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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P R O C E E D I N G S

(9:10 a.m.)

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

(Applause)

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

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

Board to order.

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

(Moment of silence)

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

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

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

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

MG VOLPE: Good morning. Phil Volpe.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. GINSIG: Donald Gintzig, Deputy

Chief, Bureau of Medicine and Surgery.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Trauma System at Fort Sam Houston in San Antonio.

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

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

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

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

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

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

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

at the Uniformed Services University.

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

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

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

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

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

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

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

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

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

MS. CAIN: Christina Cain, DHB Support Staff.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

service to America.

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

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

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

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

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

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

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

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

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

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

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

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

it to them to prevent every suicide that we can.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

suicides or investigation suicides.

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

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

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

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

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

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

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

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

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

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

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

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

developing the report.

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

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

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

the various installations, too.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

While all of that is important, also on

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

recommendations in that area, those areas.

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

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

from. So this is a very important strategy.

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

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

And leaders -- Service members,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

becomes important.

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

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

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

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

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

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

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

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

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

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

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

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

Next slide. Focus Area 4, surveillance and investigations.

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

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

any other use on that.

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

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

Next slide. Okay, foundational

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

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

and programs in the future.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

suicide and saving lives.

That's all I have, sir.

(Applause)

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

MS. CARROLL: No --

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

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

General Myers?

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

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

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

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

to do that.

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

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

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

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

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

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

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

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

MG VOLPE: Yes.

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

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

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

DR. POLAND: Wayne?

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

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

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

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

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

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

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

more impactful. Thanks.

DR. POLAND: Dr. Oxman?

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

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

And just let me say I think it's so

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

DR. POLAND: Dr. Kaplan.

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

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

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

about?

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

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

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

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

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

DR. KAPLAN: Yes, please.

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

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

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

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

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

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

DR. POLAND: Dr. Silva?

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

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

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

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

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

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

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

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

DR. POLAND: Other comments? Dr. Walker?

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

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

DR. POLAND: Robert Certain?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

what the most important things are to do first.

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

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

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

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

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

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

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

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

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

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

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

people will read it and they will grab them.

DR. POLAND: Dr. Parkinson?

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

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

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

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

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

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

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

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

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

DR. POLAND: Dr. Lednar?

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

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

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

DR. POLAND: Dr. Oxman?

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

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

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

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

DR. POLAND: Jim?

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

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

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

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

DR. POLAND: General Myers?

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

If you really have recommendations, if

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

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

DR. POLAND: Dr. Parkinson?

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

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

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

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

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

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

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

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

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

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

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

I think increasing the sense of urgency

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

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

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

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

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

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

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

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

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

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

(No audible response)

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

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

(Recess)

DR. POLAND: Okay, as I said right

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

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

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

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

SPEAKER: Isn't there one?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Applause)

DR. POLAND: Yes?

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

My colleague, David Litts, from the

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

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

ago.

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

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

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

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

(Applause)

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

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

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

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

So with that, General Myers, do you --

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

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

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

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

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

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

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

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

DR. POLAND: No.

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

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

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

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

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

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

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

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

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

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

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

DR. POLAND: Thank you.

SPEAKER: Yeah, that's great.

GENERAL MYERS: Thank you, Task Force.

(Applause)

DR. KAPLAN: Greg?

DR. POLAND: Yes.

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

DR. POLAND: Everybody except Dr. Kaplan, I think could. (Laughter)

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

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

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

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

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

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

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

MS. BADER: Across the hall.

(Recess)

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

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

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

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

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

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

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

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

Historically, in the CENTCOM AOR we are

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

These are just some of performance

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

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

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

And these are just all of them. They're

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

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

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

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

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

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

And there are electronic systems, as you

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

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

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

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

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

(Applause)

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

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

Col Costanzo: Right.

DR. KAPLAN: But yet you analyze data to

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

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

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

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

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

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

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

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

all through IRB-approved protocols.

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

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

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

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

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

DR. LEDNAR: Dr. Silva?

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

Col Costanzo: A few.

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

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

we're going to use it.

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

DR. LEDNAR: Dr. Lockey?

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

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

Col Costanzo: It's probably both formal

and informal. So we have since this initiative has started in early '06, we have developed a very close relationship with the American College of Surgeons Committee on Trauma. We are actually -- I went quickly over the slide, but you see there's a -- we're developing a military white book that is an overall document that talks about the trauma system. We are mirroring it off of the Committee on Trauma's white book and working directly with Mike Rotondo and many of the guys within the College of Surgeons.

We also now have specific parts of their meetings where we present our military stuff, and the interaction between us and the civilians has absolutely grown exponentially whereas we continually learn from them, and they are now beginning to learn from us as well.

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

Col Costanzo: And our goal was to

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

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

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

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

Guess what. We still don't have a

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

DR. LEDNAR: Dr. Oxman?

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

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

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

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

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

And as Dr. Butler just said, the way

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

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

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

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

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

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

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

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

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

Dr. Parkinson and then Dr. Oxman.

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

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

the equipment that goes along with the body.

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

Col Costanzo: I would say absolutely because --

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

Col Costanzo: I was.

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

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

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

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

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

DR. PARKINSON: Okay.

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

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

DR. PARKINSON: Yeah.

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

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

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

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

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

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

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

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

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

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

Col Costanzo: Thank you. I appreciate it.

DR. LEDNAR: Okay, thank you.

(Applause)

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

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

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

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

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

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

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I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

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