 high, medium, low risk individuals? Those kinds
8 of things, but also to keep it in the leadership,
9 line leadership lane, suicide prevention, and keep
10 it a leadership issue and not a medical issue.

11 It also has to do with making sure that
12 we're addressing any negative leadership aspects,
13 a negative command climate, holding leaders
14 accountable, making sure that we have a positive
15 command climate and that we have command climates
16 that augment or assist or foster help-seeking
17 behavior, not obstructing help-seeking behavior.
18 There's enough stigma already in suicide that
19 leadership needs to make sure that they are the
20 key to overcoming a lot of the stigma that's out
21 there on mental health and help-seeking behavior.

22 And leaders -- Service members,

1 soldiers, sailors, airmen, Marines, model their
2 leaders to a tremendous amount, noncommissioned
3 officer leaders and officer leaders. And if
4 leaderships are involved at every level, we think
5 this will make a significant difference in suicide
6 prevention. And so that's one of the strategies
7 we want to make sure that are adopted by the
8 Department of Defense.

9 Develop positive strategic messaging, I
10 alluded to this before. A lot of the messages and
11 reports are all about the bad things that go
12 wrong, and while there's a place and location for
13 that, there are some very good things going on.
14 But the messages that have to go out to the troops
15 are ones that'll help convince them that going to
16 seek help when they do have problems is good, and
17 it's going to work, because that's what we want
18 them to do, okay. But positive strategic
19 messaging, moving -- moving the conversation of
20 suicide to more positive actions where people will
21 not look at it from the negative aspect all the
22 time because we believe that adds to the stigma

1 and the fear about discussing suicide and those
2 kind of things in suicidal behavior.

3 Reduce stigma and overcome cultural
4 barriers to help-seeking behavior. Each of the
5 Services have their cultures; the military has a
6 culture in and of itself. And this is very
7 important to understand that this culture, while
8 it is important for mission accomplishments on
9 dangerous battlefields around the world and for
10 survival skills, you know -- I'm talking about the
11 military culture, suck it up and drive on -- you
12 know, win, we'll get through this on ourselves --
13 don't ask for help, you know, we gotta solve the
14 problem now. These are very important battlefield
15 skills. They don't -- they're not -- they're
16 also destructive for help-seeking behavior on the
17 other end of the scale.

18 And so what we're saying here, is that we
19 have to both reduce the stigma for behavioral
20 health care and help-seeking behaviors, and at the
21 same time we want to overcome the Service cultures
22 because that has further emphasis on that stigma

1 and further impact on that because we do see
2 Service members that hoped that everything will
3 get better on its own; that they're not going to
4 ask for help because it's a sign of weakness, and
5 we inculcate some of that. And while that's
6 important for survival skills and mission
7 accomplishment skills, it works against suicide
8 prevention.

9 And so -- and I got to tell you, we
10 don't have the exact answer on the Suicide
11 Prevention Task Force, but this has to be looked
12 at and looked into and addressed in a methodical
13 fashion by the Department of Defense.

14 Standardized policies, procedures, and
15 ensure program evaluation is incorporated in all
16 programs, suicide prevention programs. And this
17 is important because the one thing we were asked
18 to do was to assess Service suicide prevention
19 programs, and I gotta tell you, it's pretty
20 difficult to do.

21 First of all, there is no model of
22 assessment. There is no suicide prevention

1 program in the world or in the United States that
2 you would model after and say good or not. That's
3 why we came up with our focus areas and started
4 looking at the Service programs and realizing they
5 had policies and procedures and programs in place
6 that cover the areas we're talking about, but one
7 piece that is lacking, not in every program but in
8 the vast majority of programs, is program
9 evaluation.

10 Any program that we institute, any
11 initiative that we do, they should build in a
12 program evaluation model to ask, to be able to
13 answer the question in the future: Is the program
14 accomplishing what it set out to accomplish? Is
15 it getting the effects that it is meant to get? What
16 are the metrics when measuring to see if the
17 program's working? And that is not in place, it's
18 not locked in enough, and more thought has to go
19 in when we develop programs for suicide prevention
20 of putting in program evaluation. And I think we
21 will learn a tremendous amount from that as we
22 move to the future. And that has to be done

1 pretty soon here as there is a sense of urgency
2 for that.

3 Next slide. The next, Focus Area 2?
4 Okay, Focus Area 2, wellness enhancement and
5 training. There are three strategies that we
6 believe need to be adopted: enhance well-being,
7 life skills, and resiliency. This again -- this
8 is again, and all the Services have various
9 programs that they have developed and are involved
10 in with this, but this really gets down to quality
11 of life, well-being, the human health factor, if
12 you will.

13 The problem we have with equating
14 well-being with health is people then see health,
15 and then they say the next step is to say
16 "medical," and then they put suicide prevention
17 programs in the medical lane, okay, and that's not
18 what we're talking about. Health and well-being
19 is important, it needs to be in the leadership
20 lane. And this gets to a primary -- this is the
21 essence of primary prevention in a public health
22 model and a preventive medicine model for suicide

1 is enhancing well-being. Leaders have to be
2 trained to enhance the well-being of their folks
3 in their charge, and taking care of those human
4 dilemmas that have come up, whether it's a tragedy
5 or things go wrong with individuals, and be
6 helpful in resolving that.

7 But there's also life skills that need
8 to be trained for self-care in individuals
9 themselves -- soldiers, sailors, airmen, Marines
10 -- develop life skills to deal with these
11 tragedies so they don't go on a path to suicide;
12 to help them get over -- get over the tragedies,
13 to be more constructive rather than taking
14 behaviors that are destructive in nature. But
15 this is very important, and this has to be adopted
16 and looked at as a strategy.

17 Reduce stress on the Force and on
18 families. The stress on the Force is enormous.
19 There's a lot going on. The Force is fatigued,
20 and they are under stress. And there's a supply
21 and demand mismatch. I don't know how to say it
22 any other way when you look at -- and I'm not

1 going to get into all aspects of national security
2 and requirements -- but we're asking soldiers,
3 sailors, airmen, Marines to do an awful lot for
4 our nation. And they are doing an awful lot, and
5 it's amazing how resilient the Force is and how
6 the Services have had the leadership and
7 involvement in making sure folks accomplish
8 missions.

9 But we're worried about what we're
10 mortgaging by doing all that and what -- the
11 problem comes in as time, is time. It takes time
12 to establish strong relationships. It takes time
13 to train people on what to look for, for suicide
14 prevention. It takes time for people to
15 reintegrate after a deployment. It's not like
16 flipping a switch and coming back and everything's
17 back to normal in their lives after being gone for
18 a year or 15 months, or however long they've been
19 gone for, six months -- we have to recognize that
20 and understand that there is a stress on the Force
21 and that has to be addressed.

22 And I'm not -- while we have a lot of

1 thoughts on how that could be addressed, we'll
2 leave it up to the Defense Department, but it has
3 to be addressed. If we're going to make a dent in
4 suicide prevention, we need to decrease the stress
5 on the Force. We need to enhance well-being,
6 decrease the stress on the Force, and then all of
7 these other things will fall into place at the
8 same time.

9 Transform training to enhance skills.
10 This is important. Skills-based training or
11 demonstration of skills, not just the PowerPoint
12 briefing on suicide prevention and then,
13 intuitively, because they attended the briefing
14 they know the skills of recognizing signs and
15 symptoms in a buddy and they know the points of
16 contact and the phone numbers to call to
17 intervene, we need to go well beyond that.

18 We need small group discussion; we need
19 people to be able to demonstrate that they've
20 learned the skills: buddy aid, family aid, family
21 skills. And then also this has to do with the
22 competencies training that needs to take place as

1 far as behavioral health areas, too, that their
2 normal routine training in social work,
3 psychology, psychiatry, counseling, family
4 counseling, substance abuse is not enough in the
5 behaviors for suicide prevention, and modifying
6 those behaviors and recognizing what's stress from
7 distress and other interventions that can be
8 applied. There needs to be some formalized
9 training in this area that is done.

10 But this whole piece, this training is a
11 pretty wide and broad category. We had a lot of
12 deliberations and discussion about training. We
13 observed a whole lot of training and got briefings
14 on what training gets taken place from all of the
15 Services.

16 Next slide. The next focus area is
17 access to and delivery of quality care. This is
18 another line of defense that is important.
19 Besides being organized well and leaders doing
20 their job in the first line of defense, and
21 besides enhancing well-being and resiliency in
22 that primary prevention area, in the second line

1 of defense, we need to make sure we have somewhere
2 to catch.

3 There are people that are going to get
4 through regardless of how much resiliency or
5 wellness we build, or well-being we build in
6 there. There are people that are going to need
7 services. There are people with real
8 psychological health problems and diseases, and
9 diagnoses that need to be addressed, and
10 behavioral problems that need to be addressed by
11 skilled, trained individuals that are managing
12 their health care, or their health or their
13 restoration back to normal or what we would
14 consider a non-disease state.

15 In these areas, these are the five
16 recommendations that we have. Leverage in
17 synchronized community-based services, this is
18 important. We're not convinced, the Task Force,
19 that we've leveraged a lot of the community-based
20 services.

21 Now understand when I say
22 "community-based service" -- because every Service

1 looks at community-based a little different, too,
2 we've realized and learned -- that we're talking
3 about installation services, but also off-
4 installation services. These are the
5 non-health care services, the counseling, the
6 alcohol and substance abuse, the crisis hotline,
7 crisis intervention, hot line intervention. This
8 has to do with chaplains, an individual that goes
9 seek their chaplains and those kind of things.

10 These are community-based services, and
11 what's real important here is while a lot of the
12 Services for the active component, Title 10 folks,
13 are on our installations that we provide on our
14 camps -- post stations in the Army, Navy, Air
15 Force, and Marine Corps -- for the Reserve
16 components, this is particularly challenging
17 because they live throughout America in towns and
18 cities all over.

19 And so when you say "community-based
20 services," with a Reserve component soldier on an
21 ongoing basis, you're literally talking about
22 where they live and work in their local

1 communities and stuff, where there aren't any
2 installations and a lot of DoD resources, I should
3 say, in that area. And how we connect and train
4 community providers and counselors and local
5 clergy and those things, I think, it is also
6 important for the Reserve components' health and
7 well-being, and suicide prevention because they
8 get mobilized, will serve for a year, and then we
9 demobilize them, pull them off of active duty and
10 they go back home with their families, many times
11 without the training and resources that the active
12 component has.

13 And that has some particular concern. I
14 know the Army is particularly concerned about that
15 now because their statistics this year show that
16 while the active component numbers have slightly,
17 are slightly coming down right now -- although,
18 you know, you can't conclude that because the
19 data's got to be looked at on an annual basis --
20 but early indicators are the Reserve component
21 looks like it's slightly going up in this current
22 year that's going down right now. So I think that

1 becomes important.

2 Ensuring continuity of quality
3 behavioral health care especially during
4 transitions, and this is key. Behavioral
5 health care is provided -- and we need to make sure
6 we have access in quality behavioral health care --
7 but also the continuity of it, how information is
8 passed when people move and these transition
9 points are very key.

10 There's a number of suicides that take
11 place surrounding transitions or close to
12 transitions, during the deployment process, or
13 early into a deployment, the redeployment process
14 when people PCS or move from unit to unit and
15 they're leaving one unit and reintegrating into a
16 new unit, a new environment where some of their
17 protective factors are the people they knew are no
18 longer there, and they may have those same
19 stresses in relationships, financial problems.
20 But the protective factors of the leaders they
21 knew and buddies they were with are now gone, and
22 they're now in a new unit, and they haven't made

1 those -- haven't had the time to make those
2 trusting relationships yet that are protective
3 factors for overcoming distresses of whatever's
4 going on. These transition periods are key.

5 And many are undergoing behavioral
6 health care at the time, and they still move for
7 whatever it is, and this gets into people on
8 medications that are moving, medication
9 management, pain control -- I mean I can go on --
10 pain control, et cetera, et cetera. But this is a
11 vulnerable area, these transition periods, and how
12 we communicate and transition, so continuity of
13 what we're doing for suicide prevention, suicidal
14 behavior prevention and intervention, is very,
15 very important here.

16 Standardized effective crisis
17 intervention services and hot line, and I got to
18 tell you, there are a bunch of crisis intervention
19 outlines out -- hot lines out there. And I think
20 we've called just about every one of them
21 mimicking a suicide, suicidal individual, and the
22 responses you get are pretty highly varied. And

1 our recommendation for this area is that DoD needs
2 to standardize and make sure that we have
3 effective crisis intervention. There needs to be
4 the 911 equivalent, if you will. It has to be
5 reliable because you're talking about a moment in
6 time where the right crisis intervention will save
7 a life, and the wrong crisis intervention will
8 not. And it's that simple.

9 And there's a wide variation of training
10 of individuals that are at the other end of these
11 crisis hot lines, and the responses that you get
12 and their ability to discern true crisis from
13 urgency from non-urgent issues when they get a call
14 on a hot line. So that's an area that needs to be
15 looked at. That's an important area, strategy
16 that DoD needs to adopt.

17 Train health care professionals, I
18 mentioned this already to you. Help in the
19 competencies to deliver evidence-based care for
20 the assessment, treatment, and management of
21 suicidal behaviors. This is a focus training
22 area. We're going to be asking for formalized

1 training in this area for behavioral health
2 people. Again, their degree alone and their
3 routine training that they get in their behavioral
4 health training is not enough for suicidal
5 behavior prevention.

6 And then the last strategy in this focus
7 area is develop effective postvention programs.
8 And this is important. We did meet with attempted
9 suicides, individuals that are alive today who
10 shared their information with us so we could learn
11 and glean from their experience having attempted
12 suicide. And real important is what we're doing
13 in postvention programs. Postvention programs not
14 only for family members of suicide, but
15 postvention program for Service members who have
16 tragedies in fellow Service members, deployed,
17 convoy, those kind of things. We need to see what
18 we're doing in postvention programs because
19 postvention can make a difference in prevention.

20 We attended a number of lectures by
21 experts from around the nation and stuff, and many
22 said, you know, prevention begins with good

1 postvention in a way. And what they were
2 emphasizing was the risk factors when someone has
3 been exposed to a tragedy and hasn't had the right
4 intervention for how they're personally dealing
5 with that tragedy, and how that tragedy, that
6 tragedy implication and impact is to them based on
7 their current life situation with other things
8 going on. There needs to be intervention services
9 on those kinds of activities. And I could go on,
10 but there's a whole host of things about
11 postvention, so postvention is important.

12 Next slide. Focus Area 4, surveillance
13 and investigations.

14 This is important, conduct comprehensive
15 and standardized surveillance -- I think I've
16 spoken to this already -- this is an areas that
17 has to be done.

18 Standardized investigations, I mentioned
19 this already. Suicide attempts to identify target
20 areas for informing and focusing suicide
21 prevention policies and programs. The purpose of
22 investigation is for suicide prevention, not for

1 any other use on that.

2 And then support and cooperate ongoing
3 research to inform evidence-based suicide
4 prevention. I mean clearly this Task Force was
5 formed with experts in the field of suicidology.
6 It was formed because there's a lack of research,
7 there's a lack of a lot of evidence-based
8 information. And we needed expert opinion in
9 order to assess Service suicide prevention
10 programs, and, trust me, we had enough debate and
11 discussion on this topic over and over.

12 And so the research needs to be
13 supported and continued so everything from
14 clinical care, clinical practice guidelines, et
15 cetera, et cetera, in the areas of suicide. There
16 is a general lacking of research commensurate with
17 the tragedy that occurs with suicide that is out
18 there. And so we believe that we need to support,
19 continue to support this, especially for suicide
20 prevention programs: what works, causal factors,
21 et cetera, et cetera.

22 Next slide. Okay, foundational

1 recommendations, which I think I've already
2 mentioned in here, but I want to repeat them
3 because these are founda-- this is the foundation.
4 Yes, all, I don't know, 50 to 60 to 70
5 recommendations that we will have in our report
6 are important, you know. It's sort of like
7 building a house: the walls and roof and
8 everything is important, but you got to have the
9 foundation first for that to all stand up. And we
10 need to make sure there's not cracks in that
11 foundation for things to fall through.

12 But we believe that the Office of the
13 Secretary of Defense needs to structure and form
14 an office in the Undersecretary of Defense's
15 office for Personnel and Readiness, a Suicide
16 Prevention Division, or Suicide Prevention
17 Directorate. Why? Standardized policy. There
18 needs to be an advisor at that level to
19 standardize guidance and information to the
20 Services, and also determine what reporting
21 requirements need to come up to the Services with
22 the analysis to inform suicide prevention policy

1 and programs in the future.

2 I think it closes the loops. Within the
3 Services, we believe they have -- they have some
4 very good -- you know, I don't -- they have some
5 very good programs and offices and everything,
6 because the Services have always done these
7 independently. It is a responsibility of the
8 Service Secretary and the Chief of the Services
9 for, in their Title 10 authorities, that the
10 well-being of their people and suicide prevention
11 is a Service program. So we don't want to detract
12 from that, because we want leaders to be, take on
13 the ownership and responsibility for that. But
14 they could benefit from a centralized office for
15 policy and surveillance and standardization.

16 Keep suicide prevention programs in the
17 leaders' lane, I mentioned that. Reduce stress on
18 the Force, mismatch, supply and demand -- that is
19 clear -- distress on the Force, the Force is
20 fatigued, and this needs to be addressed.

21 Develop skills-based training I
22 mentioned. Mature and standardize the DoDSER's,

1 or the DoD surveillance of that report that's
2 currently done, we believe that that is a good
3 foundation, and it needs to be further matured and
4 standardized across the Services, and it needs to
5 be informed by surveillance and investigations to
6 further mature it. And that needs to be a
7 centralized process and more discipline in the
8 system that provides the DoDSER Report. But
9 that's a great -- great start.

10 Develop comprehensive stigma reduction
11 campaign plan, we believe that the Department of
12 Defense with the Services together as a team need
13 to look at this as a campaign plan against stigma.
14 Multiple lines of operations and address this from
15 everything from strategic communications, to
16 leader development, to training, to soldier
17 education, and I could go on and on and on in that
18 whole area. But there needs to be a methodical
19 campaign.

20 I say a campaign plan because it clearly
21 needs to be where someone can develop a timeline
22 and some metrics and ask the question, is our

1 campaign plan working? Are we reducing stigma in
2 the Service, in Service members for help-seeking
3 behaviors and stuff? So we gotta be able to have
4 metrics and track that and see if we're really
5 accomplishing that.

6 And there are initiatives going on;
7 they're just not organized into a campaign plan,
8 part of a centralized campaign plan for that.

9 Next slide. Focus efforts on
10 well-being, the development of life skills, and
11 resiliency, and we think this is, again, an
12 important area. This is foundational. We have to
13 focus on well-being, people well-being, and
14 developing those life skills. Otherwise we'll
15 keep chasing the duck with more intervention and
16 more intervention in doing that.

17 And many of the folks that come into the
18 military, many of our young folks don't have the
19 life skills to deal with the amount of demands
20 that we're placing on them at a young age with
21 these deployments and the OPTEMPO. And we owe it
22 to them to help develop those skills as they come

1 in the military and sustain those skills as they
2 go along. And we believe that that will do a lot
3 for suicide prevention.

4 Incorporate program evaluation, I
5 mentioned. That's a bottom line thing that has to
6 be done. Coordinate community health services,
7 which I mentioned already, these installation
8 services but also the communities where Reserve
9 component folks live. And there's some programs
10 out there, the Soldier Citizen Support Program and
11 those kind of things, which will help do that:
12 local clergy, local community services, local
13 family advocacy and those kind of things in
14 America, in small towns and cities in America and
15 stuff where our Reserve component Service members
16 are.

17 Standardized suicide investigations,
18 again: non-attribution suicide investigations that
19 are standardized that may or may not have a
20 psychological autopsy component to them that needs
21 to be sorted through, but we really need to know
22 the dynamics of what's going on in those last few

1 days, last few weeks in order to help for the sole
2 purposes of informing suicide prevention programs
3 and preventing future suicides.

4 Behavioral health, continuity of care
5 especially during transitions, strengthen positive
6 messaging in the area of suicide prevention
7 because we can do this, and it is helpful, and we
8 got to get people to seek help and overcome
9 stigma, et cetera.

10 And then support and fund ongoing
11 research. This is foundational. This is
12 foundational. We need more research, and there
13 are -- the great thing and the great thing for
14 hope is there's been a lot of new research that's
15 being initiated right now and in the last couple
16 of years. And I could go on and start talking
17 about all that, and I don't need -- we've spent a
18 significant amount of time getting briefings from
19 these ongoing research areas and also including
20 some of it in our report.

21 But the Department of Defense needs to
22 support and fund ongoing research, especially

1 because there are some unique aspects of suicide
2 prevention research because of Service members,
3 and the demands on Service members. And this
4 whole thing about separating from families and
5 coming back in a sustained combat deployment
6 environment.

7 Next slide. We are going to ask some
8 guidance from the Defense Health Board. Is there
9 anything we've not considered that you deem
10 important, because we want to make sure we include
11 that in the report? We tried to be as
12 comprehensive as possible, and your advice,
13 guidance, we will listen to every bit of it and
14 take it all serious.

15 How can we be more effective in
16 clarifying the content and style in our report?
17 And I realize we're not done yet. We still got to
18 do final editing and clean up some portions, and
19 there's some overlap. And we got to merge some
20 areas, but the content is there somewhere, and we
21 want a ledger, but we want to make sure we're not
22 missing anything. We want to make sure that we

1 present this in the right style, because the only
2 thing that really matters is the actions that
3 follow on the report.

4 You know, the Task Force, we always make
5 sure we understood that the message received is
6 more important than the message sent. And so the
7 impact of the report, it has to be useful and
8 valuable to effect change. And that's what we
9 want to make sure, that we do what is your advice
10 on how best to proceed in getting our messages out
11 and what we need to do.

12 Next slide. And I've finished my time
13 here, and I will open it up to whatever questions.
14 The members of the Task Force are really the smart
15 people in the group here that can answer most of
16 those questions, so they'll chime in, in the
17 appropriate areas. But it's really been -- it's
18 been a great experience this past year, and I have
19 to tell you, the members took this to heart and
20 very serious. And I was impressed by the focus.
21 And you could tell by our discussions and
22 deliberations that we were focused on preventing

1 suicide and saving lives.

2 That's all I have, sir.

3 (Applause)

4 DR. POLAND: I'd like to structure our
5 discussion two ways, first to ask Ms. Carroll is
6 there anything that you'd like to add or reinforce
7 or reiterate?

8 MS. CARROLL: No --

9 DR. POLAND: Okay. Second, could we go
10 back to the previous slide, just one back, and
11 let's take this sort of step by step as a way to
12 handle this.

13 So first for members of the Board,
14 anything that in your estimation the Task Force
15 hasn't considered that you would like to put
16 forward as important?

17 General Myers?

18 GENERAL (ret) MYERS: Thanks, General Volpe,
19 and for the Task Force for the amount of time you
20 have spent on this issue. Having been involved in
21 another task force on another issue, I know you
22 can -- it takes -- it takes a lot of time, and a

1 lot of energy, and I think -- I certainly
2 appreciate that.

3 What I was looking for in the report
4 when you talk about organization and leadership,
5 Focus Area No. 1, I think that's right, and I
6 think some of the recommendations are exactly
7 right. But what I found lacking in my view -- and
8 this is my view and it may be something you
9 considered -- is what tools do you provide to
10 commanders, not just general officers but
11 lieutenant, colonel, battalion commanders, and
12 squadron commanders, and NCOs and all the -- you
13 know, what tools are we providing them?

14 We say they've got to be -- you say
15 they've got to be involved. Well, it's not just
16 involvement. I mean they're going to be involved,
17 but they've got to be trained and then they have
18 to have the tools to look at their population and
19 I think have some ability on their own to, with
20 help from the medical community, to kind of
21 identify those at risk. And I don't see anything
22 in here that says we're going to do that, we ought

1 to do that.

2 The idea of creating a focus point in
3 OSD, we always do that when we have a crisis, so
4 we create an office. You know, it rarely solves
5 the problem. The problems can be solved where the
6 boots are on the ground, and at least from the
7 data that I've seen here.

8 So that's an area I don't know that it's
9 been fully developed that how you -- how we're
10 going to develop or who should be responsible for
11 developing tools. And I guess along with that, you
12 have seen every Service and the entirety of the
13 DoD and plus public sector, you've got these
14 experts from around the United States, there's got
15 to be programs that are -- that we can benchmark
16 against. And maybe you ought to highlight those
17 in the report.

18 We don't need to reinvent the wheel
19 here, and I don't think you've tried to do that,
20 but I've read through the report briefly, by the way,
21 going through this as fast as I could here in the
22 last day and a half, I don't see the benchmarking

1 efforts. And some Services do very well and
2 others don't -- in certain areas -- and some don't
3 do as well. And I think highlighting that would
4 be extremely valuable for those in the other
5 Services, say, Oh, they got a good program in the
6 Army, well, let's go find out what that is, any
7 specifics.

8 Those would be my comments, but it's
9 really about providing leaders, particularly
10 lower-level leaders who are right there with the
11 troops to have the tools to be able to figure out
12 what to do. I mean other than just being involved
13 and say, I care, and I went to some kind of
14 training, and I know I've got this
15 installation-wide support or unit-wide support.
16 But you need -- they need more than that, I think.
17 But that's my comment.

18 MG VOLPE: Yes, thank you very much,
19 sir. That -- it was quite a discussion on that
20 area in our deliberations, and there is no tools
21 for commanders. There's no good tools for -- the
22 biggest thing that we found commanders want and

1 need, because we do hold them responsible and
2 accountable for the well-being, they do not get
3 all the information on their Service members who
4 are seeking assistance. And so there's no tool
5 right now that connects the dots for a commander
6 to understand where their particular Service --
7 and this is the first-line supervisor level person
8 I'm talking about.

9 GENERAL (ret) MYERS: Yeah, if we're going to
10 hold them accountable and responsible, we've got
11 to give them --

12 MG VOLPE: Yes.

13 GENERAL (ret) MYERS: -- we've got to give
14 them the authority, I guess, to gather the facts
15 they need to make these kind of decisions, and
16 perhaps other screening tools that may be
17 prevalent in certain sectors of our society that
18 we don't know about that could help with this.

19 I just -- I think it's the whole tool
20 issue that would be something, if you have some
21 recommendations or some suggestions in that area.
22 Or just if you acknowledge that we need that, just

1 to acknowledge that in the report, I think would be
2 a helpful thing.

3 DR. POLAND: Wayne?

4 DR. LEDNAR: General Volpe, many thanks
5 to you and Ms. Carroll for the leadership you've
6 brought to this and all of the efforts in the Task
7 Force, a really important issue and a Herculean
8 effort in the last year to bring this together.

9 One question that's kind of a specific,
10 and then one, I'll call it plea. First the
11 specific. You mentioned the active Force, and you
12 mentioned the Reserves, but you don't say anything
13 where National Guard is included kind of
14 specifically. So I assume that where your -- the
15 scope of this is to reach the Guard and the
16 Reserve, and the active component, but for those
17 who might read this report literally, we want to
18 make sure they don't think that there's some other
19 activity or solution separate from this, oriented
20 towards the Guard unless there is.

21 MG VOLPE: No, sir, you're right. We'll
22 make sure we have that in the glossary. But

1 Reserve component means the Reserves and National
2 Guard, Compel 2 and 3. And we'll make sure that
3 we include that in there so it'll clarify that.

4 But we're talking about the National
5 Guard when we say Reserve component.

6 DR. LEDNAR: That's great, certainly.
7 In the second aspect of the plea, in the spirit of
8 trying to prevent suicide and save lives,
9 sometimes our approach to this is statistical,
10 programmatic, systemic, and it begins to feel
11 a-personal, impersonal. So to the extent that you
12 can put a human face, a human touch that is really
13 felt in this report, I think that'll make it even
14 more compelling.

15 And I might ask of the Task Force
16 membership, your senior noncommissioned officers
17 to feel that this report is getting the message
18 across as you feel it in the Service members. If
19 what's really the hot button issues and the
20 urgencies are not coming across in your view
21 strongly enough, please incorporate that energy
22 because that will really make this report even

1 more impactful. Thanks.

2 DR. POLAND: Dr. Oxman?

3 DR. OXMAN: The report contains this in
4 several places, including the last bullet in Focus
5 Area 4, and that's evaluation. But I think that's
6 so important, particularly in this area where
7 there are no benchmarks. And expertise 100 years
8 ago, expertise recommending tri-findings for many
9 of these things.

10 And so I think the evaluation of the
11 techniques employed, the study designs, the
12 quality and reliability of the data collected and
13 the reliability and applicability of the results
14 should be evaluated on a regular basis by an
15 external group with expertise and reported to the
16 very senior leadership with the expectation that
17 there will be a response by the leadership to
18 those reports. Because without that, the content
19 of the training and the interventions will be
20 unproven, and it won't be evidence-based
21 medicine.

22 And just let me say I think it's so

1 important that it would be, I think, a separate
2 focus area, Focus Area 5, perhaps. I don't think
3 it should be submerged in surveillance.

4 DR. POLAND: Dr. Kaplan.

5 DR. KAPLAN: Kaplan. I'd like to
6 compliment you on an extraordinary report. It is,
7 brings together a lot of things which I think, in
8 ways which I think a lot of people have not thought
9 of.

10 But what concerns me is, where does
11 it go from here, or, better still, does the
12 leadership that Dr. Oxman just referred to buy
13 into this, and that the word that kept popping up
14 during your discussion was "standardization."
15 Each of the Services is, admittedly, different,
16 and so perhaps either you or the Air Force Surgeon
17 General, who's sitting here enjoying this, could
18 help us to understand what the best way is to get
19 this information out in the different Services
20 with a little bit different take on this.

21 How does this -- how does this go about,
22 with the standardization that you kept talking

1 about?

2 MG VOLPE: Yes, sir. Thank you for that
3 question. And I probably was not clear enough in
4 this area, but we believe the programs need to
5 reside within the Services and everything. But
6 they could benefit from standardized policy and
7 guidance and reporting requirements at the OSD
8 level in order to assist the Services in their
9 programs of sharing best practices across all of
10 the Services as well as informing not only policy
11 but their suicide prevention programs.

12 But the programs are not -- the programs
13 are not all standardized. There's some
14 standardized elements that they all -- I mean some
15 of them are -- have standards in them today; they
16 just evolved that way on them, but they don't get
17 benefit from standardized policy and a
18 standardized reporting requirement from a public
19 health standpoint surveillance and information.
20 At least that was the view of the Task Force.

21 And any member of the Task Force want to
22 chime in?

1 DR. KAPLAN: If I could just take that
2 one step further, I understand that, but how
3 realistic is that in terms of implementation?

4 Lt Gen GREEN: If I can help just a
5 little bit --

6 DR. KAPLAN: Yes, please.

7 Lt Gen GREEN: -- I think that SPARRC has
8 taken us a long way in terms of the data that
9 we're collecting so that we are looking at the
10 data in the same ways. My guess is there does
11 need to be a standardized investigation in terms
12 of the data elements that will be collected, so
13 that if we're going to look at this
14 scientifically, the Army's study that's going on
15 now will probably take us a long way towards
16 arriving at that in terms of the STARRS study that's
17 going on.

18 There's a lot of effort. You have to
19 understand that when you talk standardization
20 you're really looking at the standardization of
21 approaches, trying to use the approach that's
22 evidence-based. My guess is that the marketing of

1 those approaches, okay, will be different across
2 the Services simply because of the different
3 cultures. So I don't think we should confuse the
4 marketing of the approach that's evidence-based
5 with the actual standardization, if I can be so
6 bold.

7 DR. KAPLAN: And then you think that
8 that approach is realistic.

9 Lt Gen GREEN: I do. There's tremendous
10 interest in this, both at the Congressional level
11 and also at all of the Chiefs and Vice-Chief
12 level. They are meeting fairly regularly. The
13 Chairman of the Joint Chiefs even calls meetings
14 to bring the four stars together to discuss this
15 at this time, and so I think that the time is
16 right for us to kind of reach some of this
17 standardization.

18 We really, the harder piece is the
19 evidence-based interventions. And so it's easy to
20 collect the data in a standardized manner; it's
21 much more difficult to pull out the evidence base
22 to say: Do this and you will see success.

1 DR. POLAND: Dr. Silva?

2 DR. SILVA: Wonderful report. Very
3 complicated area. It just boggles my mind the
4 complexities there.

5 I join other members on the Board in
6 saying that there must be more positive things we
7 could do to intervene.

8 Should a composite be drawn up, or a
9 couple composites? Who's high risk for suicide?
10 So people can hold a mirror up or a leader in a
11 unit to say, hey, the young kid, not much
12 schooling, recently divorced, I don't know.

13 The second thing is, you have about every
14 other day someone commits suicide in the military.
15 Is it important to develop a SWAT team approach
16 where you go in and analyze all those things? If
17 we had one case of smallpox, we'd have people
18 down there immediately dealing with the issue and
19 really putting together what are things.

20 The third thing is there are probably a
21 lot of ways to dice this cucumber up in terms of
22 treatment, but should there be some interactive

1 website where the people in the know, people in
2 the field can share their success stories or their
3 failures. It's sort of like what's occurring
4 about the airline crashes.

5 I just think we need to see some more
6 pro-positive things to try to intervene. And if
7 you have a third of the patients that trigger
8 intent they're going to commit suicide, well,
9 then, units deal with it in different ways, there
10 should be some data retrieval. Okay, you have
11 that 30 percent. This is a group you know is
12 going to pull the plug, what are you doing? And
13 what works best? And it may vary by the military.
14 There's no doubt the philosophy's very often down
15 the line.

16 So we've come a long way, but I think we
17 need to be more pro-positive. Thank you.

18 DR. POLAND: Other comments? Dr.
19 Walker?

20 DR. WALKER: David Walker. Well, do we
21 foresee a positive impact of the recommendation
22 for reduction of stress, and how could this be

1 enhanced? That seems to me to be a very important
2 recommendation, but I have difficulty in seeing it
3 having an impact on the Department of Defense. Is
4 there anything that can be done that might make it
5 more likely that that would be an outcome?

6 DR. POLAND: Robert Certain?

7 DR. CERTAIN: That's up there at the top
8 because this kind, this is a Congressional report.
9 It's not a Department of Defense issue, quite
10 frankly. The Congress is the one that sets Force
11 support strength, that funds Force strength,
12 that's underfunding Force strength, and is
13 demanding our presence in deployed areas around
14 the world on a level that the various Services are
15 required to meet. And so one of our discussions
16 has been that we need to put this back where it
17 belongs, and so my part of the recommendation
18 about dwell time and the size of the Force goes
19 back to, the size of the Force is a
20 Congressional mandate. Whether or not the
21 Congress receives it kindly is, quite frankly, not
22 our concern; our concern is that they receive it.

1 So there's -- my impression is that the
2 Secretary and the Chiefs are doing their best to
3 provide adequate dwell time, adequate rest and
4 recovery time, but with the size of the Force the
5 way it is right now, it's not necessarily
6 possible. There may be some tweaking around the
7 edges that can occur at the Force level, but our
8 bottom line, I think this is a matter of Force
9 size and strength.

10 DR. WALKER: Thanks, Robert. That helps
11 me understand.

12 GENERAL (ret) MYERS: Well, I think -- this is
13 Myers -- I think just another piece of that, and I
14 was just talking to Dr. Green about it, is the
15 Services I think still deploy on different time
16 lines. Marine Corps goes for seven months; Air
17 Force is generally four to six months, sometimes a
18 year; Army's basically a year, I don't think
19 they've backed off that yet unless -- and so you
20 can -- you can pull those levers. You can adjust
21 those levers. There's a cost to that, there's a
22 resource impact, not necessarily of manpower but

1 certainly in dollars and -- but probably in
2 manpower, too.

3 But you can -- there are some things,
4 levers that can be pulled, I think, and are
5 discussed all the time. And then there is -- I
6 don't know -- I don't know the data, but some
7 evidence that longer deployments create more
8 stress. It's sort of intuitive, but maybe not
9 either.

10 So I think there are levers you can
11 pull, clearly.

12 Lt Gen GREEN: Yeah, and there really
13 are pretty strong indicators in our behavioral
14 health assessments in the -- that we look at on a
15 fairly regular basis that deployments over six
16 months have a much higher incidence of PTS and
17 different types of psychological problems. We
18 can't relate it directly to suicide, but you would
19 think that especially the family problems because
20 of the relationship interactions would be related.

21 The harder part is that the data is not
22 as strong as to what the right dwell time is, and

1 so do you go for six months and back for a year?
2 Or you go for six months and back for two years?
3 We can't say what the right dwell time is, which
4 makes some of these problems more difficult for
5 our Service leaders.

6 DR. POLAND: You know, that -- I was
7 just reflecting that's an interesting idea in
8 terms of the research that could be conducted. We
9 don't always know with absolute certainty, but if
10 we thought of other -- think of war as a toxin,
11 certainly we have threshold levels of exposure
12 that we would not -- for example, we don't let
13 people be exposed to certain thresholds of noise,
14 or not for very long. This has even more
15 detrimental effects perhaps than noise, and that
16 may be one way to approach some of this.

17 Let's move on to the second question
18 about -- did you --

19 MG VOLPE: I'd like to just address -- I
20 want to make sure that everybody understood --
21 there is some research in this area we dwelt on.
22 And the Army Surgeon General's mental health

1 advisory team has done some research in this area,
2 and their recommendation for dwell time is 20 to
3 24 months in order to -- that would decrease some
4 of the stressors on the Force in the behavioral
5 health requirements. Not specifically related to
6 suicide, but there is some research on there.

7 The other part of that, though, that the
8 Task Force wanted to make sure that everybody
9 understood that it was -- it's not just the length
10 of dwell time, it's also the quality of the dwell
11 time. If you just fill the dwell time up with
12 training and other things -- and I think this gets
13 back to what General Myers was saying, is the
14 tweaks within the Department of Defense that can
15 be done, too, as well as at the Congressional
16 level mentioned by Dr. Certain -- but the quality
17 of that dwell time becomes very important, too, to
18 get people reset to this normalization, if you
19 will.

20 DR. POLAND: Okay. Let's move on to
21 our, the second point there. Any suggestions from
22 the Board on how they can be more effective in

1 clarifying content or style? Dr. Clements and
2 then General Myers.

3 DR. CLEMENTS: John Clements. I, so in
4 looking at the 50-plus recommendations and then
5 trying to reconcile that with the foundational
6 recommendations, my concern in any report like
7 this is, when you have this wide array of
8 recommendations, that if we don't identify what
9 the highest priority recommendations are in that
10 field, that they won't get picked out; it'll just
11 -- it will overwhelm the people who are looking at
12 this.

13 And what I found, the foundational
14 recommendations are actually more summaries that
15 include all of the recommendations if you get
16 right down to it. So I guess I'm asking if it
17 would be worthwhile looking at those 50 and
18 saying, and these are the five we think you
19 should do today, immediately. And then this is the
20 next year, and perhaps the next year to help -- to
21 help the report sort of focus the attention of the
22 people who will be trying to implement this on

1 what the most important things are to do first.

2 DR. POLAND: General Myers and then Dr.
3 O'Leary.

4 GENERAL (ret) MYERS: I don't know if this
5 comes under content, style, or what it -- but
6 context certainly, and take it for what it's
7 worth, but given that the Executive Summaries
8 probably what -- we'll be lucky if senior leaders
9 look at anything, but if they do they'll look at
10 the Executive Summary -- and I think anything you
11 put in there, then, has to have the right context.

12 And on the first page it says, "The high
13 sustained operational tempo has created a tipping
14 point for suicide risk," and I wonder if that's
15 more opinion-based or is that, do the data support
16 that? And I mean one thing I think we do know in
17 2009, we had an increase in our suicide rate in
18 some of the Services. That's probably why we have
19 this Task Force, but I think putting it into
20 context I think would be helpful. Otherwise
21 somebody's going to read that and say, oh, my
22 gosh. And we may be in an oh-my-gosh situation,

1 but, like, if the data supports that, then that's
2 a fine thing.

3 But you probably add a little con -- I
4 know where you're trying be brief here trying to
5 make an Executive Summary -- but I think that's
6 important given that only -- that's the only thing
7 some of the senior leaders are going to read.

8 And the second piece would be the same
9 thing under findings and recommendations -- we're
10 in the first -- in the second page here where it
11 says, "In general, Task Force found that current
12 suicide prevention efforts are disjointed and lack
13 overall structure and coordination." I have no
14 doubt that's right. I mean you spent a lot of
15 time looking at that, and then I just believe
16 that.

17 But what's been the effect on the Armed
18 Services? Where does the Armed Services suicide
19 rate sit with the U.S. national rate? And I don't
20 -- I don't have a good idea of that. And what
21 happened in '09? What do we see in '09 that leads
22 us to -- and so I would -- I would just put some

1 context around this as opposed to making these,
2 the clarity statements that may or may not be able
3 to be backed up by the data. You would know that;
4 I don't know that. That's my comment.

5 DR. POLAND: Yes, sir. Dr. O'Leary?

6 DR. O'LEARY: Yes, just to come back to,
7 you know, impacted is -- I mean I know something
8 about this area, but when I read really to the
9 first half of the findings and recommendations,
10 the stuff really hit me in the bread basket. I
11 mean it was really -- it was powerful stuff. And
12 then it just -- and it started to disintegrate a
13 bit. And it seems to me that it's -- I mean
14 there's, I do agree with setting priorities for
15 recommendations, but every time there's an
16 opportunity to consolidate or collapse
17 recommendations into these units and shrink the
18 number recommendations is going to significantly
19 increase, you know, the impact and that you're
20 serious.

21 Let's impact in the second half of that
22 section as there is in the first half. Some

1 people will read it and they will grab them.

2 DR. POLAND: Dr. Parkinson?

3 DR. PARKINSON: Specifically to this
4 question, I want to be a little more specific on
5 General Myers' comment because I agree with
6 General Myers on this. You know, by my read, there
7 has been a 200 percent increase in Army suicides
8 in the past five years. I mean if the dominator
9 is the same based on this, I mean hard-hitting
10 factual information in the first sentence of an
11 Executive Summary, a two-fold increase over the
12 past five years in the Force, particularly perhaps
13 in the Army and the Marine Corps, maybe not as
14 much in the Air Force and the Navy, that needs to
15 be described into why. I mean that's the
16 epidemiology of what it is. How big is the nut,
17 and why is it different?

18 What is the relationship? Thirty
19 percent of these people had no deployments at all.
20 Seventy percent did, so is it the frequency or the
21 intensity, the nature of the deployments? Dwell
22 time, durations, those types of things that

1 flushes out at least something to put in the
2 Executive Summary that could be high priorities
3 that might already be mapped to what's going on in
4 the STARRS project or other types of things. It
5 would just help policymakers connect the dots
6 immediately and lead to implementation steps that
7 could help crack the nut in a way that would be
8 good.

9 Likewise, mentioning specifically
10 relationships that General Green just mentioned, I
11 mean we have seen behavioral health indicators
12 go up with deployments, we have seen PTSD go up
13 with deployments. We have these other things that
14 are also chartered by Congress that were
15 freestanding task forces that came through the
16 Defense Health Board, but they're not at least
17 parenthetically mentioned in here in an Executive
18 Summary.

19 And policymakers will expect to see,
20 well, certainly, the PTSD thing should be kind of
21 in here. Isn't it? It's kind of in there but not
22 really in an epidemiologic fashion. So I think

1 that could strengthen it again to say that it's
2 all part of the same thing. Similarly, it's kind
3 of gotten into later on, but not specifically
4 stated that -- and I'm assuming here that the
5 Committee felt that the MOS specific analysis did
6 not yield a highest-risk group within an amenable
7 strategy to make MOS a special focus for programs
8 or for investigation.

9 I mean it's not said that way,
10 specifically, but maybe it is, but I'm intuiting
11 that because -- but yet there was such a high
12 focus of your charge from Congress to look at MOS,
13 and that gets into the other model I always use,
14 is agent, host, environment, the epi-triad.

15 Seventy percent or more are people
16 shooting themselves, and what about gun issues as
17 it relates to the Army and the Marines, when you
18 have your weapon and when you don't. I mean those
19 types of things you probably talked about in much
20 more detail, but it may be also something that you
21 could put out a little more directive things, you
22 know.

1 It may speak for itself, but maybe not
2 particularly to lay policymakers. And the people
3 that are really going to read this report, as we
4 all know, may not be the Congressman himself or
5 herself, it's those 15 staffers who have less
6 familiarity with any of this than perhaps we would
7 like them to have, but they'll be making a lot of
8 the policy recommendations that derive from it.

9 DR. POLAND: Dr. Lednar?

10 DR. LEDNAR: Wayne Lednar. I don't know
11 if this is a thought that can be considered, but
12 in a report with such complexity, so many
13 possibilities for action, the more the wording can
14 be actionable, that's helpful. And if it can be
15 organized in a way of who best might consider this
16 issue for action.

17 As Reverend Certain said, some of this
18 is putting the ball in Congress' lap because some
19 of this is an issue that only they can address.
20 Some of it is an issue of those who lead the
21 Military Health System. Some of are those who are
22 the Chiefs of Staff, Vice-Chiefs of Staff. Some

1 of those are those who are organizing the training
2 and doctrine policy. So to the extent that the
3 recommendations can almost be, you know, sort of
4 put into a report that makes it easier in the
5 report to say, oh, this is something that's maybe
6 coming at me. It sort of takes the "many," and it
7 sort of makes it into a more directed sense of
8 potential consideration.

9 DR. POLAND: Dr. Oxman?

10 DR. OXMAN: One other small point. When
11 I went from the initial list of findings and
12 recommendations into the content, I was impressed,
13 in fact, that there already had been progress,
14 significant progress, made in consolidating
15 methods across Services. And I think instead of
16 pointing out, or instead of asserting that there
17 is no evidence or there is no integration, I think
18 I was impressed that there in fact were already
19 ongoing attempts that need to be emphasized and
20 reinforced. And putting it in that positive way,
21 I think would be very useful because I was
22 impressed at how much effort has been made by the

1 other Services to take some of the strong points
2 from the Air Force, for example. And so I found
3 that contradictory to the initial impression I had
4 from reading the first couple of pages.

5 DR. POLAND: Last one, then, advice on
6 how best to proceed with getting the message out.
7 Any thoughts or ideas there?

8 SPEAKER: Make Congress get into one
9 room and read now.

10 DR. POLAND: Jim?

11 DR. LOCKEY: You know, when I went
12 through that -- by the way, I think the Task Force
13 did a fantastic job. It's obviously a lot of
14 work, a lot of effort was put into it.

15 As a pulmonologist and internist, I was
16 trying to look for analogies. I don't know that
17 much about psychiatric disorders and suicide, but
18 I took the analogy of cardiovascular disease, is
19 that we have primary and secondary prevention, and
20 we can identify in cardiovascular disease the
21 potential risk factors that puts the person at
22 increased risk for an eventual adverse outcome.

1 And the level of training for the health
2 professionals in recognizing those risk factors
3 and treating those risk factors is different than
4 the level of training for somebody who is actually
5 immediately at risk for suicide.

6 Perhaps for Congress' benefit that type
7 of analogy would be understandable in primary,
8 secondary prevention, and then tertiary, which is
9 a different level of training, different level of
10 recognition. You have to have almost an immediate
11 impact at that point.

12 DR. POLAND: General Myers?

13 GENERAL (ret) MYERS: I don't think we heard,
14 you know, putting the onus on Congress to help
15 with some of these solutions, I don't think you
16 can let the Department of Defense off the hook.
17 Congress isn't going to do anything without a
18 recommendation from the Executive Branch. That's
19 the DoD, and so if you really want to get movement
20 here, then you got to hold the -- you got to hold
21 the Department.

22 If you really have recommendations, if

1 you were thinking a larger Force size is required,
2 and I'm not saying one way or the other, but if
3 you think -- if you think that is one of the steps
4 to reduce stress, then you got to hold the
5 Department accountable for that. Congress isn't
6 going to just do it, because it's going to -- it's
7 got to go to the Executive Branch where that springs up.

8 So I wouldn't let the Department off the
9 hook, I guess is my point.

10 DR. POLAND: Dr. Parkinson?

11 DR. PARKINSON: Yeah, I'm sorry to come
12 to it again, but something that I think would be
13 very useful is to hit home for dissemination is
14 the iceberg icon that represents that the tip of
15 the iceberg is the unfortunate successful suicide,
16 and there are strata beneath it which create a
17 great framework for early detection. And it's
18 probably in some of the other models, General
19 Green.

20 But getting that visual in the report,
21 that becomes an iconic product of the report so
22 that everybody from a two-striper to a two star

1 understands that this is a cascading effect, and
2 without upstream effects it doesn't matter how
3 well you counsel a suicide attempt who doesn't
4 succeed, it's a bigger thing.

5 So, but a visual like that would stick
6 out from all the verbiage. And there are models
7 around.

8 DR. POLAND: Okay, I'm going to wrap up
9 in the following way. I just want to go through
10 the major suggestions that I heard from the
11 Defense Health Board. We're going to take --
12 after I do that we'll take a 10-minute break.
13 When we come back, I'm going to ask for comments
14 from any members of the Task Force and members of
15 the public and other SMEs that are in the
16 audience. And after that, then the Board will
17 vote on the report.

18 But just to summarize so we don't lose
19 track of it, let me go through the 15 major things
20 that I heard.

21 One, a couple from General Myers about
22 the need for developing tools for leaders, so how

1 do we develop those and disseminate those? What
2 can we learn from benchmark programs, and his last
3 comment about holding DoD accountable here, too,
4 whether that means recommendations about Force
5 size or others.

6 I had three issues which, one, that we
7 frame this in part as a readiness, albeit
8 psychological, but as a readiness issue; a call
9 for increased personnel trained in suicide
10 prevention issues; and reconsidering the impact of
11 the vision statement.

12 Dr. Lednar recommended in being sure
13 that it's obvious that we include National Guard
14 and Reserve components in here.

15 Dr. Oxman recommended evaluating program
16 effectiveness, and I think importantly, and I
17 don't want to lose something he brought up that I
18 think is excellent, and that is for whatever
19 entity becomes responsible that we include the
20 idea of incorporating an external review group on
21 that entity's progress.

22 I think increasing the sense of urgency

1 of response and resources -- I just did a very
2 rough calculation, the numbers aren't such that
3 you can easily add them up -- but over the last
4 nine years there's been a suicide every one-and-a
5 half days.

6 Dr. Silva mentioned web-based materials
7 training, and sharing of best practices.

8 Dr. Walker mentioned emphasizing other
9 ways to decrease stress factors.

10 Dr. Clements mentioned identifying the
11 highest priorities of recommendations and, in
12 particular, maybe giving emphasis to, these are the
13 top five which must be done now.

14 Dr. Parkinson mentioned including other
15 issues and indicators, behavioral health
16 indicators such as PTSD and others.

17 And then Dr. Lednar recommended making
18 the recommendations in language actionable as well
19 as at least an early indication of who might be
20 responsible for those things.

21 And Dr. Lockey, your recommendation was
22 that we pay attention to primary and secondary

1 prevention efforts and a suggestion about how to
2 frame that using the cardiovascular screening.
3 And I kind of liked that. I mean we don't look
4 for -- it would be nice -- but there is no test or
5 screening test that's 100 percent sensitive or
6 specific, so we do things like family history or
7 measure cholesterol levels, knowing how imperfect
8 those are.

9 Given the rates that we're seeing here,
10 maybe there's some sort of routine screening that
11 should be done as a primary effort, and then the
12 secondary efforts he mentioned.

13 Did I capture the Board's major
14 recommendations and/or did I state them fairly
15 trying to paraphrase you?

16 (No audible response)

17 Okay, we're going to take a 10-minute
18 break.

19 We'll come back and ask for comments
20 from the rest of the audience. Thank you.

21 (Recess)

22 DR. POLAND: Okay, as I said right

1 before our break, what we'll do now is ask for any
2 members of the audience, Task Force members, any
3 of the SMEs in the audience if they would like to
4 make comments or suggestions in regards to this
5 Task Force report. And, if so, if you'll just --
6 there's a microphone -- Lisa, have the -- okay.
7 Lisa can bring you a microphone if you would just
8 raise your hand.

9 MS. OETJEN-GERDES: Lynn Oetjen-Gerdes. I
10 have a background in anthropology, and I think
11 this is part of where this is coming from. But
12 I'd like to see the report.

13 I haven't seen the report, but I'd like
14 to see it acknowledge the role of the social and
15 cultural factors that have been ongoing,
16 particularly in the last two to three years, the
17 economics, the cultural acceptance of suicide, and
18 what the Services are doing proactively, for
19 example, to provide financial skill-building at a
20 time when the economy is going down, where spouses
21 might be losing employment and what role this is
22 having on the increase in suicide rates.

1 DR. POLAND: Thank you. Any other
2 comments from other members of the audience?
3 None? Okay, any other last comments from --

4 SPEAKER: Isn't there one?

5 DR. POLAND: Oh, sorry. Sergeant Major.
6 Please. Go ahead.

7 Sgt Maj GREEN: I just wanted to make a
8 -- I just wanted to comment, I'm going to be very
9 brief. That one, one individual in all that
10 travels, those 17 bases, they said they were
11 giving up the fight. It's like the Code of
12 Conduct, the first code. It says, "We Americans
13 fight for our country and our way of life and are
14 willing to die in the defense of our country." So
15 don't think for one moment that because we're
16 talking about suicide and that the Force is tired,
17 weary, that we're giving up. That's not the case.

18 We're not giving up as a country, we're
19 not giving up as a Service. Make no mistake about
20 that.

21 I jotted down a few notes, and I wanted
22 to wait until I heard the comments from everyone

1 on Defense Health Board. This is a different type
2 of war. It's a different kind of war. I never
3 thought in my 27 years in the Marine Corps, as we
4 prepare for war every day, that we'd be battling
5 IEDs. I don't think anyone sitting at this table
6 ever thought that.

7 It takes the mind a period of time to
8 adjust on the battlefield, especially when you
9 introduce a dynamic that's so far from what we
10 train to do. Technology travels a lot faster than
11 the human psyche, than we can adjust our minds.
12 We build stronger vehicles. The computer got a
13 lot faster so we can track things a lot better,
14 but the human never changed. That's the one thing
15 that doesn't change.

16 If the 15 staffers and Congress members,
17 DoD and the Service Chiefs do not take the time to
18 read thoroughly through the report -- I know the
19 Defense Health Board, you all received the report
20 maybe yesterday, some today, you haven't had time
21 to go through it -- a lot of things you said are
22 in the report, such as the social dynamics,

1 recruiting effort, there's a whole lot of that in
2 there.

3 We've gone back and forth. Just as you
4 have a short period of time, so did the Task Force
5 to try and gather a lot of data. We could have
6 gone two years and still been talking about this,
7 and we would have still been going back and forth
8 on what are the 16 most important things? What
9 are the four most important? There are no four,
10 there are no 16. Everything in there is
11 important, and we didn't tell you anything that,
12 collectively, we don't know here in America about
13 war and about the human beings that defend this
14 country.

15 It's like a puzzle. We just have to
16 take the time to put it all together. If the
17 staffers don't take the time to thoroughly go
18 through the report, if they're looking for
19 something in the beginning or some page with a few
20 things on there that's going to give them the
21 answer, that's going to solve the problem or even
22 help with the problem that we have, they're going

1 to miss it like we've missed it a lot of times.

2 With the technology, with the
3 understanding of war that we have now which is
4 much different, much more different than any other
5 battle we've every fought, I hope the next time,
6 and I pray that we break the glass in case of
7 emergency. We have some documentation, we have
8 the studies, we have something that can keep us
9 from going through this evolving door that we've
10 gone through each time we've gone to war. We have
11 the capability in this war, in these wars, at this
12 date and time in America and in the world to
13 capture the needed resources, to pool those
14 resources.

15 But if we don't -- if we weren't worried
16 about the Services being, you know, running their
17 own programs, I understand that. I am one of
18 those leaders. I'm the senior listed leader
19 advisor for 2000 Marines in the National Capital
20 Region, I've been on this Task Force for a year,
21 almost one week out of every month. We've been
22 together at least that amount of time. I'm on the

1 phone worried about those who are living. I'm
2 here at the Task Force worried about those who are
3 deceased.

4 I deliver flags to families at Arlington
5 Cemetery, and not once do I distinguish between
6 those who've committed suicide and those who died
7 in combat. I deliver their flag the same way
8 because no matter what the reasoning was for the
9 death, that individual served this country, which
10 is a lot more than a lot of people do in this
11 country that will talk down about those who serve.
12 Understand my passion.

13 And I'm not the only one. There are
14 thousands of leaders out there just like me.
15 Yeah, we're tired. The first day of war you're
16 tired and you hope that it ends. No one wants the
17 war to go on, but we're willing to fight this war
18 until -- until the President and our Congress
19 brings us home. We're not going to quit. We're
20 not going to quit.

21 And I'm going to be -- I got a few more
22 points, and I'm going to leave this subject alone.

1 The Reserves -- and I was just talking to a
2 retired chief over there, Master Chief -- the
3 Reserves. Did we ever think for one second that
4 an individual defending their country and they're
5 employed, their main employment is somewhere out
6 in the nation can go to war three, four, five, six
7 times, come back to the same job and not be
8 affected? That employer is going to be affected,
9 that employee is going affected, that family is
10 going to be affected. Everyone is going to be
11 affected.

12 So there's your reason why the longer we
13 fight, the more rise you're going to see in suicide
14 because we haven't learned enough. This is a
15 different dynamic. We don't have to point the
16 finger, we just have to apply the correct
17 resources.

18 Three elements where we must focus:
19 education, training, and awareness. That must
20 start when we recruit individuals until the time
21 they leave the Service and then on. Those three
22 elements. Educate us, train us, keep them aware,

1 and be willing to commit the resources needed to
2 support the Force. No resources, we come home.
3 Those are the only options. Either we commit the
4 resources needed to make the change, and when the
5 resources -- when America says we have no more
6 resources, then we come home. But we all know
7 that's not the case. That's not the case.

8 So please take the time to read the
9 report thoroughly. Please help us to help
10 everyone. Thank you.

11 (Applause)

12 DR. POLAND: Yes?

13 DR. MCKEON: Hi. My name's Richard
14 McKeon from SAMHSA, one of the Task Force members.
15 I just have a couple of comments that I wanted to
16 make in response to some of the discussion
17 earlier. I wanted to commend the Services and the
18 Department of Defense for the fact that of the
19 many activities that are going on -- but let me
20 just point out one way in which the Services are
21 unique.

22 My colleague, David Litts, from the

1 Suicide Prevention Resource Center, has tried to
2 find a single other employer in America than in a
3 larger national scope who's tracked -- who tracks
4 the number of people who died by suicide. We
5 don't even know about it, let alone trying to work
6 aggressively and assertively to stop it. We've
7 not been able to find any other. The military is
8 unique in the fact that you are looking at this,
9 you are identifying it, and you are working
10 actively on trying to prevent it.

11 By comparison, and you're working pretty
12 much in real time. By comparison nationally, the
13 surveillance data on suicide in the United States
14 just came out for the year 2007, okay. In that
15 year, there was approximately a two to three
16 percent increase in suicides. So we don't even
17 know yet what the impact of the economic turmoil
18 will be on suicide on a national basis and are not
19 able to make a direct comparison between national
20 suicide rates and suicide rates within the
21 military. We're combining -- we're comparing the
22 military today to what had happened several years

1 ago.

2 But I do want to emphasize that there is
3 -- that while suicide prevention is challenging,
4 that the military is doing exactly the right thing
5 by prioritizing suicide prevention, by giving it
6 the best efforts that you can, because there is a
7 research that shows that suicide can be prevented.
8 Not enough. There are two randomized trials that
9 have shown a reduction in deaths by suicide, and a
10 larger number that have shown reductions in
11 suicide attempts.

12 There are some benchmarks but not
13 enough. There is a national strategy for suicide
14 prevention but it needs to be moved forward. So
15 there is much to be done for us as a nation, but I
16 think that the military deserves to be commended
17 for the efforts that you have made, and we hope
18 that those of us who have served on this Task
19 Force, that these efforts will make some
20 contribution.

21 I do want to say it has been an honor to
22 serve on it, and I am grateful to the other

1 members of the Task Force and by the leadership of
2 our Co-Chairs over this past year. Thank you.

3 (Applause)

4 DR. POLAND: Okay. I'm going to call
5 for a vote. The nature of this vote is we heard
6 no comments surface in regards to concerns about
7 anything that's in the report; rather, we heard
8 only commendation about the report and a number of
9 suggestions which I've already articulated for
10 enhancing tone, content, et cetera.

11 So what I'm going to do is call for a
12 vote. This will be for the Core Board members,
13 endorsing the report. Along with that, the
14 results of that vote, will go our cover letter
15 with however we've voted, and our recommendations
16 for how that report should -- suggestions for how
17 that report should be altered or enhanced.

18 I do hope that one immediate thing that
19 could be done, and I don't know who it is that
20 would do it, but the Sergeant Major mentioned it
21 and I agree with him, that it is the antithesis of
22 leadership, I think, that any military member who

1 dies by whatever means wouldn't be accorded
2 whatever honors they were otherwise due in that
3 service of their country. It would be and is, I
4 think, what Robert Frost would call "an
5 unendurable tragedy" that something like that
6 wouldn't happen. And this is more than symbolic,
7 so I hope whoever it is that sends the message
8 from last week forward, there's no possibility
9 that any members who died -- military member who
10 dies by whatever means wouldn't be accorded the
11 normal honors that they would be due could be
12 fixed.

13 So with that, General Myers, do you --
14 GENERAL (ret) MYERS: I'm sorry, Dr. Poland,
15 but this last comment about the report and about
16 efforts that the military has taken to deal with
17 suicide was quite a different tone than the
18 Executive Summary that I read. And I think we
19 need to reconcile that somehow before I'm willing
20 to vote for this report. I don't -- I don't -- I
21 guess what I'm saying is I'm not sure that the
22 Task Force has given enough credit to the military

1 for some of the work they've done, although
2 imperfect.

3 This tone was certainly different, and I
4 just -- I don't know how we reconcile this, or how
5 I reconcile it in my mind.

6 DR. POLAND: So perhaps among our
7 suggestions then could be the suggestion that
8 there be a part of the report that does
9 acknowledge that.

10 I -- I, on the other hand I must say I
11 like the tone of the report because I think for --
12 this is a report for public consumption, and I
13 think it is an unflinching look and boldly
14 transparent look at the particular issue. I don't
15 think anybody could say, gee, you haven't really
16 addressed this, or you've sugar-coated it. I
17 think this is boldly transparent.

18 DR. JOBES: I'm Dave Jobes on the Task
19 Force. You know, I've been in the field of
20 suicide prevention for well over 25 years, and
21 this Task Force has been an incredible experience,
22 I must say. When you get immersed in it the way

1 that we've been for the last year, you lose
2 perspective, and I've found this morning to be
3 unbelievably helpful just to get feedback and to
4 have some perspective on the work that we've done.

5 General Myers, I think your point is
6 well taken and this is one of the things that gets
7 lost in the version, you know, trying to funnel
8 this down into a final form. But every chance I
9 get on the road or in public forums, you know, I
10 will always say that no one's doing more for
11 suicide prevention than DoD and the VA. There's
12 no organization in the world that's doing more for
13 suicide prevention. I can say that as a
14 suicidologist. So I wouldn't want that spirit and
15 that sentiment to be lost in the report.

16 DR. POLAND: No.

17 DR. JOBES: I also do feel strongly that
18 we had to be very forthright about the challenge
19 and about the fact that we think we can do things
20 that are substantive to make a difference.

21 DR. POLAND: But I think the way -- I'm
22 sorry, I don't know your name --the gentleman over

1 here framed it is probably the right way to say
2 that much positive has been done, but there's more
3 to do, and this report outlines what that more
4 that needs to be done is.

5 MG VOLPE: Yes, sir, just to make
6 comment, it is clearly stated like that in the
7 report. What we haven't done is pulled it into
8 the Executive Summary. So we have it in the
9 report, just as General Myers stated.

10 GENERAL (ret) MYERS: Well, I may -- I'll
11 correct myself. I think having it pointed out to
12 me, there is a -- the second paragraph in the
13 Executive Summary that I now have is not -- is not
14 bad. It is somewhat positive. And, but that sort
15 of contrasts with the rest, and not that we
16 shouldn't -- we have to be critical. I mean
17 that's absolutely, uh -- I'm probably not as hard
18 over as maybe my first -- because I've been
19 corrected. But I still think it's an issue we
20 need to think about, tone and perspective, as you,
21 you know, now take a 30,000-foot view, which is
22 what people are going to do when they read this

1 piece of it. And then they get in the details
2 that the (inaudible)

3 DR. POLAND: So what I'll ask for, then,
4 is a motion from the Board endorsing the report
5 that we've received today with the -- and appended
6 to that would be our suggestions for how the
7 report might be enhanced.

8 There's a first. A second motion?
9 Mike? All in favor, or any discussion first in
10 regards to that?

11 Okay. All in favor, if you could signify
12 by raising your hand. Any opposed? Any
13 abstentions? It's unanimous. Thank you very much,
14 all members of the Task Force, General Volpe and
15 Ms. Carroll, for your leadership of the Task Force,
16 and we hope this process ha been helpful.

17 MG VOLPE: Thank you very much. And to
18 the members of the Defense Health Board, thank you
19 very much for your comments. We actually have
20 sessions the next two days so we could incorporate
21 all the comments that were made and the
22 recommendations and get this done now. So this

1 has been very helpful. Thank you all very much,
2 and again this is about making a difference,
3 translating the report into action, and saving
4 lives. And that's what our goal is, so thank you
5 all very much. I appreciate it.

6 DR. POLAND: Thank you.

7 SPEAKER: Yeah, that's great.

8 GENERAL MYERS: Thank you, Task Force.

9 (Applause)

10 DR. KAPLAN: Greg?

11 DR. POLAND: Yes.

12 DR. KAPLAN: A question. I assume, then,
13 that after you have had your meeting for two days,
14 the minor modifications and so forth will be
15 incorporated into the final report. Is it possible
16 that the members of the Board could receive copies
17 of that?

18 DR. POLAND: Everybody except Dr.

19 Kaplan, I think could. (Laughter)

20 Absolutely. Okay, thank you very much
21 for that. Okay, I think we are going to adjourn
22 for our administrative session. Colonel Bader

1 will give some instructions on that after the
2 lunch at -- how far are we here, we have to
3 readjust time --

4 MS. BADER: We can come back at 12:45.

5 DR. POLAND: Twelve forty-five. Okay,
6 at 12:45 we'll regather and we'll have an
7 information brief on the Joint Theater Trauma
8 System. So, Colonel Bader, do you want to give
9 some directions now for lunch?

10 MS. BADER: Sure. I had mentioned a
11 little earlier that the lunch will be provided for
12 the Task Force members, the Board members, the
13 Service liaisons, Ex-Officios, distinguished
14 guests, and speakers for the afternoon session.

15 I will ask, please, for those who are
16 staying at the hotel, if you have not requested a
17 late departure to please check out during lunch,
18 and again thank you very much for your time and
19 attention this morning, and we will readjourn
20 [sic] at 12:45.

21 DR. POLAND: We will eat lunch here, or

22 --

1 MS. BADER: Across the hall.

2 (Recess)

3 DR. LEDNAR: Our next presentation will
4 be delivered by Colonel George Costanzo. Colonel
5 Costanzo serves as the Director of the Joint
6 Theater Trauma System, formerly established in
7 October of 2006 through a collaborative effort
8 undertaken by the Service Surgeon General, United
9 States Army Institute for Surgical Research, and
10 the American College of Surgeons Committee on
11 Trauma.

12 The goal of the JTTS is to provide the
13 right care to the right casualty at the right
14 location at the right time.

15 Prior to this assignment, Colonel
16 Costanzo served as Chief of Medical Staff at Moody
17 Air Force Base in Georgia.

18 He's commanded trauma hospitals in Texas
19 and in the Iraqi theater of operations, and has
20 served as an instructor in advanced life trauma
21 support since 1983. Colonel Costanzo was
22 certified by the American Board of Surgery, he's a

1 member of the Society of Air Force Clinical
2 Surgeons, and a life member of the Association of
3 Military Surgeons of the United States.

4 Without further delay, we present
5 Colonel Costanzo. Thank you.

6 Col Costanzo: And I'd like to thank the
7 Board for inviting us here. In the interest of
8 time, I'm going to go fairly quickly through the
9 slides so that we'll have time to answer your
10 questions and hear your comments. The brief is
11 fairly lengthy, because we wanted to make sure you
12 had enough information background.

13 What we're really going to focus on and
14 what we're really asking the Board to do is to
15 advocate for the Joint Trauma System to become a
16 program of record within the Department of Defense
17 with a permanent funding stream in the POM cycle.
18 Trauma systems have been around the United States
19 for some 30 years, and over that time research has
20 shown that well-run trauma systems can reduce
21 mortality, morbidity by 15 to 20 percent.

22 Historically, in the CENTCOM AOR we are

1 doing, as you can see, about 8,000 trauma
2 evaluations for a population at risk of 200,000,
3 which is significantly more than most Level 1
4 trauma centers see in the United States. It's a
5 very active trauma system out in the AOR.

6 Briefly, the history. When we went to
7 war with Iraq, when we went to war in Afghanistan,
8 we did not have an organized trauma system. The
9 organized trauma system developed out of a
10 recognized need in early 2003 after the invasion,
11 and we did not have a systemized care, a
12 systemized approach to the care, of severely
13 injured trauma patients. They were treated in
14 stovepipes. We couldn't get good information out,
15 we couldn't take, ensure that patients were taken
16 care of in standardized ways, and so quickly
17 people realized we needed to develop a trauma
18 system.

19 That still took about two years. In
20 March '05, then CENTCOM Surgeon, now Major General
21 Robb, established a Joint Theater Trauma System as
22 the trauma system for the entire CENTCOM AOR.

1 That then required a need for a trauma system to
2 support them within the United States, and that's
3 where the trauma system was built at the ISR to
4 support the theater systems. And I'll show you
5 how that all works.

6 That is the vision: that our job is to
7 ensure to the best of the system's ability that
8 every injured soldier, sailor, airman, and Marine
9 has their best chance for survival, their best
10 chance for functional recovery if they are
11 injured.

12 We have multiple missions. We are
13 primarily a performance improvement organization.
14 We are not a research organization. We do support
15 research with our data, significant support to
16 research with our data, but our number one reason
17 for existence is performance improvement to ensure
18 that the care of the injured victims is the best
19 possible under any given circumstance.

20 Within that we have multiple
21 initiatives, clinical practice guidelines. One of
22 the main initiatives we have -- and I'll go into

1 that a little bit later on in the talk -- we do
2 improve communication amongst all the different
3 medical facilities within the theater who treat
4 trauma, and we do populate a Joint Theater Trauma
5 Registry -- and I'll talk to you about the difference
6 between a trauma system and a trauma registry in a
7 minute.

8 This is the organization as it exists in
9 San Antonio right now. We have about 65 people,
10 although a recent manpower study showed that we
11 need about 104 people to do the work we're doing
12 right now. But we have 65 people that cover
13 everything from data acquisition to IT, clearly
14 performance improvement -- again our reason for
15 existence, performance improvement -- and support
16 to research and answering multiple, multiple data
17 requests to support performance improvement, to
18 support research, and to support command
19 decision making.

20 Within the theater, the team works for
21 the theater Surgeon; they don't work for us at the
22 JTTS. Although we have a close, close

1 relationship, we train this team before they go
2 into theater. Immediately following their
3 training is when they go into theater. We
4 communicate with them on a daily basis, and we are
5 their main support. But their true chain of
6 command goes through the CENTCOM Surgeon because
7 they work for that COCOM.

8 Right now we have
9 trauma coordinators of level hospitals in
10 Bastion, Kandahar, and Bagram, and just as of July
11 5th, we moved one of the trauma coordinators
12 to Dwyer, Camp Dwyer, which became a Level 3 on
13 June 14th with the 31st Cache.

14 This is the manning document, just
15 enough to say that all Services participate.
16 That's why it's a joint organization. We have
17 also started a new MedEvac Project that was given
18 to us by CENTCOM. And we've done some additional
19 manning to run that MedEvac Project, looking at
20 outcomes of patients moved, critically ill
21 patients moved from point of injury and from Level
22 2s to Level 3s, rotary wing.

1 These are the team, Army, Navy, Air
2 Force, nurses, physician, one physician as a
3 theater medical director, and some technicians to
4 help out with both the trauma coordinators and
5 the MedEvac Project.

6 We also, since September of 2007, have
7 worked hand in hand with the Canadians. The
8 Canadians have sent us trauma coordinators in
9 every rotation since September of 2007.

10 For those of you who are not familiar,
11 very quickly the fear of operations, the two big
12 countries that we're interested in, Iraq and
13 Afghanistan, Afghanistan, Iraq, and then patient
14 movement is from point of injury usually to Level
15 2s, it can be directly to Level 3s. Most patients
16 will move out of theater from Bagram, so no matter
17 where they're injured, most of them will move to
18 Bagram; they will be strategically airlifted from
19 Bagram to our Level 4 facility in Germany. And
20 then from Germany, they will be strategically
21 airlifted to Level 5 facilities at, mostly at
22 Bethesda and Walter Reed, but also others within

1 the United States, BAMC and the Burn Center being
2 another.

3 Okay, and the same with Iraq, although
4 as you know, Iraq right now, the violence,
5 thankfully, is very low in Iraq, and so what we
6 were doing in Iraq two years ago, that same level
7 of effort is what we're now seeing in Afghanistan.

8 This is what we call, actually, the
9 discontinuous environment. So we govern care of
10 patient from point of injury through
11 rehabilitation, not -- "govern" is not the right
12 word -- but we have the system approach governs
13 from point of injury to rehabilitation. We want
14 to ensure that once a Service member is injured,
15 that their level of care never decreases across
16 this discontinuous environment. That's where the
17 trauma system has its focus. That is a system
18 that traverses about 7,000 miles in sometimes as
19 little as 24 to 72 hours those patients are
20 moving. And so that's what we look at, and that's
21 what we concern ourselves with for every single
22 patient within the system.

1 We do it from a system-wide approach.
2 In order to do that, the system needs data. We
3 need to have data to know what we're to do and
4 what to do right, and that's where the Joint
5 Theater Trauma Registry comes in. The Registry is
6 the backbone of the system, being the organized
7 approach to taking care of trauma patients.

8 The Data Registry is the JTTR, and that
9 registry begins population for any patient
10 admitted to a Level 3 in theater and continues
11 throughout their course Level 4 and Level 5.

12 These are the components of a trauma
13 system. If you can just think "prevention through
14 rehabilitation" and everything that goes on in the
15 middle, including supporting research, including
16 leadership, including IT, that's the trauma
17 system. And it is geared to performance
18 improvement.

19 I say this probably 15 times, 20 times
20 this talk because it's very important that people
21 understand we are not a research organization.
22 There are many research organizations, and they

1 are important organizations. Our focus is
2 performance improvement. We support research that
3 then rolls into performance improvement. We are
4 focused on the patient and the care of populations
5 of trauma patients.

6 Performance improvement is a data driven
7 process. Again, that's why the importance of the
8 registry. It's a very, very involved registry,
9 and I'll show you the numbers here in a second.
10 And patient outcomes and populations of patients
11 is what we're looking at.

12 These are just some of the performance
13 improvement initiatives that go on and some of the
14 areas of performance improvement that we look at.
15 All of them are based in the data we collect on
16 these patients, and we collect it basically real
17 time, as real time as can be.

18 One of the initiatives -- there are many
19 initiatives that we do performance improvement.
20 One of the ones that has gone on now for several
21 years is a weekly VTC that involves Level 2, Level
22 3, Level 4, Level 5, simultaneously on a VTC or

1 telecon discussing the care of patients traversed
2 through LRMC for that given week, U.S. patients.

3 That's real time performance
4 improvement. We look at the care from a
5 system-wide perspective. If there are system
6 issues that come up, we deal with them, we attack
7 them in whatever format is necessary. So we are
8 continuously doing performance improvement checks
9 on the system. We have multiple, multiple
10 partners on that phone call. It has grown. We
11 have the people who run AirEvac, we have,
12 obviously, the Level 3s. We have the TRANSCOM is
13 on, is online JPMRC. Many of the hospital in the
14 States are online. It's a very, very important
15 and we think very useful performance improvement
16 tool.

17 In fact this and the Joint Trauma System
18 itself was pointed out by Dr. Eastman at the
19 recent American College of Surgeons meeting as the
20 trauma model that all civilian trauma systems
21 should mimic.

22 These are just some of performance

1 improvement filters that we utilize. Some are
2 very similar to civilian, and some are very
3 different based on our military needs.

4 Clinical practice guidelines have become
5 a huge tool that we've worked very, very hard to
6 be as evidence-based as possible, but clearly
7 involves subject matter expert input as well. We
8 have worked very, very hard. We now have 30 of
9 them, approximately.

10 We have also placed them -- we have them
11 all OPSEC'd and PAO Review, and then they are
12 placed on a public web site so that any person
13 treating a trauma patient can get access to them
14 if they have an internet access. And we work
15 very, very hard to do this. These are the tools
16 that help to standardize the care of our trauma
17 patients within the CENTCOM AOR. This has led to
18 a significant decrease in the morbidity and
19 mortality of our patients by the utilization --
20 development, utilization, and monitoring of the
21 CPGs.

22 And these are just all of them. They're

1 in your -- and these are updated on a regular
2 basis yearly at a minimum, approved through the
3 CENTCOM JTT -- or through the CENTCOM Surgeon, but
4 through a very large vetting process before that.

5 I'll talk a little bit about the
6 registry. The registry is a repository of
7 patient-identified data that is coded and can
8 therefore be queried, and it is used to look at
9 populations of trauma patients. So that if you
10 want to know what happened to Sergeant Smith who
11 got injured three days ago, if you want to know
12 what happened to his care, you need to go to his
13 medical record. But if you want to know what kind
14 of injury, if Sergeant Smith had a fractured femur
15 and you want to know how many fractured femurs
16 have we seen within the course of the war, you
17 need a trauma registry to give you that kind of
18 information. That is the difference between a
19 medical record and a registry.

20 But the registry, because it's a coded
21 registry, can be queried, in any number of ways.
22 It is the largest combat registry in existence.

1 Currently, there are 24,000 U.S. patients in that
2 registry, but a total of 53,000 patients, because
3 we extract data on every patient treated in a U.S.
4 facility within the AOR, including host nation
5 coalition.

6 There are a number of different fields
7 in the JTTR. This is just a screen shot, but if
8 you were to look at all those tabs, everything
9 from performance improvement information,
10 outcomes, demographics, mechanisms of injury,
11 blood transfusions, and those types of things are
12 all within the registry.

13 And, of course, data has to come from
14 someplace, it doesn't just appear, and so we
15 impress upon all our people going into theater
16 that the better documentation they do on an
17 individual patient, the better information we're
18 going to have, A) to treat that patient, and B) to
19 treat populations of patients in the future. And
20 that's where the data is extracted from for the
21 registry.

22 And there are electronic systems, as you

1 know, in theater. TMDS, you've heard about them,
2 I'm sure; MC4 I would imagine this group has heard
3 about. But there is an electronic record in the
4 theater that collects a lot of the information on
5 these patients, not all of it but a lot of it.

6 All right. So what I've shown you
7 really is the CENTCOM JTTS system as it relates to
8 the Joint Trauma System at the ISR. It is
9 important to realize that we did not exist. There
10 was never an organized trauma system within the
11 DoD. Our goal and our hope is to convince you
12 that the DoD should never be without an organized
13 trauma system again, because the next conflict we
14 go to, we're going to end up having to relearn the
15 lessons we had to relearn this time. And that
16 cost people's lives, and that costs unneeded
17 morbidity. And so what we are asking the Board to
18 consider is strong advocacy for our Joint Trauma
19 System, strong advocacy for our Joint Trauma
20 System to be permanently funded and become a
21 program of record within the Department of
22 Defense, a joint system which takes care of the

1 needs of all the Services but a standardized
2 approach to the treatment of all trauma patients.

3 Right now we're located at the ISR under
4 the Army. That's a reasonable place for us to be
5 right now. We are in the Army's POM funding, but
6 there is no guarantee. The cycle is over in
7 September. Right now we're not being guaranteed
8 funding, and we would certainly request the Board
9 in its capacity to advocate for that for the good
10 of the patients.

11 And with that, I'd be happy to take your
12 questions or hear your comments.

13 (Applause)

14 DR. LEDNAR: Thank you, Colonel
15 Costanzo. Dr. Kaplan?

16 DR. KAPLAN: Kaplan. I'm, as usual,
17 confused. Could you help me to understand the
18 difference between data collection and research?
19 You said three or four times you don't do
20 research.

21 Col Costanzo: Right.

22 DR. KAPLAN: But yet you analyze data to

1 improve. So what's -- what's -- so --

2 Col Costanzo: If somebody wants to do a
3 research protocol, for instance, somebody wants to
4 design a study to look at orthopedic injuries over
5 the past two years in IED explosions, they need to
6 get an appropriate IRB-approved protocol. Once
7 they have the IRB -- the first thing they'll
8 actually do is ask us if we have such data, and we
9 will tell them within our registry we have 2,000
10 patients who would fit into your research
11 protocol, if it's approved.

12 They go, yeah, that's good enough, I can
13 do that. So then they go through an IRB, and they
14 get an IRB-approved protocol, and they can run that
15 -- then we get the data request, and we give them
16 the data. We can give them patient-identified if
17 that's what's approved by the protocol, or not.

18 For performance improvement, for
19 instance, just to give you a quick example, we
20 recently wanted to know the incidence was of
21 splenectomies in patients who were managed

1 non-operatively in theater. That was a performance
2 that was on a research. We wanted to know because
3 we were writing a CPG at that point in time and
4 wanted to know for sure that what that data was.
5 And we pulled that data out of our registry to get
6 those numbers to support our CPG to govern care of
7 those patients.

8 DR. KAPLAN: But that seems more like a
9 matter of semantics to me than it does anything
10 else, 'cause you really are gathering data, and
11 you're using the data to do better care of your
12 injured warriors.

13 Col Costanzo: We don't write papers
14 based on performance improvement, that's one
15 thing. And, quite frankly, within the military
16 there are two different funds of money for
17 research and separate from performance
18 improvement, and never the twain shall meet. So
19 we do have to govern them very, very differently.

20 There is a fine line, but I think it's
21 very important to stress that that line does
22 exist, and we do a lot of support for research but

1 all through IRB-approved protocols.

2 DR. O'LEARY: That's, you know, that
3 division exists in the private sector as well and
4 is actually much debated, but, you know,
5 performance improvement generally is being
6 separate from research, and it's much cleaner that
7 way. And you just -- and you're not working out
8 of IRBs then.

9 DR. KAPLAN: No, that I can understand,
10 but research is research is research. It may not
11 be the right word to use, it may be a bad -- but
12 anyway I --

13 DR. LEDNAR: Okay, Dr. Oxman and then
14 Dr. Silva.

15 DR. OXMAN: I think the distinction is
16 semantic, and there's a purpose for it, and this
17 is, obviously, to govern performance improvement
18 based upon evidence, you have to do research; but
19 research directed at performance improvement isn't
20 called research and doesn't have the same restraints
21 and liabilities. And I think that's the important
22 aspect of it.

1 It should have the same intellectual
2 quality, and it should have the same stringency,
3 but because it's designed only for performance
4 improvement, and since everyone recognizes how
5 important that is to medicine, it's exempt from a
6 lot of the restrictions that apply to typical
7 research. But it is research; it's just defined
8 differently.

9 DR. LEDNAR: Dr. Silva?

10 DR. SILVA: Yeah. I don't really relate
11 it to, whether it's research or not, it's a good
12 product. But you have foreign nationals that are
13 treated inside trauma system.

14 Col Costanzo: A few.

15 DR. SILVA: Are their data separated and
16 kept out of review?

17 Col Costanzo: That's a good question.
18 So their data can be utilized. We do utilize it
19 for performance improvement, we do utilize it for
20 de-identified data. We never use it for any data
21 that's identified, and it has to be specifically
22 mentioned and approved through an IRB protocol if

1 we're going to use it.

2 For the most part, we do not use non-US data in any
3 patient-identified format. We will use it in a
4 denominator to say, we've seen this number of patients
5 with gunshot wounds, but otherwise we don't use that
6 data.

7 DR. LEDNAR: Dr. Lockey?

8 DR. LOCKEY: I mean I congratulate you
9 on your performance improvement algorithm. I
10 think you're doing outcome measurements, and how you
11 continue to achieve excellence, I wonder if there's
12 any learnings to be applied there in relationship
13 to psychological trauma and suicide for what we
14 heard this morning; whether there's anything that
15 can be learned by that Task Force by what you're
16 doing.

17 That's one comment. The second comment,
18 or you can comment on that, but is there
19 interaction with the civilian trauma centers,
20 either formally or informally, and how does that
21 occur?

22 Col Costanzo: It's probably both formal

1 and informal. So we have since this initiative
2 has started in early '06, we have developed a very
3 close relationship with the American College of
4 Surgeons Committee on Trauma. We are actually --
5 I went quickly over the slide, but you see there's
6 a -- we're developing a military white book that
7 is an overall document that talks about the trauma
8 system. We are mirroring it off of the Committee
9 on Trauma's white book and working directly with
10 Mike Rotondo and many of the guys within the
11 College of Surgeons.
12 We also now have specific parts of their meetings
13 where we present our military stuff, and the
14 interaction between us and the civilians has
15 absolutely grown exponentially whereas we continually
16 learn from them, and they are now beginning to learn
17 from us as well.

18 DR. Lockey: I think that's excellent
19 'cause that -- there's synergism, there's
20 learnings that can be applied to the civilian
21 population, which is excellent. And that's --

22 Col Costanzo: And our goal was to

1 maintain that. Even if there were to be no war,
2 we would maintain a system that continued to grow
3 with currency in trauma.

4 DR. LEDNAR: Dr. Butler, do you have a
5 question you'd like to ask?

6 DR. BUTLER: Yes. To echo what Colonel
7 Costanzo has said, it is really hard to overstate
8 how important this organization has been to our
9 efforts in this war in caring for our wounded
10 warriors. All of the advances that you may have
11 read about in bits and pieces in various
12 newspapers have been enabled, chronicled, and
13 perpetuated by the Joint Theater Trauma System.

14 And I know you've heard it once, but
15 I'll just say it again: this was identified as a
16 major deficiency by the Congress after we didn't
17 have a trauma system in the Gulf War. When we
18 went to war in Iraq and Afghanistan, guess what.
19 We still didn't have a trauma system; it was again
20 identified as a major deficiency by the Surgeons
21 General and Health Affairs.

22 Guess what. We still don't have a

1 permanent trauma system. They are funded entirely
2 by wartime contingency dollars. Translate: war
3 goes away, JTTS goes away. So, you know, it is
4 absolutely time right now to bring this to the
5 attention of the Board. When this came to the
6 Trauma and Injury Subcommittee, 100 percent
7 support for what they are proposing, and just
8 hope that the Board will consider these issues
9 favorably as well.

10 DR. LEDNAR: Dr. Oxman?

11 DR. OXMAN: I, like all of us, are very
12 impressed with what you do, its importance, and
13 its tremendous importance to our warriors. I only
14 ask one question since you're asking the Board to
15 support your specific proposal: is there any
16 alternative to, say, the site or the Army that's
17 been brought up that we should know about before
18 we vote?

19 Col Costanzo: There has been a lot of
20 discussion about the appropriateness of where we
21 ought to be and how we ought to be in, and all
22 that. I will tell you that right now we are well

1 set up within the ISR. They have housed us,
2 they've taken care of us since our inception. The
3 Army Surgeon General in March of this year signed
4 us on a decision paper to say: I will take care of
5 you and I will put you in my POM cycle.

6 I've actually talked with General Green
7 about this as well. We feel right now this is the
8 best place for us to be. The future, who knows?
9 But right now this is the best place for us to be,
10 and the most important thing for us is to get a
11 funding stream, to get permanency, and then all
12 those other things can be looked at 18 months or
13 two years from now if necessary.

14 DR. LEDNAR: Just for the Board to
15 understand that what Colonel Costanzo is giving us
16 today is an information brief. So we are not
17 voting today, but I think what Colonel Costanzo
18 has done today, what Dr. Butler has done
19 previously, is really bring to the Board's
20 visibility the work that's being done, the
21 importance.

22 And as Dr. Butler just said, the way

1 things are structured administratively right now,
2 the war goes away, the Joint Theater Trauma System
3 goes away. And this recurring assessment of
4 deficiency, when you think about Force health
5 protection and readiness, doesn't seem like the
6 right place for an important, you know, support to
7 disappear.

8 So, but we are not voting today, and the
9 Board will have more opportunities to become
10 familiar with the work of the JTTS, and then we'll
11 figure out the best way for the Board to not only
12 understand but to participate in a helpful way in
13 terms of the giving advice.

14 We also just have to remember we are
15 independent and advisory. We don't basically, by
16 some decision, basically commit DoD in a POM
17 funding. That's really for DoD to decide, you
18 know, if and when and how to do it. But, clearly,
19 our opinion, if well supported, I'm sure would be
20 -- would be listened to.

21 DR. CLEMENTS: Well, in that note,
22 though, I would -- I'd like to see us try and

1 frame this in some context that did not involve
2 the funding word. I think it may be appropriate
3 to put this in the context of we think it should
4 find a permanent home in this organization to that
5 organization, making clear that we want this to
6 transcend the current -- the current uncertainty,
7 funding uncertainty, but to make a recommendation.

8 We've always shied away from making a
9 recommendation about specific funding issues and
10 how the Department ought to fund X or Y. So if we
11 could think about it in terms of finding the right
12 home for it, or the right structure for it, then
13 the funding would, I think, would follow.

14 DR. LEDNAR: Lednar. I think there are
15 some analogies to a different discussion we've had
16 on the Board in the past and that is, the injuries
17 that have been developed during the war and the
18 needs for rehabilitation have basically created a
19 capability within DoD around the treatment and
20 functional restoration of these patients which is
21 extraordinary. As these casualties reduce in
22 number, or if they stop all together, it would be

1 a real shame to have that capability lost unless
2 there were yet another war and then start all over
3 again.

4 So I think we have some learnings of
5 functional support that are critical to the
6 missions accomplishment and part of what we could
7 do as a Board is to understand that and to convey
8 the importance of that, and then for the
9 Department to take that in and to deliberate on
10 it.

11 Dr. Parkinson and then Dr. Oxman.

12 DR. PARKINSON: Yeah, Colonel Costanzo,
13 good job of the presentation, and Frank and
14 everybody, excellent. It's been building for some
15 time.

16 One question and then one comment.
17 First, I see the Air Force uniform on there and,
18 traditionally, the old word of AirEvac and control
19 of AirEvac, and all of that and the various things
20 to the Surgeon General and the Air Force, this was
21 kind of their bailiwick in a way, at least, you
22 know, the moving the body, tracking the body, and

1 the equipment that goes along with the body.

2 So am I right in seeing this as kind of
3 moving to true jointness around the entire care
4 and patient flow, not just patient flow than say
5 10 years ago?

6 Col Costanzo: I would say absolutely
7 because --

8 DR. PARKINSON: Yeah, because I see
9 enough, you know, medals that you've got, and you
10 were around in all those times as I was.

11 Col Costanzo: I was.

12 DR. PARKINSON: But it was pretty much
13 we were tracking the bodies and the planes and the
14 litters and all that type of stuff, right?

15 Col Costanzo: Right. And we still have
16 tracking systems. The beauty of the trauma system
17 is exactly that: it is truly joint, and the
18 service brings corps competencies and
19 Service-specific needs that otherwise could be
20 easily missed. The system integrates all the best
21 of that into the single purpose of the care of the
22 patients.

1 And within that system we have just seen
2 absolute tremendous synergy and working
3 relationships amongst all the Services, whether
4 it's at an MTF, whether it's in the back of an
5 airplane, in the back of a helicopter, all geared
6 to bring the best to bear to the care of that
7 patient. And it is true joint, yes.

8 DR. PARKINSON: The other question, I
9 guess, and then a comment. Is the one function
10 that you have there, which makes me a little
11 nervous putting on an old -- will the taxpayer and
12 POM manager was when you talked about the
13 evaluation of new medical equipment or existing
14 medical equipment for the purposes of this. As at
15 least I recall, there are numerous places within
16 the Services -- DoD, Materiel Command, USAMRIID
17 that supposedly have jurisdiction and funding
18 associated with them to do medical equipment
19 design evaluation off the shelf. How -- have you
20 tried to deconflict that, because I think it would
21 further your approach if you could go on forward
22 in the --

1 Col Costanzo: I think probably the best
2 way to -- that, what that really means is we help
3 in the evaluation of the equipment.

4 DR. PARKINSON: Okay.

5 Col Costanzo: So from a systems
6 perspective, if a new piece of equipment is being
7 PMI'd for, or new piece PMI'd for aircraft
8 reliability, we can help with that system ensuring
9 that the equipment is utilized appropriately from
10 point of injury through that flight to the next
11 level of care. And that's what we do.

12 The same thing with tourniquets. We
13 didn't develop tourniquets. Recently, USA ISR did
14 a lot of that research, however, once tourniquets
15 were developed we helped to evaluate their use
16 within theater by data collection and a lot of
17 things.

18 DR. PARKINSON: Yeah.

19 Col Costanzo: So help to evaluate is
20 probably a better way of putting it.

21 DR. PARKINSON: Sure. And you know that
22 -- you know the DoD is very good at establishing

1 new programs, very poor at integrating or leveraging
2 existing programs, entirely interface it. So if
3 they agree that that's part of what you do, that's
4 great.

5 Then the last thing is just, is just a
6 comment. I would wish that for the millions of
7 interactions beyond the 8,000 that get in the
8 trauma care system, unfortunately, that we had the
9 same sense of jointness urgency, performance
10 improvement around any immunization registry,
11 around sprains and strains, or asthma care, that I
12 had a web site for five common chronic diseases
13 that consume 80 percent of health care costs that
14 would be posted online with CPGs that anybody
15 could look at.

16 So I think there's a lot of lessons here
17 for the Board and for DoD. If we can do it with a
18 sense of urgency, this does not consume DoD's
19 dollars and doesn't put us \$50 billion in the red
20 over the next 10 years for health care, so there's
21 a lot of good things that your team has done, and
22 we need to just leverage it across the system. I

1 think that's kind of what we heard and -- some of
2 the things. That's enough preaching at the end of
3 the day.

4 DR. LEDNAR: One last comment. Dr.
5 Oxman?

6 DR. OXMAN: I realize that it is
7 premature to endorse the specific proposal, but I
8 do think we should not lose the opportunity to
9 make it clear that we are enormously supportive
10 and impressed by the job that the JTTS has done
11 and recognize that support.

12 DR. LEDNAR: And the deliberations of
13 the Board right now are being transcribed, and
14 that thought is part of our transcription. So
15 thank you for making that.

16 And, Colonel Costanzo, thank you for
17 coming and sharing the work of the Joint Theater
18 Trauma System, and we look forward to getting to
19 know more about it.

20 Col Costanzo: Thank you. I appreciate
21 it.

22 DR. LEDNAR: Okay, thank you.

1 (Applause)

2 DR. LEDNAR: With that, we'll ask Ms.
3 Bader, our Designated Federal Official, if she
4 would perform her next official duty.

5 MS. BADER: Thank you, Dr. Lednar. This
6 concludes today's session of the Defense Health
7 Board. We look forward to our continued role in
8 providing advice to the Secretary of Defense to
9 optimize care provided to military members and
10 their families.

11 Directly following this meeting, there
12 is a meeting of the Infectious Disease
13 Subcommittee in the Chesapeake Room, which is
14 right down at the end of the hall.

15 So we can give the folks in that
16 Subcommittee a 15-minute break, and if we can
17 convene that meeting at 1:45, that would be great,
18 in the Chesapeake Room.

19 So I will now adjourn the meeting.
20 Thank you, everybody.

21 (Whereupon, at 1:33 p.m., the
22 PROCEEDINGS were adjourned.)

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