

# Task Force Resilient Final Report



April 2013





## Introduction

The Vice Chief of Naval Operations established Task Force Resilient on 22 January 2013 to explore factors impacting the resilience of our Navy and to make recommendations to improve organization, training, resources and metrics. This multi-disciplinary Task Force comprised of 19 Officers, Chief Petty Officers, and enlisted Sailors, consulted expert opinion and senior enlisted leadership along with the latest scientific findings on resilience, while doing analysis of programs to include suicide prevention.

Our Navy men and women are the key to our readiness and success. Readiness is a central tenet of the Chief of Naval Operations' Sailing Directions. Technology changes rapidly but our people are the constant in keeping our Navy strong. Men and women in khaki and blue operate the sensors, systems, and platforms that preserve freedom of navigation and ensure our freedom of action on the high seas. Leaders at every level must support them if they are to succeed in their mission. This includes promoting resilience in the force.

Task Force Resilient found Navy leaders at every level are devoting tremendous energy to promoting resilience and reducing suicide, but a strategic plan directing greater integration and synchronization of effort is required to ensure more efficient and effective outcomes. Additional changes to policies and processes can also improve current efforts. I present this report in the belief that its recommendations, if acted on, will produce greater unity of effort and more effective procedures resulting in improved readiness through a more resilient force that is less vulnerable to suicide.

Sincerely,



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## ***Foreword***

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The U.S. Navy defines resiliency as the “process of preparing for, recovering from, and adjusting to life in the face of stress, adversity, trauma, or tragedy.”<sup>1</sup> Academic studies contend that there is an inherent connection between resilience and suicide prevention and that resilience can be learned.<sup>2</sup> However, there is no accepted way to measure individual resilience or agreement on levels of resilience required to “inoculate” a person against suicide. Suicide has been studied longer and to a far greater extent than resiliency. Recognizing this, Task Force Resilient focused its efforts on understanding Navy suicide and current prevention efforts to provide Navy leadership with recommendations that build resiliency and prevent suicide.



# ***Executive Summary***

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## **Introduction**

The three tenets of the Chief of Naval Operations' Sailing Directions are: Warfighting First, Operate Forward, and Be Ready. Building resilience and preventing suicide are essential to producing a force that is always ready to operate forward and execute its warfighting mission. The Vice Chief of Naval Operations (VCNO) established Task Force Resilient on 22 January 2013 to review Navy resiliency efforts as well as suicide related events in order to increase resilience and reduce suicides. In executing its analysis the Task Force received fleet input and expert opinions. The Task Force examined: suicide rates, trends, and high risk groups; suicidal risk factors and causal agents; the latest scientific literature on resilience and suicide prevention; Navy resiliency efforts; and Department of Defense (DoD) and civilian resiliency and suicide prevention efforts.

## **Suicide in the Navy**

The Task Force found that the most typical profile for a Navy suicide involves an enlisted white male between the ages of 17-24. However, recent data confirms that anyone of any age or rank can become susceptible to suicide. Relationship difficulties with spouse or significant other, legal and/or disciplinary problems, health problems, and a history of psychiatric problems lead the list of factors and stressors related to suicide. Firearms are the primary method used in Navy suicides and that rate is rising. Alcohol is a factor in just over a third of suicides. Sleep deprivation is a common factor and a concern, as nearly half our Sailors in the fleet today get less than five hours of sleep per night. Hospital Corpsman and nuclear power ratings currently have a heightened incidence of suicide.

## **Resilience and Suicide Prevention Programs**

Navy suicide prevention efforts are governed by OPNAVINST 1720.4A but the Task Force found no policy governing resilience in the Navy. Navy Tactics, Techniques and Procedures Publication NTPP 1-15M, *Combat and Operational Stress Control*, does, however, provide doctrinal guidance for resiliency efforts. Despite the lack of an overarching resilience policy, the Navy has no fewer than 123 programs specifically designed to build resilience, prevent suicide, or enable those ends. All contribute positively to Navy wellness, but they typically address niche needs and are not necessarily coordinated as part of a strategic plan. This lack of strategic coordination reduces effectiveness and produces inefficiencies.

The Task Force found that DoD resilience and suicide prevention efforts outside the Navy can guide and inform Navy programming. The Final Report of the DoD's Task Force on the Prevention of Suicide by Members of the Armed Forces provides valuable insight and actionable recommendations for preventing suicide. Other Service programs include elements

suitable for use by the Navy such as a strong emphasis on resilience programming, community involvement, small unit leadership, recruit screening, and tiered/targeted training initiatives. Programs outside the DoD also hold promise for informing Navy efforts. Task Force Resilient examined these various efforts and initiatives and shaped its recommendations accordingly.

## **General Findings**

The Task Force discovered a variety of general findings during analysis that informed many of its specific recommendations. These included the following:

- Navy suicide rates are historically lower than national and DoD rates but are trending upward indicating a problem.
- Suicide protective factors and their relationship to military service needs to be better understood.
- The current Navy operating environment and operational tempo do not appear to directly increase the risk of suicide.
- Navy suicides are not unique to specific generations but generational data can inform resilience and suicide prevention efforts.
- Suicide is not connected to service accession waivers.
- Suicide clustering is rare and existing Navy guidance already incorporates best practices with regard to its prevention.
- Resiliency training can have a positive effect on individual readiness and may reduce the risk of suicide over time.
- Comprehensive “care for the caregiver” must be a critical element of Navy suicide prevention efforts.
- A continuous “chain of care” for at-risk Sailors must be included as an element of Navy suicide prevention efforts.

## **Specific Findings and Recommendations**

In addition to the above general findings, the Task Force arrived at nine specific recommendations with 35 supporting recommendations organized in five primary focus areas as summarized below.

**Organization:** The Navy should establish the Chief of Naval Personnel (CNP) as the VCNO’s executive agent for Navy resilience and suicide prevention efforts. CNP should establish the 21<sup>st</sup> Century Sailor Office (N11), led by a 2-Star Line Officer, to assume overall lead for Navy resilience and suicide prevention efforts. N11 should establish a registry of all resilience and suicide prevention programs, standardize measures and metrics, and have authority to direct resources and require reorganization to capture efficiencies and increase effectiveness. This office should contain three program offices corresponding to three identified lines of effort. A Total Sailor Fitness Program Office should oversee policy for all resilience related efforts. A Behavioral Health Program Office should manage policy related to behavioral health support for resilience and suicide prevention. A Suicide Prevention Program Office should formulate policy

and investigate events, collect data, and provide lessons learned and recommendations to inform all suicide prevention efforts. Specific policy initiatives should include: behavioral health screening for recruits; periodic behavioral health checkups for all personnel; clinical care guidelines; standards of care for returning warriors; and managing access to lethal means.

**Training:** The Navy must further develop a comprehensive, tiered, targeted, improved, and adaptable resilience and suicide prevention training program. This training should be designed to span each stage of the leadership training continuum. It should target the needs of family members, different service providers, and high-risk communities while improving content and delivery methods. It should also be coordinated with other training requirements to reduce the overall training burden on the fleet but remain adaptable over time to meet emerging needs.

**Assessment:** The Navy must improve data collection quality for resilience and suicide prevention efforts. Specifically, the Navy must coordinate with the DoD to execute recommendations made by the DoD Task Force on the Prevention of Suicide by Members of the Armed Forces relative to DoD Suicide Event Report (DoDSER) revision and improvement. In addition, the Navy must ensure existing DoDSER and Unit SITREP requirements are met, lessons are captured, root causes for suicide are identified, and data is used to further inform resilience and suicide prevention efforts. The Navy also collects a great volume of data to measure the health of the force. The 21<sup>st</sup> Century Sailor Office (N11) should manage and use this data to enable continuous program improvement.

**Care:** Access to behavioral health care is crucial to promoting resilience and preventing suicide in the force. The Navy must review means to increase access to such care. Access can be attained in a variety of ways from hiring additional behavioral health care specialists, to providing hotline and online services, to embedding providers in specified units, to equipping persons to serve as behavioral health care extenders. The Navy must also develop means to ensure continuity of behavioral health care for Sailors during times of transition, such as PCS moves, inter-deployment cycles, and disciplinary actions. Continuity of care should include “warm-handoff” procedures for at risk personnel and policies that foster greater communication and collaboration within commands, between commands, and between leaders and service providers. Finally, the Navy must enhance the quality of behavioral health care for suicidal personnel in particular through increased standardization of best practices in the field.

**Learning and Culture:** A consistent barrier to a Sailor seeking mental health assistance is the stigma associated with the subject. The Navy must implement a communications plan along with senior officer engagement to reduce the stigma associated with seeking behavioral health care. In addition, Personal Readiness Summits should be reinstated to promulgate a standardized readiness message to the fleet and serve as an instant feedback vehicle to the 21<sup>st</sup> Century Sailor Office (N11).

## **Implementation and Impact**

The Task Force believes that initial reorganization can be achieved rather quickly. Policy and procedural changes will take additional time. Initial operating capability can be attained within six months; full operating capability within 18 months; and steady state within 30 months after initiation of reorganization.

## **Conclusion**

Navy leaders at every level are devoting tremendous energy to promoting resilience and reducing suicide, but a strategic plan directing greater integration and synchronization of effort is required to ensure more efficient and effective outcomes. Delivering a resiliency program to improve total fitness (physical, mental, social and spiritual) will empower our Sailors with skills for life and wellness, and will improve overall readiness. Better identification, assessment, and support from fellow Sailors, leaders and family members can overcome stigma and with increased access to mental health care, we can reduce suicides in our ranks.

# Task Force Resilient Final Report

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## I. Task

The VCNO established Task Force Resilient on 22 January 2013 in response to an upward trend in suicides among Navy personnel.<sup>3</sup> The organization, comprised of 19 Officers, Chief Petty Officers, and enlisted Sailors from across the fleet, was chartered to “conduct a review of Navy resiliency programs, policies and resources to assess the ability of our current efforts to enable an appropriate degree of resiliency in the force for the future.”

## II. Methodology

Suicide has been the focus of considerable study at both the national level and throughout the DoD. According to the *2012 National Strategy for Suicide Prevention*, suicide “prevention efforts must be comprehensive and coordinated across organizations and systems at the national, state...and local levels.”<sup>4</sup> Accordingly, Task Force analysis of Navy suicide prevention efforts was informed by and sought alignment with national and DoD guidance. In executing its analysis the Task Force examined a variety of factors to include:

- Suicide rates, trends, and high risk groups
- Risk factors and causal agents
- Scientific literature on resilience and suicide prevention
- Navy resiliency efforts including:
  - Programs having a direct, indirect, or enabling relationship to resilience and suicide prevention
  - Delivery methods
  - Utilization rates
  - Measures of effectiveness
- Input from command senior enlisted leadership
- Expert opinion

### **III. Resilience and Suicide Prevention Efforts**

#### **Navy Suicide Prevention and Resilience Efforts**

##### *Suicide in the U.S. Navy*

Navy suicide has been studied for more than 40 years. The majority of observations have remained consistent since 1966 and are corroborated by ten years of formal Navy and DoD collection efforts. Recent studies by the RAND Corporation, the DoD, and the Navy Bureau of Medicine and Surgery (BUMED) provide a valuable resource for understanding suicide characteristics and potential risk factors. Collective results from 1999-2009 corroborate national trends and point to the following profile for Navy suicides:<sup>5</sup>

- **Sailor Profile**                      (% Suicide vs % Force)
  - Male:                                      95%                      85%
  - Caucasian:                                69%                      61%
  - Enlisted:                                   91%                      85%
  - Age 17-24:                                40%                      37%
  - Married:                                    58%                      54%
  
- **Factors and Stressors**
  - Relationship problems:                      59%
  - Discipline/Legal problems:                      35%
  - Physical health problems:                      31%
  - Psychiatric history:                              29%
  - Prior self-injury:                                18%
  - Financial problems:                                16%
  
- **Event Profile**
  - In CONUS:                                      91%
  - In residence:                                      63%
  - Method firearm:                                51%
  - Method hanging:                                26%
  - Alcohol likely used:                                35%
  
- **Navy Rates with Highest Suicide Incidence**
  - Hospital Corpsman (HM) (% Suicide vs % Force)<sup>6</sup>
    - 2008:                                      2.6%                      7.5%
    - 2009:                                      4.3%                      7.5%
    - 2010:                                      15.4%                      7.5%
    - 2011:                                      13.5%                      8.0%
    - 2012:                                      22.0%                      8.5%<sup>7</sup>
  
  - Nuclear Power Rates                      (% Suicide vs % Force)<sup>8</sup>
    - 2010:                                      5.0%                      5.0%
    - 2011:                                      8.0%                      5.0%
    - 2012:                                      10.0%                      5.0%

## History of Navy Suicide Prevention

Prior to 1990, the Navy's approach to suicide prevention was decentralized. Policies and training efforts were developed locally, if at all. As national awareness grew in the early 1990's, the Navy centralized its suicide prevention efforts under OPNAV direction and officially recognized prevention as a key element of health promotion programming.

The Secretary of the Navy mandated a comprehensive assessment of suicide prevention policies, programs, and resources following a spike in suicide rates and the death of Admiral Jeremy Boorda in 1996. Formal reporting of Navy suicides began in 1999 with the Navy Suicide Incident Report (DoNSIR).

Though the Navy mandated suicide prevention training for more than a decade, its first overarching suicide prevention policy was not published until 2006. That policy, OPNAVINST 1720.4, consisted of the following 10-point action plan:

- Annual training
- A command Suicide Prevention Coordinator
- Messages of concern
- Command-level suicide prevention and crisis intervention plan
- Local medical, religious, and family services, along with health promotion and substance abuse services to support leaders in their plans
- Plans for identification, referral, access to treatment and follow-up for at-risk personnel
- Training that it is every member's duty to obtain assistance for other Service members
- Suicide prevention as part of life skills/health promotion education
- Sensitive support provided for families and units affected by suicide events
- Post-suicide data collection, surveillance and analysis

The DoD standardized suicide reporting for all Services in 2008 by creating the Department of Defense Suicide Event Report (DoDSER) which superseded the DoNSIR. OPNAVINST 1720.4 was revised a year later extending DoDSER surveillance to drilling Selective Reserve (SELRES) personnel and focusing on the four key elements of suicide prevention:

- Training
- Intervention
- Response
- Reporting

## Navy Resilience Policy and Doctrine

There is no Navy-wide resiliency program, policy, or instruction. NAVADMIN 332/08 (Oversight, Training, and Development of the Operational Stress Control Program) discusses the need for resilience as critical to operational readiness in the context of combat operations. The message

describes Navy-wide initiatives organized around Operational Stress Control (OSC) under Deputy Chief of Naval Operations N1.

Aside from NAVADMIN 332/08, the Task Force could not identify any overarching policy or executive agent responsible for delivering resiliency programming. In fact, the terms “resilience,” “resiliency,” and “resilient” occur in only six Navy-wide policies – three related to religious ministry, two related to family programming, and one related to Returning Warrior Workshops.

Despite a lack of official resiliency policy, there is a Navy Tactics, Techniques, and Procedures Publication that deals with resilience – *Combat and Operational Stress Control (NTTP 1-15M)*. According to NTTP 1-15M, “...the goal of Combat Operational Stress Control (COSC) and Operational Stress Control (OSC) is resilience, the ability to withstand adversity without becoming significantly affected, as well as the ability to recover quickly and fully from whatever stress-induced distress or impairment has occurred.”<sup>9</sup> The terms “resilience,” “resiliency,” and “resilient” occur a total of 136 times throughout the publication. Clearly, the COSC/OSC doctrine forms the theoretical foundation for much of the Navy’s efforts to promote resilience and considerable resources have been invested in the development and promulgation of this model.

Based on visits and discussions with subject matter experts, the Task Force determined that OPNAV N135 (Director, Personnel Readiness and Community Support) is effectively acting as the Navy Resiliency Program Office.

### *Navy Resilience and Suicide Prevention Programs*

Navy suicide prevention efforts intensified following the suicide of the Chief of Naval Operations in 1996. However, gaps in treatment and newly developed prevention techniques became increasingly evident during the prolonged combat operations that followed 9/11. The Navy responded quickly to implement new programs that addressed these gaps and needs. Today the Navy employs no fewer than 123 programs designed to prevent suicide and/or contribute to the overall wellness and resiliency of our Sailors. All contribute positively to Navy wellness, but they typically address niche needs and are not necessarily coordinated as part of a strategic plan.

Task Force Resilient reviewed these programs to assess the effectiveness of the Navy's current effort. It identified the program’s purpose and/or mission and divided them into three tiers adapted from the DoD Suicide Prevention Office (DSPO):

- Tier 1: Programs whose mission and desired outcome are specifically stated to influence suicide prevention and stress control.
- Tier 2: Programs whose mission and desired outcome are not specific to suicide prevention, but one or more of its objectives may impact suicide risk/protective factors which may influence suicide prevention.

- Tier 3: Programs whose mission or desired outcomes are not specific to suicide prevention, but may have tangential effects that contribute to the prevention of suicide.

Initial analysis identified 16 Tier 1, 19 Tier 2, and 56 Tier 3 programs. An additional 32 programs were identified, but were unable to be classified into the Tiers in the timeframe of the study. These programs should be classified following the reorganization recommended at the end of this report.

Following categorization, each program was further reviewed to determine the date it was developed, its cost, the number of full time equivalents (FTE) employed in executing the effort, number of persons served by the program, whether it is a mandatory program or training effort, and the overall organizational flow of the program. Additionally, the Task Force assessed each program along six sub categories:

- Alignment and Leadership: The effort aligns at a strategic level with a senior decision maker who has authority over the entire spectrum of wellness efforts and execution flows logically from the strategic through the operational to the tactical level.
- Policies and Processes: The policies and processes are clear so that the effort is universally applied in a consistent and predictable manner across the entire fleet.
- Resources: Financial and manpower resources are adequate to meet the stated mission.
- Training and Support: Sufficient training and support are in place to sustain, monitor, and modernize the effort on an ongoing basis.
- Metrics and Measures: The program uses measures of effectiveness that track outcomes over time rather than measures of performance that only indicate use and self-reported impacts.
- Communications and Messaging: Program availability, mission, and desired outcomes are well known and the program is accessible to the Sailor on the pier.

Each of these sub categories was rated green, yellow, or red, using a “fully meets mission objectives” to “falls short of meeting mission objectives” continuum. Since there currently is no standardized program registry that captures the above listed data, and no commonly accepted metric for formal program evaluation, this evaluation was based on an analysis of the information at hand.

Finally, the Task Force attempted to assess the overall effectiveness of each Tier 1 program. Based on this assessment, recommendations are made to either keep the program as is, alter the program to improve efficiencies, or refer the program for further study.

Figures 1-3 below provide a summary of the program assessment for Tier 1 and Tier 2 programs; appendix B includes the full program analysis; appendix C provides additional information specific to the Chaplain Corps as derived from the program review; and the following comments provide a summary of the most significant programmatic findings:

- **Alignment and Leadership:** Tier 1 programs align under BUMED, CNP, and Commander, Navy Installations Command (CNIC); Tier 2 programs generally align under the Chief of Chaplains, BUMED, and CNP; and Tier 3 programs generally align under a wide variety of sponsors. Although it was easy to identify major program sponsors (BUMED, CNP, CNIC, and the Chief of Chaplains), the Task Force found that chains of command for many programs were frequently vague or difficult to identify.
- **Policies and Processes:** On an individual basis, most Navy wellness programs have well developed and mature policies and processes. However, these policies and processes require updating to accommodate improved alignment and collection of data to determine outcomes over time.
- **Resources:** Tier 1 programs allocated no less than \$41.5 million with 231 Full Time Equivalent (FTE) toward their specific suicide and resilience missions. Cost data for Tier 2 and 3 programs is less precise than that of Tier 1. However, based on partial data, Tier 2 programs allocated no less than \$31.6 million toward their suicide and resilience objectives. Tier 3 programs are generally well established but have the least available costing data.
- **Training and Support:** Most programs use effective service delivery models with well trained staff. However, fleet surveys indicate that training delivery methods require updating to improve their impact on Sailors.
- **Metrics and Measures:** Most programs employ measures of performance but lack measures of effectiveness. Though the programs often measure activity, they rarely measure outcomes.
- **Communications and Messaging:** Most programs provide information about their services but better outreach to customers is warranted and strategic synchronization of communication across all resilience and suicide prevention efforts is needed.

**Program Effectiveness:** Of the 16 Tier 1 programs assessed, three were identified as requiring no change and 13 were identified as prospects for alteration or modification to capture efficiencies.

**Lines of Effort:** The review of all identified Navy resilience and suicide prevention programs disclosed that they generally fall into three broad lines of effort:

- Suicide prevention
- Operational stress/resilience
- Mental/behavioral health

Based on these findings, the Task Force believes that the Navy’s suicide prevention and resiliency efforts should be organized along the three identified lines of effort under a lead agency authorized to establish policy and direct resources across the entire wellness enterprise. That agency must:

- Establish the Navy’s overall wellness strategy
- Establish standardized measures of effectiveness to inform decisions regarding program value
- Synchronize, coordinate, and consolidate programs into one strategically directed effort with clear authorities at all echelons
- Reinvigorate and modernize the suicide prevention program
- Oversee behavioral health care efforts to ensure consistent and universal access for all Sailors with tailored add-ons for specific communities.

		Alignment	Policies	Resources	Training	Metrics	Comms
<b>BUMED</b>	Returning Warrior Workshop	Alignment	Policies	Resources	Training	Metrics	Comms
	Navy MORE	Alignment	Policies	Resources	Training	Metrics	Comms
	NC-COSC	Alignment	Policies	Resources	Training	Metrics	Comms
	Behavior Health Integration Program	Alignment	Policies	Resources	Training	Metrics	Comms
	Coherence Advantage Training	Alignment	Policies	Resources	Training	Metrics	Comms
	REACH	Alignment	Policies	Resources	Training	Metrics	Comms
	Psychiatric Rapid Intervention Team	Alignment	Policies	Resources	Training	Metrics	Comms
	N & MC Health Outreach Programs	Alignment	Policies	Resources	Training	Metrics	Comms
	USMC WWR	Alignment	Policies	Resources	Training	Metrics	Comms
<b>N135</b>	OSC	Alignment	Policies	Resources	Training	Metrics	Comms
	N-OSC Training Team	Alignment	Policies	Resources	Training	Metrics	Comms
	Navy OSC Leader	Alignment	Policies	Resources	Training	Metrics	Comms
	Navy Suicide Program	Alignment	Policies	Resources	Training	Metrics	Comms
<b>CNIC</b>	WW-Safe Harbor	Alignment	Policies	Resources	Training	Metrics	Comms
	WW-Anchor	Alignment	Policies	Resources	Training	Metrics	Comms
<b>NECC</b>	NECC Resiliency	Alignment	Policies	Resources	Training	Metrics	Comms

LEGEND: Significant Obstacles to Meeting Mission Objectives Partially Meets Mission Objectives Meets Mission Objectives

Figure 1: Navy Tier 1 Program Assessment

		Alignment	Policies	Resources	Training	Metrics	Comms
BUMED	FOCUS	Alignment	Policies	Resources	Training	Metrics	Comms
	Mobile Care Team	Alignment	Policies	Resources	Training	Metrics	Comms
	Psychological Health	Alignment	Policies	Resources	Training	Metrics	Comms
Chief of Navy Chaplains	Devine Services	Alignment	Policies	Resources	Training	Metrics	Comms
	Religious Ministry Support to IA	Alignment	Policies	Resources	Training	Metrics	Comms
	CREDO	Alignment	Policies	Resources	Training	Metrics	Comms
	Cooperative Religious Ministry	Alignment	Policies	Resources	Training	Metrics	Comms
	Spiritual Fitness Guide	Alignment	Policies	Resources	Training	Metrics	Comms
	Chaplain Care	Alignment	Policies	Resources	Training	Metrics	Comms
N135	Substance Abuse Rehabilitation	Alignment	Policies	Resources	Training	Metrics	Comms
	Sexual Assault Prevention	Alignment	Policies	Resources	Training	Metrics	Comms
	Family Advocacy Program	Alignment	Policies	Resources	Training	Metrics	Comms
	Navy Family Ombudsman Program	Alignment	Policies	Resources	Training	Metrics	Comms
	Personal Financial Management	Alignment	Policies	Resources	Training	Metrics	Comms
	Family Readiness Group	Alignment	Policies	Resources	Training	Metrics	Comms
	Health Promotion and Wellness	Alignment	Policies	Resources	Training	Metrics	Comms
N61	Military and Family Life Counselor	Alignment	Policies	Resources	Training	Metrics	Comms

LEGEND: Significant Obstacles to Meeting Mission Objectives Partially Meets Mission Objectives Meets Mission Objectives

Figure 2: Navy Tier 2 Program Assessment

Tier 1 Programs		Tier 2 Programs			
BUMED	Returning Warrior Workshop	Overall	BUMED	FOCUS	Overall
	Navy MORE	Overall		Mobile Care Team	Overall
	NC-COSC	Overall		Psychological Health	Overall
	Behavior Health Integration Program	Overall	Chief of Navy Chaplains	Devine Services	Overall
	Coherence Advantage Training	Overall		Religious Ministry Support to IA	Overall
	REACH	Overall		CREDO	Overall
	Psychiatric Rapid Intervention Team	Overall		Cooperative Religious Ministry	Overall
	N & MC Health Outreach Programs	Overall		Spiritual Fitness Guide	Overall
USMC WWR	Overall	Chaplain Care		Overall	
N135	OSC	Overall	N135	Substance Abuse Rehabilitation	Overall
	N-OSC Training Team	Overall		Sexual Assault Prevention	Overall
	Navy OSC Leader	Overall		Family Advocacy Program	Overall
	Navy Suicide Program	Overall		Navy Family Ombudsman Program	Overall
CNIC	WW-Safe Harbor	Overall		Personal Financial Management	Overall
	WW-Anchor	Overall		Family Readiness Group	Overall
NECC	NECC Resiliency	Overall		N61	Military and Family Life Counselor

LEGEND: Investigate Further Capture Efficiencies No Change

Figure 3: Overall Program Assessment

## Case Studies

### BUMED Case Study – A proven methodology for analyzing Navy suicide

In response to an increasing number of suicides among Navy Medicine personnel the Surgeon General of the Navy directed a comprehensive review of all 22 suicides of medical personnel between January 2011 and October 2012. Rear Admiral Elizabeth S. Niemyer, Deputy Chief, Wounded, Ill, and Injured (BUMED M9), led a multidisciplinary team in a robust analysis of each case to produce useful data to better inform prevention efforts.

A 13 member team was convened with representation from BUMED M9; OPNAV N135H; Marine Corps Headquarters Suicide Prevention Program; Navy and Marine Corps Public Health Center (NMCPHC); CNIC; Naval Criminal Investigative Service; Center for Naval Analyses; Armed Forces Medical Examiner System; Navy Chaplain Corps; Senior Enlisted Medical Corpsmen; and the Navy Nurse Corps. An analysis of each individual case was conducted, risk factors were assessed, and recommendations were made in four key areas: leadership (including policy), prevention and training, access to and delivery of care, and surveillance. The team examined the empirical data, but also utilized their extensive expertise to “think outside of the box” in making recommendations.

The BUMED "deep dive" demonstrates a methodology that the Navy should adopt for all suicide events. Further, the report corroborates decades of suicide research, noting similarities between Navy Medical suicide events and suicide events in general, such as demographics, risk factors (relationship problems, changes in duty status, and personal loss among others), the stigma of mental health treatment, and training inadequacy. Additionally, it found that even though a DoDSER is required for every suicide, it is often inadequate or incomplete. Thus, performing "deep dives" as needed to determine causal factors can supplement DoDSER data and provide valuable insight to inform resilience and suicide prevention efforts. BUMED's key findings are summarized below, and provided in Appendix E for reference:

#### Key BUMED Findings:

- Only three of the 22 cases presented factors potentially unique to Navy Medicine.
- The use of multiple suicide prevention techniques, including ACT (Ask, Care, and Treat), was identified, indicating leadership implementation of Navy training and suicide prevention strategies.
- A marked failure to communicate the warning signs or risk factors detected by commands, providers, family members, or peers was found; this failure to "connect the dots" of information was more often evident during times of transition.
- A history of psychiatric disorders was reported in 11 (50%) cases and 14 (64%) had sought prior mental health treatment.
- Multiple risk factors were identified including relationship problems in 10 (46%); change in duty status in 15 (68%); significant personal loss in 15 (68%); facing military disciplinary action in seven (32%); excessive or increased use of alcohol in 12 (55%); and transitional stressors such as changes resulting from force shaping

practices and relocations, divorces, and school failure in all but one where data was available (20 of the 22).

- Sleep problems (both diagnosed and undiagnosed, and for which medication may or may not have been prescribed) were identified in 13 (59%) suicides.
- A lack of awareness of support resources existed among family members who were concerned about their Sailor.
- Stigma related to mental health/suicide behaviors was found - families and friends reported fearing potential negative impact on the member's military career if they communicated their concerns to the command.
- While general suicide awareness and prevention training is available, current Navy required training is not evidence-informed (research is providing new findings at a rapid rate).
- The lack of a Clinical Practice Guideline (CPG) for Suicide Assessment and Treatment and Safety Planning undermines the care and treatment of suicidal personnel..
- Insufficient information prohibited analysis of Reserve Component Sailor suicides.
- While modest improvement in DoDSER completion has occurred since 2010, 15 (68%) of cases reviewed had a DoDSER partially or fully completed, current compliance remains insufficient for robust surveillance.

### NECC Case Study – A proof of concept for Navy resiliency efforts

An example of a successful program aimed at increasing resilience is the Navy Expeditionary Combat Command (NECC) Warfighter Resilience Program. Recognizing an increasing trend in SITREPS and casualty reports, NECC sought an in-house solution to build the resilience of its Explosive Ordnance Disposal and Seabee Sailors. Using a holistic approach, NECC crafted its Warfighter Resilience Program with three interconnected components: (1) advanced OSC training, (2) a family readiness team, and (3) an embedded Mental Health Program (eMHP).

### Operational Stress Control

The Navy OSC program began in 2008 providing initial program awareness training for Sailors at Recruit Training Command, annual fleet-wide training through GMT, and targeted senior leadership training at the Senior Enlisted Academy and Command Leadership School. Mobile Training Teams (MTTs) were developed in 2010 to better reach the fleet and provide more effective training to commands. There are currently 4 MTT's, two each in Norfolk and San Diego, with the capability and funding to deliver robust worldwide training. Although the OSC MTTs are a resource available to any command, there is no requirement for commanding officers to conduct training beyond the scope of GMT.

Recognizing the value of OSC training and NECC's own specific needs, NECC directed OSC training for frontline supervisors (E6 and above) and deckplate leaders (E4-5) making NECC the only Type Commander with mandatory OSC training above and beyond the Navy required GMT.

## Family Readiness Team

Believing that Sailors with properly trained and supportive families are better able to perform their duties, NECC mandated the creation of command family readiness teams.<sup>10</sup>

Required team members include the commanding officer, executive officer, command master chief, family readiness officer, family readiness group leader, ombudsman, and chaplain.

Recommended members include the casualty assistance calls officer, public affairs officer, administration officer, and representatives from the Fleet & Family Support Center (FFSC), Exceptional Family Member Program, morale, welfare and recreation committee, and Chief Petty Officer Mess. The program includes targeted readiness and resiliency training developed for families and presented by either the force family readiness director or the force warfighter resilience coordinator.

## Embedded Mental Health Program (eMHP)

The cornerstone of NECC's Warfighter Resilience Program is the embedded Mental Health Program (eMHP). The eMHP program employs 10 embedded mental health providers who conduct briefs, advise command leadership, consult with medical providers, and provide Sailors 24/7 access to counseling, check-ups, and resilience training. The cost of this program in FY12 was \$1.25M with 10 mental health providers supporting 2,412 Sailors.

Beginning in 2009, NECC required Sailors to meet with their unit's embedded mental health provider for an initial screening but did not require them to disclose any information related to their mental health. Trust in the program was developed with command leadership signing up for their own individual mental health check-ups. This lead-by-example approach began the process of removing the stigma from behavioral health care and validated the real-world value of the program to Service members.

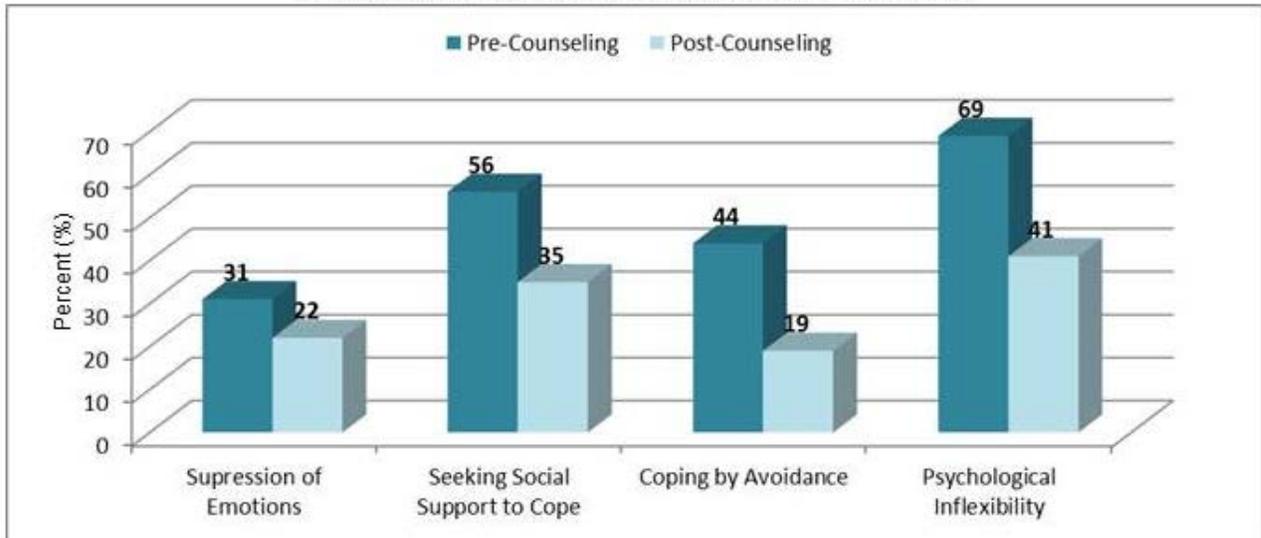
The manner in which the eMHP was implemented led to many Sailors seeking counseling help who would not have done so otherwise. To date, 63% of Sailors self-referring to eMHP have never self-referred to any kind of counseling, military or civilian, before. This large percentage of first time contacts indicates that embedded mental health professionals combined with the proper command climate can lead to the de-stigmatization of mental health treatment.

Furthermore, Sailors in counseling attest to the value of the program in anonymous surveys:

- 96% report having been helped to deal more effectively with their problems after as few as three sessions
- 99% would recommend the program to a friend in need
- Total satisfaction scores average 95% satisfaction

The eMHP program has also resulted in a measurable increase in the resiliency of those Sailors who have received counseling as illustrated in Figure (4) below. These improvements were shown after an average of only four sessions over 12 weeks.

**Decreases in negative coping & psychological inflexibility  
in those who have self-referred for eMHP treatment**



\*Note: Psychological inflexibility involves avoiding rather than accepting emotional experiences. Those who are inflexible often cope by suppressing thoughts vs. those who demonstrate flexibility by tolerating higher levels of distress.

**Figure 4: NECC Resiliency Results**

Key Lessons

The NECC’s Warfighter Resilience Program has demonstrated the ability to de-stigmatize those who seek mental health assistance, has provided an effective feedback mechanism for commanders, and has provided resiliency skills training in line with the preponderance of mental health research. Most aspects of the program are suitable for adoption Navy-wide and the eMHP model deserves further study for possible use by other high-risk communities in the Navy at large.

***Other Efforts Within DoD***

There are a number of suicide prevention efforts across the DoD – most notably the DoD Task Force on the Prevention of Suicide Among Members of the Armed Forces, the Defense Suicide Prevention Office, the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, and the Suicide Prevention and Risk Reduction Committee. What follows is a brief description of each along with Service specific information relative to resilience and suicide prevention efforts.

***The DoD Task Force on the Prevention of Suicide***

The DoD established a Task Force in 2009 to examine suicide by members of the Armed Forces. They were directed to submit a report containing recommendations for a comprehensive prevention policy. The Task Force consisted of seven DoD and seven non-DoD professionals with expertise in suicide prevention policy, military personnel policy, suicide prevention research, mental health clinical care, military chaplaincy and pastoral care, and military families.

The Task Force's final report was released in August 2010 and included 49 findings and 76 associated recommendations in four areas: Organization and Leadership; Wellness Enhancement and Training; Access to, and Delivery of, Quality Care; and Surveillance. Task Force Resilient reviewed the DoD Task Force findings to ensure proper focus and alignment of its efforts.

### *The Defense Suicide Prevention Office (DSPO)*

DSPO is the suicide prevention policy office within the Office of the Secretary of Defense (OSD). It was established in 2011 under the authority of the Under Secretary of Defense for Personnel and Readiness after the release of the DoD Task Force Final Report. DSPO oversees the development of policies, procedures and messages to prevent suicide across the U.S. Armed Forces. Influenced by the *2012 National Strategy for Suicide Prevention*, DSPO is responsible for creating a DoD strategy to implement the findings of the DoD Task Force and address the problem of suicide among members of the US Armed Forces. During its analysis, Task Force Resilient conferred with representatives from DSPO for best practices and to ensure alignment.

### *The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE)*

DCoE is part of the DoD's Military Health System and chairs the Suicide Prevention and Risk Reduction Committee (SPARRC), the primary venue for inter-service and inter-agency collaboration on suicide prevention activities. N135 Suicide Prevention Program Office represents the Navy at SPARRC.

DCoE was "...established in November 2007 to integrate knowledge and information about programs for psychological health and traumatic brain injury." DCoE executes its mission through three component centers:

- Deployment Health Clinical Center works to improve psychological health and deployment-related health care.
- National Center for Telehealth and Technology develops telehealth and technology solutions for psychological health and traumatic brain injury.
- Defense and Veterans Brain Injury Center provides clinical care for military and family members with traumatic brain injuries.

Collectively, DCoE products and services address stigma, depression, military children and family member issues, PTSD, resilience, stress management, substance abuse, and transition.

### *U.S. Army*

The Army's suicide prevention program began in 1984. In 1999, the Army Chief of Staff called for a review of existing suicide prevention efforts. Since that review, the Army has increased its emphasis on suicide prevention, intervention, and postvention measures while directing commanders to better coordinate resources at all levels. Specifically, the Army is integrating and

synchronizing multiple programs and lines of effort to improve Army readiness and resilience by executing the Ready and Resilient Campaign. Though a recent initiative, the Ready and Resilient Campaign will:

- Integrate resilience training throughout the entire training continuum.
- Synchronize and integrate programs to reduce or eliminate suicide and suicidal ideations; sexual harassment and sexual assault; bullying and hazing; substance abuse; domestic violence; and any stigma or barriers associated with seeking help.
- Develop improved methods to provide timely and accurate information and metrics to identify "at risk" and "high-risk" Soldiers which empower early intervention efforts.<sup>11</sup>

The Ready and Resilient Campaign builds on nearly five years of Army resilience training efforts. The Army has closely tied suicide prevention efforts with resiliency in the belief that increased individual resilience will lead to stronger individuals resistant to suicide or other forms of destructive behavior. In 2008 the Army established a Comprehensive Soldier Fitness (CSF) Directorate and program based on the Penn Resiliency Program discussed later in this report. CSF program components include:

- An online Global Assessment Tool (GAT), allowing individuals to confidentially assess their emotional, social, spiritual, and family fitness.
- Twenty-four hours of unit-level Master Resiliency Training (MRT) led by one of the Army's more than 15,000 master resiliency trainers, each of whom has completed a 10 day training course.<sup>12</sup>
- A CSF – Performance and Resilience Enhancement Program component which provides classroom training and field exercises based on principles taken from the fields of performance and sport psychology.
- Online, evidence-based training modules that support social, emotional, spiritual, family, and physical resilience.
- Institutional training which incorporates CSF principles throughout the Army's training continuum.<sup>13</sup>

The Army recently evolved CSF into CSF2, Comprehensive Soldier and Family Fitness, to promote family well-being and to help family members recognize when their Soldiers stand in need of additional assistance.

Also in 2008, the Army established a memorandum of agreement with the National Institute of Mental Health (NIMH) to conduct a five year study of Service member risk and resilience factors called Army STARRS (Army Study To Assess Risk and Resilience in Servicemembers). STARRS is the largest mental health risk and resilience study ever conducted among military personnel and looks for both mental health protective and risk factors. The Army sought out NIMH because of its status as the premier mental health research organization in the United States. The STARRS team not only includes NIMH members but also members from the Uniformed Services University of the Health Sciences (USUHS), the University of California, San Diego, the University of Michigan, and Harvard Medical School. The study is scheduled to conclude in 2014 and will doubtless produce significant finding for use by all of the Services.<sup>14</sup>

## U.S. Air Force

The Air Force Suicide Prevention Program (AFSPP) was established in 1996. The Air Force program is the only Service program to claim a statistical reduction in suicides, associated with a 33% reduction in suicide risk during the program's first six years<sup>15</sup>. Between 2002-2011, the Air Force had the lowest suicide rate amongst the Services for six of ten years.<sup>16</sup> This success is grounded in the strenuous application of 11 program elements:

- Leadership involvement – foster wingman culture via frequent messaging
- Professional military education – oriented toward rank and level of responsibility
- Use of mental health services – aimed at improving duty performance
- Unit-based preventive services – designed to increase access
- Wingman culture – stresses responsible choices, peer support, and early help-seeking behavior
- Hand-off policy – person-to-person direct contact vice mere referral during investigations
- Post-suicide response (postvention) – supportive checklist for commanders
- Command Action Information Board (CAIB) and Integrated Delivery System (IDS) – enable a community-based, comprehensive approach
- Limited Privilege Suicide Prevention Program – limited protection with regard to information revealed in or generated by a clinical relationship with a mental health provider<sup>17</sup>
- Commander consultation tools – unit assessment tools
- Tracking and analysis – dissemination of useful findings for local application

The Air Force employs a community-based approach to suicide prevention through the use of the CAIB and IDS which "...provide a forum for the cross-organizational review and resolution of individual, family, installation, and community issues that impact the readiness of the force and the quality of life for Airmen and their families. The CAIB and IDS help coordinate the activities of the various military and non-military helping agencies to achieve a synergistic impact on community problems and reduce suicide risk."<sup>18</sup>

In addition to its community-based suicide prevention approach, the AFSPP provides tiered, targeted training to include:

- Foundational Training. Total Force Awareness Training (TFAT), given at accession as well as annually to all Airmen, focuses on protective factors and the benefits of seeking help.
- Targeted Training for At-Risk Groups. At-risk groups (currently identified as intelligence, maintenance, and security forces), complete annual face-to-face training in lieu of TFAT. Additionally, new supervisors in at-risk groups attend a one-time frontline supervisors training within 90 days of assuming duty.
- Managing Personnel in Distress. Given to those with high probability for encountering distressed personnel, this includes specific training on intervention and referral procedures.

In addition to its suicide prevention program, the Air Force has an Airman Resiliency Program Division under the Deputy Chief of Staff for Manpower, Personnel, and Services and has developed a Comprehensive Airman Fitness (CAF) program similar to the Army's CSF program. CAF provides skills training to increase proactive coping, self-management, and leadership skills that enhance individual resilience across the mental, physical, social, and spiritual domains. Like the Army, the Air Force employs Master Resilience Trainers to deliver training to Airmen and family members at the local level.<sup>19</sup>

All of the above is supported by the Air Force's Behavioral Evaluation and Screening of Troops (BEST) program. The BEST program screens recruits within the first 72 hours of arrival at Lackland Air Force Base during "Week 0" to identify trainees with the most serious mental health and behavioral problems. BEST uses the Lackland Behavioral Questionnaire (LBQ), which began in 1974 and has been used in its current form since 2007. Trainees that score in the top 1% on the unsuitability scale have a 56% likelihood of separation within 4 years due to mental or behavioral problems and 57% likelihood of receiving a mental health diagnosis.<sup>20</sup>

### *U.S. Marine Corps*

The Marine Corps suicide prevention program was established in 1992. The Corps began to target Marine non-commissioned officers in 2009 as the small unit leaders with greatest influence on the young enlisted who comprise the majority of the Corps' suicide risk. A line-led initiative through Manpower and Reserve Affairs (M&RA), Marine Corps suicide prevention strategies have closely paralleled Navy Operational Stress Control development. The Marine Corps is currently developing a pilot program of "Force Preservation Teams", similar to Aviation Human Factors Councils.<sup>21</sup> The intent of these teams is to focus command and small-unit leadership on Marines identified with challenges that may require additional help/resources. At present, no official policy has been published but MARADMIN messages reference the future procedures.

Additionally, Marine Corps efforts include the following components:

- Marine Combat and Operational Stress Control Program and Operational Stress Control and Readiness (OSCAR) identify and mitigate stress before it leads to self-destructive behavior.
- Families OverComing Under Stress (FOCUS) is just one named effort in reaching out to Marine families, couples, and children with strength-based resiliency skills.
- The Marine Crisis Hotline is a behavioral health crisis resource specifically designed for Marines and their family members.
- The "Never Leave a Marine Behind" program is taught by trained instructors in small-classroom environments, compiling numerous Marine Corps suicide prevention efforts.<sup>22</sup>
- Marine Corps Suicide Prevention Program Instruction, MCO 1720.2, includes a sample award for Marines seeking help and saving the life of another Marine.

- Marine Corps Mentoring Program (MCMP, MCO 1500.58) is specifically designed to increase unit cohesiveness, positively affect the development of subordinates, and ensure accountability, responsibility, and evaluation of mentored Marines.
- Development of a case management system, linking several medical systems.

Throughout the Marine Corps there is a focus on involved and informed leadership at the very lowest level. To quote MARADMIN 240/11: “There is absolutely no information that a battalion or squadron commander should not have about his/her Marines...Leaders at every level must learn to recognize what can be mitigated at their level and only push up what needs to be addressed and resolved at higher levels. Problems should not be pushed up to support a process vice an end; solutions are encouraged at the lowest level possible.”

### Summary of DoD efforts

DoD and Service efforts are aligned to promote resilience and prevent suicide. The Task Force identified specific program elements within each Service that are particularly noteworthy: the Army Ready and Resilient Campaign, the 11 elements of the Air Force AFSPF, and the Marine’s small unit leadership initiative. When aligned with the larger DoD strategic initiative, these efforts, coupled with recruit screening, tiered/targeted training and a community-based approach to suicide prevention, serve as a model for Navy suicide prevention programming.

### **Efforts Outside of DoD**

There are a number of suicide prevention and resilience programs throughout the country which demonstrate best practices the Navy should adopt for internal use. Generally, these efforts fall into two broad categories: (1) those that raise awareness and teach skills and (2) those that provide screening and referral for mental health problems and suicidal behavior.<sup>23</sup> Many programs combine elements of both into a comprehensive approach. In performing its analysis, the Task Force conducted a review of what current literature and expert opinion considers the most promising approaches for preventing suicide outside the DoD. The four projects or studies below are specifically highlighted for their potential applicability to current Navy efforts and include elements from across the continuum of prevention programs.

#### Penn Resiliency Program (PRP)

The University of Pennsylvania’s Penn Resiliency Program (PRP), is a group intervention program for late elementary and middle school students. Central to PRP is the Adversity-Beliefs-Consequences (ABC) model that contends beliefs about events influence their impact on emotions and behavior. PRP teaches students to detect and evaluate the accuracy of thoughts and to challenge negative beliefs by considering alternative interpretations.<sup>24</sup>

PRP is typically delivered in 12 90-minute lessons or 18-24 60-minute lessons that present concepts and practice skills in a variety of ways. In studies of PRP’s one hour a week 24 weeks resiliency training program, positive results were seen in the areas of assertiveness, the ability to focus, and the ability to find alternative options in difficult circumstances. These positive

results were observed immediately after completion of the training and for the three years thereafter. No studies beyond the three year period were administered.

The Army's CSF Program is based in part on PRP principles thereby demonstrating its adaptability for use in a military environment.

### *Department of Veterans Affairs (VA) Study: Predicting Post-Deployment Mental Health Substance Abuse and Services Needs*

Veterans exposed to combat and other traumatic experiences are at higher risk for post-traumatic stress disorder (PTSD), depression, and other psychiatric and substance abuse conditions. Recognizing this, the VA studied how risk and resilience factors interact to determine whether an individual will develop a psychiatric or substance abuse disorder.<sup>25</sup>

The study's specific objectives were to: (1) examine the association between pre-deployment risk and resilience factors and deployment experiences and post-deployment factors in a national sample of OEF/OIF veterans up to one year post-deployment; (2) examine changes in post-deployment life events, social support, mental health and substance abuse status, functioning and service use over a 6-9 month period following baseline assessment; and (3) identify risk and resilience factors that predict mental health status, functioning, and service use six months after baseline assessment.

The VA study identified Army and Marine personnel as subject to higher levels of risk and worse mental health in a number of areas as compared to Air Force and Navy personnel. More importantly, it found that greater resilience is associated with better mental health which resulted in the study advocating efforts to build resilience in OEF/OIF veterans. This finding supports the importance of resilience training and programming for the Navy.<sup>26</sup>

### *New Mexico Suicide Intervention Project*

New Mexico's Suicide Intervention Project began in 1994 in response to an increasing number of youth suicides in northern New Mexico. It's a comprehensive program of suicide awareness and training, providing a continuum of prevention, intervention and postvention (support for schools after a suicide crisis) services. It increased access to counseling services for at-risk youth, and trained peers to help extend the reach of behavioral health providers. Additionally, the project provides programs for professionals and educators to better prepare them to identify and assist those in crisis. *Building Bridges* is a professional development seminar series for teachers designed to increase the personal effectiveness of teachers K-12 in the classroom and offers a collaborative approach to teacher-student-family relationships. The project also provides crisis services to assist school communities after a student suicide and provides trained professionals who can offer appropriate support to help lessen the risk of further suicides. New Mexico's youth suicide attempts have decreased from 14% in 2003 to 8.6% in 2011 and the state attributes these results to program success.

Navy Behavioral Health Surveys repeatedly note that Sailors are more likely to go to peers and family members than the chain of command during times of stress or crisis. This program's focus on peers and families has value in a Navy comprehensive program.<sup>27</sup>

### Jed Foundation

The Jed Foundation was created in 2000 by Donna and Phil Satow after their college-aged son Jed took his own life. Targeting college students, the foundation promotes a comprehensive approach to suicide prevention and mental health promotion by:

- Developing life skills
- Promoting social networks
- Identifying students at risk
- Increasing help-seeking behavior
- Providing mental health services
- Following crisis management procedures
- Restricting access to potentially lethal means

Through the Jed Foundation, campus professionals are provided with research based models to assess current campus efforts and to identify existing strengths and areas for improvement. Parents are provided information to recognize signs of a potential mental health problem and resources to help their child find proper support and treatment. Student programs are designed to reach students where they are, and in a way they understand...from MTV's college network to social networking sites to campus papers to popular tours and events. The foundation's goal is that every student understands how to look out for their own mental health, how to support friends who may be struggling, and how to advocate for access to mental health care.<sup>28</sup>

The Jed Foundation's comprehensive approach is modeled on the Air Force program. They cite the Air Force's success as proof of their program's efficacy though no specific studies on the efficacy of Jed Foundation initiatives have been conducted. Given the age similarity between college students and the majority of Navy Sailors, the Jed foundation provides a model for the Navy as it develops its own comprehensive program.

### Summary of Non-DoD Efforts

Programmatic efforts outside the DoD provide a menu of best practices that can be adapted for Navy use. The majority of national efforts focus on two key elements: (1) programs that build coping skills to increase individual resiliency, and (2) suicide awareness and intervention training programs that help family, friends, and peers break the chain of events leading to suicide.

## IV. General Findings

### ***Navy suicide rates are historically lower than national and DoD rates but are trending upward indicating a problem***

The Task Force found that Navy suicide rates have historically been lower than national and DoD rates but the Navy rate has increased over the past three years. The 2012 Navy suicide rate was the highest it has been since 1995. Totalling 59 Active Duty and 6 Reserve Component suicides, 2012 marked the highest number of suicides in 17 years. Detailed analysis indicates that Navy suicide rates remained relatively constant from 2001-2010 but increased from 11.1 per hundred thousand in 2010, to 14.5 in 2011, to 16.4 in 2012. Civilian rates for the representative male ages of 17-60 (~85% of the Navy) climbed from 21.8 suicides per hundred thousand in 2001 to 23.6 per hundred thousand in 2008. However, because of a three year lag in available national data, the Task Force was unable to compare current Navy rates with current national rates and trends.<sup>29,30</sup>

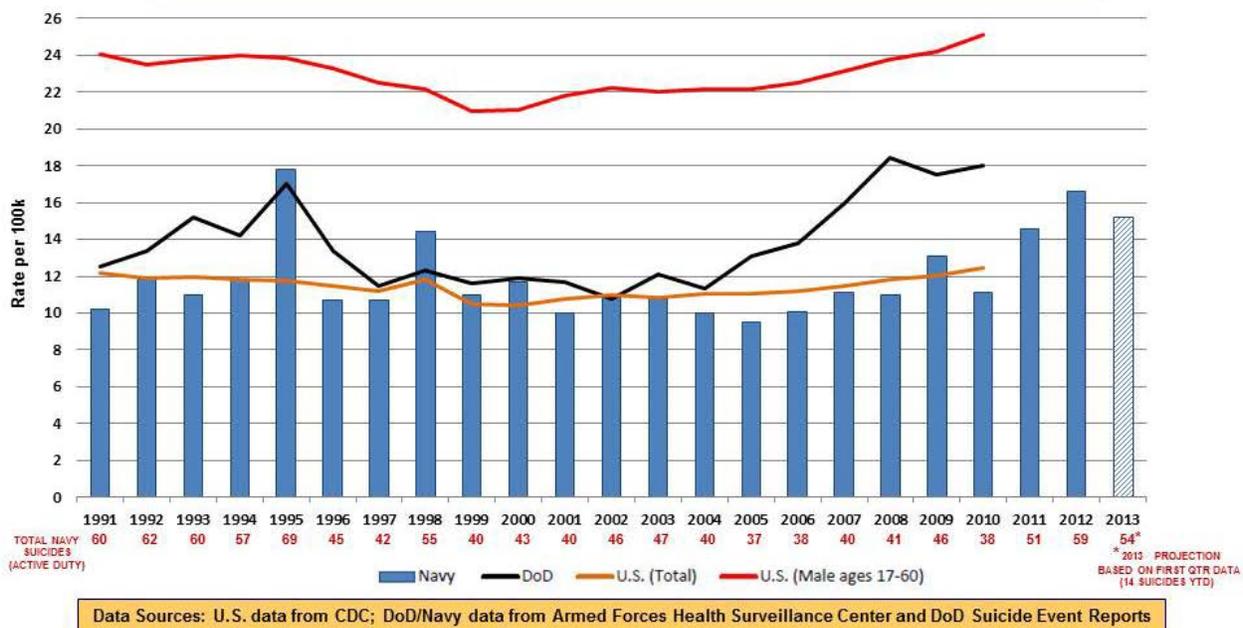


Figure 5: Navy, DoD, and National Suicide Rates

### ***Suicide protective factors and their relationship to military service needs to be better understood***

A 2011 study by the Center for a New American Security (CNAS), suggests three factors combine to preclude suicide: belongingness, usefulness and an aversion to pain or death.<sup>31</sup> Per the CNAS study, wartime service may undermine these protective factors. For example, unit cohesion and camaraderie are high during deployment and foster a sense of belonging but time away from the unit following deployment may weaken this protective factor.

Similarly, feelings of usefulness cycle from high to low in conjunction with deployment cycles and permanent change of station orders. Service members often feel highly useful while in operational deployments and/or combat but return to less perceived meaningful stateside routines. Finally, the aversion to pain or death may also be affected by military service since military training prepares Service members for the dangers of their profession and builds within them a tolerance for pain while reducing the aversion to death.

Navy suicide data may support the CNAS observations since the majority of suicides occur on shore duty about 1-2 years following a deployment and during times of transition, such as permanent change of station moves, when feelings of belonging and usefulness may be at their lowest.<sup>32</sup>

### ***The current Navy operating environment and operational tempo do not appear to directly increase the risk of suicide***

It is sometimes asserted that the stress of multiple deployments may increase the risk of suicide. Task Force analysis does not substantiate this claim. Specifically, a 2011 Navy report shows that 80% of suicides had either no deployments or only one deployment.<sup>33</sup>

Individual Augmentee / GWOT Support Assignments (IA/GSA) do not appear to increase the risk of suicide either. A Center for Naval Analyses report found that Sailors deployed ashore during Operations IRAQI FREEDOM, ENDURING FREEDOM, or NEW DAWN were less likely to take their own life (7.4%) than those who had no such deployments (10.3%).<sup>34</sup> The 2011 DoD SER report of suicides from 2009-2011 also noted that most Navy suicides during those years had zero OIF, OEF, or OND deployments (89 per cent in 2009, 92 per cent in 2010, and 72 per cent in 2011).

Traditional shipboard deployments and IA/GSA tours may indeed result in increased stress but suicide rates do not appear to increase as a direct result.

### ***Navy suicides are not unique to specific generations but generational data can inform resilience and suicide prevention efforts***

There is a belief that the Millennial generation, born between the 1980s and early 2000s, is more susceptible to anxiety, depression, and maladaptive stress putting them more at risk for suicidal behaviors. However, a review of literature does not show Millennials have a heightened risk of suicide but indicates a formal resiliency program will have positive benefits.

Studies of Millennials point to reduced suicide and violence rates that have, at times, lowered the national average. They indicate an optimistic generation with a genuine concern for their country, friends, and family. Coincidentally, the literature gave no indication that this generation considers suicide as a viable option for escaping life's problems.<sup>35,36,37,38,39</sup>

On the other hand, the literature does support some generalizations and stereotypes about Millennials which require consideration by the Navy. For example, several surveys, articles, and studies cite the same characterizations and traits for Millennials:

- Sheltered – by parents and society
- Confident – consistently told they can and will achieve greatness
- Pressured – by higher expectations to achieve more
- Entitled – feel they have a right to receive something even if it isn't earned
- Seek Instant Gratification - as a result of technology that provides more information, faster than ever before

These traits are not always compatible with military culture and life's stressors. As a consequence, some Millennials may have difficulty adjusting to the military lifestyle.

One of the most troubling trends for the Millennials continues to be an increase of reported mental health issues, particularly depression, anxiety disorders, and ADHD. In his piece for the USA Today, titled "Born This Way", Ross points to the rising reports of adolescent depression—one out of eight was officially diagnosed.<sup>40</sup> Gould draws a correlation between the decline of Millennial suicides with the increase in antidepressant prescriptions for this generation.<sup>41</sup> According to the *U.S. Department of Health and Human Services Annual Report on the Health and Status of the Nation* (HUS 2011), between 1994 and 2008 antidepressant prescriptions increased almost fivefold (1.6% to 7.8%), prescriptions for anxiolytics (for anxiety disorders) slightly more than doubled (1.4% to 3.2%), and central nervous system stimulants (for ADHD) quadrupled (0.8% to 3.7%).<sup>42</sup> It has even been remarked that this generation is severely over-medicated.<sup>43</sup>

Furthering the argument of depression and anxiety disorders in the Millennials, Jayson cites several sources (including the American Psychological Association's survey of U.S. adults) that corroborates the fragile mental condition of this generation: 39% reported increased stress in the last year; on a 10-point scale, average stress for Millennials was 5.4 compared to the 4.9 national average; and more than any other age group, Millennials report being told by a health care provider that they have either depression or an anxiety disorder.<sup>44</sup>

There are signs that this generation may be susceptible to some risky behavior. Though drug use remained relatively constant, the HUS 2011 reported increased occurrences of Ecstasy and Heroin use in Millennials. HUS 2011 also cites an increase in alcohol use and binge drinking amongst the 18-25 year-old group.<sup>45</sup>

Lastly, according to a Pew Research Center report, Millennials self-reported a lack of religiosity that surpasses other generations.<sup>46</sup> They reportedly pray less, are more atheistic and agnostic, are less likely to profess a particular faith, and are less likely to attend religious services. As a consequence, many members of this group lack religious and/or spiritual resources to foster coping and resilience.

Millennials are not taking their life at a higher rate than other generations, nor is there any data to suggest they may. But well-designed resilience programs can help Millennials prepare for,

recover from, and adjust to life in the face of stress, adversity, trauma, and tragedy in line with Navy resilience doctrine.

## ***Suicide is not connected to service accession waivers***

Historically high retention rates afford the Navy a unique opportunity to select the most qualified enlistees, with only 0.9 per cent of recruits currently requiring accession waivers. If retention rates drop in the future, the economy improves, and more accession waivers are required, Army data suggests that Navy suicide rates are not likely to rise.

Since 2001, Army recruiters have granted 57,475 conduct waivers and 10,699 drug waivers to meet operational needs. The perception is that this waived group may be more susceptible to suicide behavior. In reality, while the waived population (as a cohort) was more likely to have disciplinary issues directly related to their waivers, there was and currently is no data or evidence to support a risk of suicidal behavior.<sup>47</sup>

## ***Suicide clustering is rare and existing Navy guidance already incorporates best practices with regard to its prevention***

“A suicide cluster can be defined as a group of suicides or acts of deliberate self-harm (or both), that occur closer together in time and space than would normally be expected on the basis of statistical prediction and/or community expectation.”<sup>48</sup> Clustering occurs in only a very small fraction of suicides.<sup>49</sup>

Although clustering is rare, some evidence suggests that suicide may have a contagious effect where one suicide inspires others to do the same.<sup>50</sup> The Commanding Officer’s Suicide Prevention and Response Toolbox recognizes this fact and provides guidance on how to appropriately respond to a suicide to reduce the chances of contagion.

## ***Resiliency training can have a positive effect on individual readiness and may reduce the risk of suicide over time***

Expert opinion and recent studies highlight the importance of fostering resilience as a protective measure to prevent suicide. For example, according to the *2012 National Strategy for Suicide Prevention*, an effective suicide prevention program should:

- Stress the importance of resiliency
- Include resources to provide resiliency training
- Disseminate messages that promote resilience
- Contain guidelines for clinical practice that address building resilience.<sup>51</sup>

Likewise, the *Final Report of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces* states that “Military life, particularly in wartime, is inherently stressful on individuals and presents a unique challenge to maintaining wellness.

Efforts to enhance well-being, mental fitness, resiliency, and the development of life skills in Service Members will have significant impact on preventing suicide.”<sup>52</sup> The report’s view of the relationship between resilience and suicide prevention is perhaps best summarized in the following statement: “Wellness and fitness are essential to maintaining a healthy outlook on life. Therefore, the Task Force strongly believes that any effort to enhance the well-being, resiliency, life skills, and mental fitness of Service Members will have significant impact on preventing suicide as a primary prevention effort.”

These claims are echoed by the 2011 RAND study on *Promoting Psychological Resilience in the U.S. Military*. The RAND study involved a review of resilience literature and resilience programming to identify evidence-informed factors useful for promoting resilience among Service and family members. As a result of their study, RAND identified nine resilience factors, and five resilience programs demonstrating positive, if modest effects. As a consequence of their findings, RAND made a total of nine recommendations for policy and programming, all of which called for the continued employment of resilience training by the military.<sup>53</sup>

In addition to the RAND study, the Army has performed three scientific studies of CSF to determine its validity and efficacy. The most recent report was published in December of 2011 and concluded that there is sound scientific evidence that Master Resiliency Training (MRT) improves the resilience and psychological health of Soldiers.<sup>54</sup> More specifically, the report found:

- Soldiers receiving MRT exhibited better scores on eight of the dimensions/subscales used by the GAT to measure resilience and psychological health.
- Soldiers receiving MRT experienced significantly higher rates of growth in resilience and psychological health on four of the dimensions/subscales than those who didn’t receive the training.<sup>55</sup>

In a separate 2010 report, the Army noted that Soldiers who committed suicide measured lower in resilience and psychological health on the GAT than did other Soldiers.<sup>56</sup> The report was careful to note that this statistical observation does not establish a causal link between levels of resilience and suicide. Therefore, the relationship between resiliency training and suicide prevention, though reasonable, remains somewhat uncertain despite assertions to the contrary.<sup>57</sup>

The Task Force recognizes that suicide related behaviors are often rooted in mental health issues that are not positively influenced by resilience training and require medical and psychiatric interventions. Every effort must be made to reduce the stigma associated with behavioral health care and ensure Sailors are properly diagnosed and treated for psychological conditions which might lead them to harm themselves. Nevertheless, expert opinion and scientific evidence suggest that resilience training can have a positive impact on the individual readiness of most Sailors and may serve to reduce the risk of suicide throughout the force.

## ***Comprehensive “care for the caregiver” must be a critical element of Navy suicide prevention efforts***

Studies support the theory that counselors and medical personnel who work with the trauma of others have an increased likelihood of experiencing a change in their own psychological functioning.<sup>58</sup> Caregivers are trained to be compassionate, but there is little training in the military on how to handle the stresses of their jobs.<sup>59</sup> As evidence for this, Navy DoDSER data for 2011-2013 highlights an emerging trend of increasing suicide rates amongst Navy Hospital Corpsmen. Making up approximately 8 percent of the force, Hospital Corpsmen accounted for 22 percent of all Navy suicides in 2011 and 2012.<sup>60,61</sup>

There is an urgent need for caregivers at all levels to recognize and receive proper education and/or intervention and for leaders of caregivers to be vigilant for early signs of stress related behavior. The Task Force found that the DoD and the Navy are making significant efforts to provide “care for the caregiver” programs. However, as a critical element of suicide prevention, these programs must be strategically aligned as part of the Navy’s overarching prevention effort.

## ***A continuous “chain of care” for at-risk Sailors must be included as an element of Navy suicide prevention efforts***

A significant proportion of Sailors who commit suicide have a history of previous behavioral health care issues. The 2011 Navy DoDSER data indicates that almost 30 percent of suicides had some history of behavioral health care treatment, with nearly 10 percent receiving treatment within 30 days of the event. This data clearly indicates the need for a “chain of care” or “warm hand-off” approach when Sailors re-integrate into their units following behavioral health care treatment. Currently the Navy has no standard “chain of care” process.

The “warm hand-off” concept is the process by which a primary care provider directly introduces a client to a behavioral health provider at the time of the client’s medical visit. The “warm hand-off” is designed to establish an initial face-to-face contact between the client and the behavioral counselor and confer the trust and rapport the client has developed with the provider to the behavioral counselor.<sup>62</sup>

Within the military, the term “warm hand-off” encompasses the member’s operational chain of command as part of the “chain of care” approach. Military “warm hand-off” examples include:

- Person-to-person referral to a behavioral health care provider from a primary care manager, chaplain, or unit representative
- Transferring or transitioning between behavioral health care providers
- Investigative hand-off of those facing criminal or administrative action
- Communication of suicide risk factors between operational commands and intermittent caring contact by commands across transition points
- Re-integration of a Service member to their unit following behavioral health care

Multiple suicide prevention studies have cited a lack of communication between and among leaders and caregivers as a key finding. In the cases studied as part of the 2012 BUMED report on medical personnel suicides, “a marked failure to communicate the warning signs or risk factors detected by commands, providers, family members, or peers” was specifically cited as a causal factor.<sup>63</sup> Collectively, findings such as this can be described as a failure to enact some form of formal “warm hand-off” policy.

Though the DoD has recently published requirements for services to improve the continuity of care between providers, communication gaps between providers and Navy operational leaders remain. In many cases this is due to legal protections on the privacy of medical information though there are certain portions of these instructions that cite exceptions for Military members.

The Task Force found a continuous “chain of care” for at-risk Sailors is a critical element of any suicide prevention effort and that the Navy should develop a comprehensive policy promoting systematic and regular communication of risk factors between health care providers and operational commands.

## **V. Specific Findings and Recommendations**

### **Organization**

#### **Organizational Structure**

The analysis of Navy wellness programs identified three lines of effort: resilience promotion, behavioral healthcare, and suicide prevention/intervention and learning. A lead agency needs to be designated with the necessary authorities to direct policy, strategy, and resource management across these lines of effort. This lead agency must establish the overall Navy wellness strategy, manage resilience promotion, ensure consistent and universal access to behavioral healthcare for Sailors and high risk communities, and reinvigorate the suicide prevention program to include learning from previous suicide events.

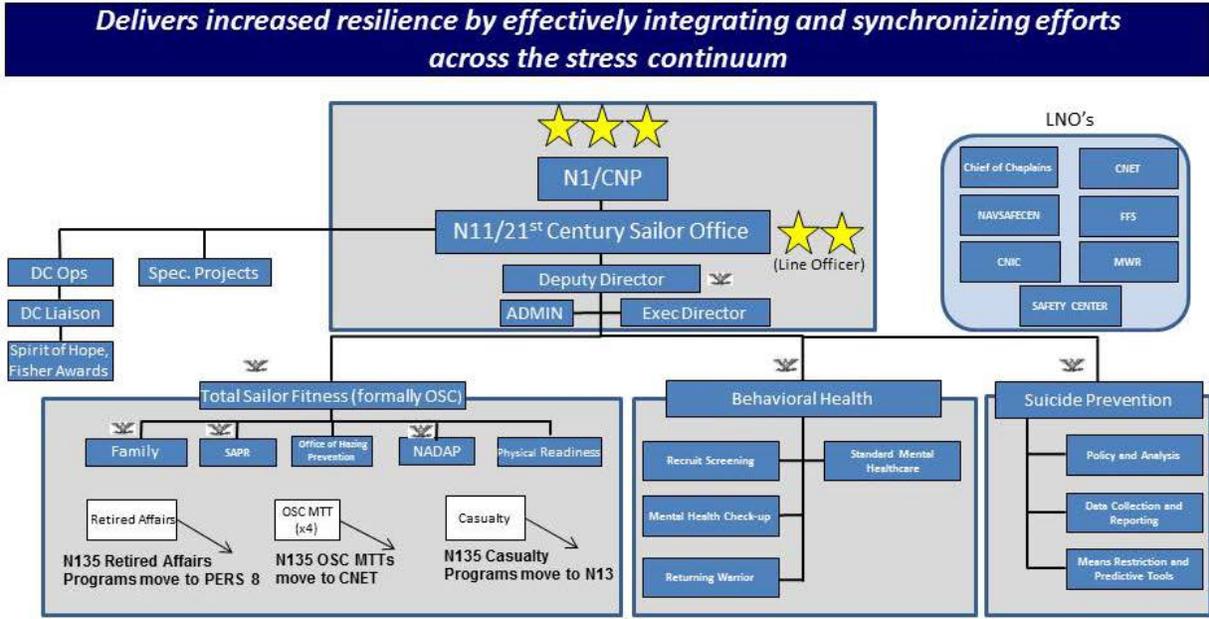
CNP currently has lead on the suicide prevention program and many programs that promote resilience and manage stress while BUMED is the lead for behavioral healthcare issues. Others play vital roles in the care continuum such as the Chief of Navy Chaplains, CNIC, the Naval Safety Center, and the Chief of Navy Reserves. In the end, the oversight agency must establish a registry of all programmatic efforts and have authority to make programmatic and policy decisions for the entire wellness enterprise.

These decisions must be informed by detailed data. In conjunction with program managers and community experts, the single oversight agency should develop metrics and measures that ensure program efficiency and effectiveness. Measures of effectiveness which inform decisions regarding program worth are particularly required. These measures of effectiveness should be applied across all programs to improve program quality and inform decisions regarding program continuance.

In conjunction with the development of measures of effectiveness, the Total Sailor Fitness Program office shall complete a comprehensive training and service delivery evaluation over the first six months in close cooperation with NETC, NAVSAFECEN, and CNIC's FFSCs.

Task Force Resilient's recommended organizational structure along the three broad lines of effort is depicted in Figure 5 below. This structure logically flows from the stress continuum informed by current OSC doctrine. The first branch, Total Sailor Fitness, manages the policy and programs that build and sustain resilience in the force. The second branch, Behavioral Health, manages policy and programs to screen and conduct mental health check-ups to identify Sailors that may be reacting to stress and need some assistance, to those that are injured or ill and require mental health care. Behavioral Health will also manage policy for mental health care to ensure that the injured or ill Sailor is tracked throughout the stress continuum and monitored once they return to a ready status. Finally, the Suicide Prevention Branch will investigate events, collect data, and provide lessons learned and recommendations to inform suicide prevention efforts in the Total Sailor Fitness and Behavioral Health branches.

# 21<sup>st</sup> Century Sailor Office



**Figure 6: Notional Design of 21st Century Sailor Office**

This organizational model fills gaps identified in our program analysis. The Navy's current efforts are organized with stress reduction and suicide prevention efforts in parallel with behavioral health care rather than along a continuum. This has resulted in a lack of screening and mental health check-ups organized with strategic intention; prevented effective "warm-handover" and post-intervention monitoring; and created disjointed, inconsistent, or duplicative efforts in the various programs created to address stress on the force. The organizational recommendations to follow are derived from this observation.

## Behavioral Health Screening and Checkups

Behavioral health screening remains an underutilized tool within the Navy. Limiting usage to specific communities or in response to personnel actions prevents the broader applicability to Navy-wide resilience efforts. The other Services have conducted effective testing in this area, and are realizing results from their efforts.

The Army is effectively using non-cognitive testing for recruits. These non-cognitive efforts attempt to measure skills not otherwise measured on the Armed Services Vocational Aptitude Battery (ASVAB). Measuring abilities such as leadership, coping, and adaptability, these metrics measure a Soldier's capacity to handle stress and serve as a valid initial proxy for resiliency. Use of such screening has measurably increased retention and reduced first term attrition

The Marine Corps, in conjunction with the Naval Health Research Center, has instituted a pilot program called the Recruit Assessment Program (RAP) which collects behavioral health data by means of voluntary questionnaire during boot camp. RAP's purpose is to establish baseline data for the Marine Corps, with an eye on measuring the impact of Service-related exposures on health; however it also is acknowledged as a potential tool for determining pre-existing issues which might be identified and treated. The BUMED review of Navy Medical personnel suicides recommended use of RAP within the Navy to establish a base line of pre-induction risk factors.

The BUMED Report and the DoD Task Force report also recommend periodic behavioral health reviews by medical personnel. Formal periodic screening could easily be incorporated by adding validated questions into the Periodic Health Assessment (PHA) form. Responses would act as a starting point for examination, and would provide a "flag" for further mental health assessment and assistance.

While the Navy has collected some limited baseline recruit behavioral health data in conjunction with the Army Research Institute's efforts, there is no formal usage to date. Behavioral health screenings are not used fleet-wide, instead they are localized to specific interest groups or they are reactive tools for personnel already demonstrating high-risk behavior. The Navy should develop policies for behavioral health screening of accessions and periodic behavioral health check-ups or screening for all personnel.

### Access to Lethal Means

Controlling access to lethal mean remains a highly controversial issue, but research supports that doing so for those who are vulnerable to suicide will reduce suicide events. The 2012 *National Strategy for Suicide Prevention* states that "Reducing access to lethal means makes it less likely that the person will engage in suicidal behaviors".<sup>64</sup> The DoD Task Force reports that "Empirical literature suggests that removal of access to lethal means for those deemed to be at acute risk may serve as a robust suicide prevention strategy."<sup>65</sup>

The DoD's data appears to support these claims. Firearms have historically been the prevalent method utilized in all fatal events over the collection period of the DoDSER, and their use is increasing. In 2012, over 60% of suicide decedents possessed or had access to a firearm in their residence.<sup>66</sup>

The Navy's Suicide Prevention Program instruction includes direction to commanding officers to "restrict access of at-risk individuals to means that can be used to inflict harm". There is no specificity on how commanding officers are to execute this policy, or any limits stated to its applicability. There is also no stated policy that allows Service members to voluntarily self-restrict their access, such as using Navy armories for storing personal weapons or encouraging the use of gunlocks. The Navy needs to promulgate current policy guidance which limits access to lethal means and, in conjunction with DoD, explore additional policies which limit such access.

## Recommended Actions

1. Establish CNP as VCNO's executive agent for Navy resilience and suicide prevention efforts.
  - 1.1 CNP shall create a 2-Star line officer led organization called the 21<sup>st</sup> Century Sailor Office (N11) to assume overall program lead of Navy's resilience and suicide prevention programs.
  - 1.2 N11 shall:
    - 1.2.1 Develop a strategic plan for Navy resilience and suicide prevention efforts.
    - 1.2.2 Consolidate existing resilience and suicide prevention programs under three branch offices. Each branch shall be responsible for cognizant policy, research and programs. The offices shall be:
      - o Total Sailor Fitness Program Office
      - o Behavioral Health Program Office
      - o Suicide Prevention Program Office
    - 1.2.3 Establish and maintain a comprehensive registry of resilience and suicide prevention programs.
    - 1.2.4 Establish system of metrics to measure program effectiveness.
    - 1.2.5 Capture efficiencies by reorganizing, combining, or deleting programs.
  - 1.3 Total Sailor Fitness Program Office shall:
    - 1.3.1 Oversee policy for all resilience and stress related efforts.
    - 1.3.2 Assume responsibility for the Office of Hazing Prevention (N137).
  - 1.4 Behavioral Health Program Office shall:
    - 1.4.1 Develop policy guidance for behavioral health screening of new recruits.
    - 1.4.2 Develop policy guidance for periodic behavioral health checkups for all personnel.
    - 1.4.3 Ensure consistency of behavioral health care by development of and training on Clinical Care Guidelines.
    - 1.4.4 Establish standard of care for returning warriors.
  - 1.5 Suicide Prevention Program Office shall:
    - 1.5.1 Coordinate all suicide related behavior data collection and reporting.
    - 1.5.2 Promulgate current policies to restrict access to lethal means.
    - 1.5.3 Coordinate with DoD/OJAG to explore policies to reduce access to lethal means.
    - 1.5.4 Examine suicide predictive methodologies for prevention efforts.
    - 1.5.5 Collect and promulgate suicide prevention best practices.

## ***Training***

### ***Comprehensive, Tiered, and Targeted Training Program***

The *2012 National Strategy for Suicide Prevention* provides recommendations regarding suicide prevention training that should be incorporated into Navy training efforts. Per the report, all community-based professionals who work with at-risk persons should be trained on how to address suicidal thoughts and behaviors and how to respond to those who have been affected by suicide. The report further recommends that this training be tailored to the specific needs and roles of the various providers and should be updated and refreshed over time.

Similarly, the DoD Task Force on the Prevention of Suicide by Members of the Armed Forces calls for front line supervisor training, state of the art life skills training, and creative curricula that addresses the knowledge/skills/abilities of trainee sub-populations, training for family members, and more specialized training for healthcare providers and chaplains. Efforts to de-stigmatize mental health should be incorporated at all levels. Similar findings are found in the *2012 Navy Medicine Review of Navy Medical Personnel Suicides*, the RAND study on *The War Within*, and in the Air Force suicide prevention program.

A Task Force Resilient survey of command master chiefs found some dissatisfaction with Navy suicide prevention training efforts. Nearly three times as many command master chiefs found current suicide prevention training to be effective versus those who didn't, but the number of those who didn't was sufficiently high to warrant attention. Moreover, many expressed the opinion that interactive training, similar in format to the recent Sexual Assault Prevention and Response Leadership/Fleet (SAPR L/F) training effort, is very effective. They cited interactive training as significantly more effective than the current model of GMT or computer-based training.

### ***Recommended Actions***

2. N11 shall further develop a comprehensive, tiered, targeted, improved, and adaptable resilience and suicide prevention training program including the following actions:
  - 2.1 Expand targeted training.
  - 2.2 Incorporate the OSC training continuum (renamed as Total Sailor Fitness (TSF)) into all facets of the Navy training continuum.
  - 2.3 Develop a family-centered resilience and suicide prevention/awareness campaign.
  - 2.4 Provide family-focused training curriculum for command triad and ombudsman delivery.
  - 2.5 Look for overlaps and opportunities to consolidate existing training requirements to reduce training burden on the fleet.

## **Assessment**

### **Coordinated Data Collection Effort**

The Task Force found that a wide variety of data on resilience and suicide prevention is collected for leadership situational awareness, including DoDSERs, situational reports, behavioral health quickpolls, and tone of the force metrics. However, the value of this collection is sub-optimized because there is no central office responsible for coordinating an enterprise-wide effort to leverage this data to achieve targeted effects. N11 should be the central manager of all data related to Sailor resilience and suicide prevention efforts. Coordinating with appropriate stakeholders, N11 should synchronize current data collection efforts, identify critical gaps in data collection, develop means to collect missing data, and perform data analysis to inform policy, training, and programmatic decisions.

### **Refined DoDSER Process**

The Task Force reviewed and concurs with the DoD's *Final Report on the Prevention of Suicide by Members of the Armed Forces* relative to suicide surveillance efforts. Specifically, the "DoD does not have an effective standardized approach to suicide surveillance with the current configuration of the Department of Defense Suicide Event Report (DoDSER), and it is sub-optimized for informing the improvement of Service suicide prevention programs. The inability of the DoDSER to access the current Defense Medical Surveillance System (DMSS) further degrades its potential as a real-time, effective, surveillance tool. Moreover, the investigation of both suicide attempts and completed suicides is not standardized, hindering the ability to modify surveillance tools (i.e., DoDSER). Furthermore, investigations are usually completed to either determine the cause of death (in difficult cases) or to determine if criminal activity was involved in the death: Investigations are generally not done to improve suicide prevention programs or prevent future suicides."<sup>67</sup>

The Navy Suicide Prevention Program instruction directs DoDSER reporting by commanding officers or Medical Treatment Facilities (MTF) depending on the outcome of the event. There is no requirement for lower echelon commanders to review the report to ensure compliance. Compliance is currently met by the program office engaging directly with the commanding officer. This prevents the echelon commander from maintaining oversight and performing trend analysis to inform future preventive efforts.

### **Recommended Actions**

3. N11 shall improve data quality for resilience and suicide prevention efforts by:
  - 3.1 N11 shall coordinate with stakeholders to develop a comprehensive data collection plan for resiliency and suicide prevention efforts.
  - 3.2 Supporting DoD/DoN in execution of DoD Task Force recommendations regarding DoDSER revision and improvement.
  - 3.3 Updating the Navy Suicide Prevention Program instruction to include:

- Echelon 2 and 3 responsibilities for tracking DoDSEER compliance.
- Requirement to brief first Flag Officer in the chain of command for all suicide events.
- Coordination between the Suicide Prevention Program Office and NAVSAFECEN for dissemination of lessons learned from suicide events.

3.4 Ensuring investigation protocols focus on events leading up to a suicide/suicide event with a view to identifying and reporting root causes and potential points of intervention which can further inform future suicide prevention efforts.

3.5 Ensuring sufficient data analysis staffing is available to support data-informed policy decisions.

## **Care**

### *Access to Behavioral Health Services*

Access to behavioral health care is crucial to promoting resilience and preventing suicide in the force. This fact was recognized by every major study the Task Force consulted. Access can be attained in a variety of ways from hiring additional behavioral health care specialists, to providing hotline and online services, to realigning the current inventory of providers to deliver embedded services within specified units. Any effort to promote resilience and prevent suicide must seek to increase access to behavioral health services.

### *Risk Mitigation Through Collaborative Care*

Multiple studies have cited a lack of communication between and among leaders and caregivers as a gap in patient care. The interaction between commands and caregivers is frequently not formalized. Rather, this interaction may be left to the discretion of the caregiver who decides what the command needs to know, and the command may not be consulted to provide potentially valuable insight that might affect patient treatment. Communication regarding patient issues has historically fallen under the umbrella of doctor-patient privilege; however, there is potentially great value in fostering a more collaborative type of patient care.

In addition to formalizing communication between commands and caregivers, there is currently no requirement for a “warm handoff” of at-risk personnel. This lack of a required “hands-on” turnover of an at-risk Sailor creates potential gaps in care during an already stressful period. Likewise, a significant percentage of suicides occurs in the context of an investigation into a serious offense. In many of these instances, commanders are aware of increased risk factors but do not automatically direct individuals to qualified caregivers such as chaplains or mental health professionals for proactive counseling and care to include safety planning.

Finally, Service members in transition warrant additional attention and concern. Transitions might be normal, such as initial accession or a PCS move, or they may result from an event such as LIMDU or a school failure. Regardless of cause, Sailors and family members typically experience increased stress during transition coupled with decreased support caused by the

disruption of their support network. Any effort to promote resilience and prevent suicide must mitigate risks by establishing policies that foster greater collaboration within commands, between commands, and between commands and service providers.

### Standards of Care

There is a recognized lack of standardization within the Navy's mental health care system. The BUMED review noted that "the absence of a specific Clinical Practice Guideline (CPG) for Suicide Assessment and Treatment/Safety Planning complicates the implementation of standardized, evidence-informed assessment and management of suicidal patients."<sup>68</sup> It goes on to state that "health care providers (also non-medical providers like Chaplains or CNIC FFSC counselors) are not uniformly aware of or trained to provide evidence-informed interventions."<sup>69</sup> This results in a system that is hard to objectively assess and improve. More importantly, it means that the standard of care may differ from provider to provider and from MTF to MTF.

The Navy can combat this by providing clinicians and MTFs with evidence-informed guidance on intervention actions. Guidance and best practices should be consolidated and promulgated through the program office to ensure standardization throughout the enterprise.

### Recommended Actions

4. N11 and BUMED shall review means to increase access to behavioral health services, to include embedding more behavioral health practitioners in operational units.

4.1 Provide additional training for independent duty corpsmen and use frontline supervisor/deckplate leader trained personnel as extenders to behavioral health specialists.

5. N11 shall ensure continuity of behavioral health care, especially during times of increased risk and transition by developing policies that:

5.1 Institute formal Navy "warm handoff" procedures.

5.2 Develop sponsor-program improvements to counter non-medical transition risks.

5.3 Establish limited release procedures enabling caregivers and command leaders to communicate sensitive information regarding Sailors' behavioral health issues.

5.4 Establish procedures supporting a seamless transition between caregivers at different locations and different levels within the care continuum.

5.5 Ensure individuals in the midst of disciplinary issues are aware of and have access to chaplaincy and behavioral health care services.

6. N11 and BUMED shall enhance quality of behavioral health care to suicidal patients through increased standardization and implementation of currently accepted practices in the field.

## ***Learning and Culture Change***

### ***Enhanced Strategic Communications***

A consistent barrier to a Sailor seeking mental health assistance is the stigma associated with the subject. A cohesive, transparent and honest communications plan from Navy leadership can reduce the stigma associated with mental health and drive a change in the Service's culture. This change will require regular multi-source communication throughout the force.

Personal Readiness Summits were previously used as a means to promulgate a standardized readiness message to the fleet but were cut for budgetary reasons. These summits were facilitated by N135 in fleet concentration areas, and invitees included command triads, ombudsmen, chaplains, and local support services. The summits provided raw data and analysis directly to those who deliver training and services and their use should be reinstated as part of the Navy's strategic communication plan.

### ***Command Wellness Councils***

While the Career Review Board process looks at performance and career metrics for Sailors within a command, there are gaps on the human side that are not reviewed or assessed. Specific information regarding potential stressors on an individual are not addressed unless they have already affected performance, a lagging indicator which has limited value.

The aviation community incorporates a quarterly human factors board, reviewing aircrew members in a more holistic manner to assess their mental aptitude for operating aircraft. This concept is seen by the Task Force as easily adaptable for use in assessing individual wellness. Periodic wellness councils would give commanders a formal process to gain insight into potential issues before they result in degraded performance or other negative outcomes.

### ***Data-Informed Decisions***

The Task Force concurs with both the BUMED and DoD Task Force reports in citing the need to make data-informed decisions to improve programs and policies. Data collection and analysis must foster a culture of continuous learning and process improvement. N11 should manage data collection efforts across the resilience and suicide prevention spectrum and develop a process to continuously analyze and employ data in shaping policies, programs, and training efforts that address resilience and suicide prevention efforts.

### ***Recommended Actions***

7. N11 shall develop an improved and comprehensive strategic communications plan.
  - 7.1 Conduct an aggressive stigma reduction campaign.
  - 7.2 Reinstitute Personal Readiness Summits.

8. N11 partner with NAVSAFECEN to develop policies and practices for command-led Personnel Readiness/Wellness Councils.
9. N11 shall develop comprehensive process to ensure data-informed decision making.

## **VI. Conclusion**

The three tenets of the Chief of Naval Operations' Sailing Directions are:

- Warfighting First
- Operate Forward
- Be Ready

Building resilience and preventing suicide are essential to producing a force that is always ready to operate forward and execute its warfighting mission.

Task Force Resilient discovered numerous Navy programs supporting resilience, combatting suicide, and battling other negative behaviors. Program managers are to be commended for their excellent efforts. The Navy is better for what they do. However, the Task Force also found that these programs are not part of an integrated and synchronized strategy designed to maximize the efficient and effective use of resources to produce total force fitness. Reorganization of effort is required to bring about this integration and synchronization.

Additional measures regarding policies and procedures will follow naturally once an executive agent is established to direct and coordinate the Navy's resilience and suicide prevention efforts. Those policies and procedures will touch on issues of organizations, training, assessment, access to care, and leadership and culture. Without the establishment of an overarching executive agent, changes in policy and procedures will only provide marginal gains but perpetuate an uncoordinated effort addressing personnel readiness issues. Efficiency and effectiveness will continue to be undermined.

Reorganization can be effected rather quickly. Policy and procedural changes will take additional time. Initial operating capability can be attained within six months; full operating capability within 18 months; and steady state within 30 months after initiation of reorganization.

While detailed cost estimates must be provided by the executive agent as part of its strategic plan, the Task Force estimates that reorganization will be approximately cost neutral. Policy and procedural changes are harder to estimate, but most consist of using current people and programs more efficiently – not developing additional programs.

The Task Force strongly believes that the Navy will see the benefits of better integration and synchronization within 18 months of initial reorganization. These benefits will reach from the strategic to the tactical levels. Strategic effects will include improved resilience throughout the force, reduced stigma surrounding behavioral health care, fewer suicides, greater unity of effort, and less programmatic duplication resulting in savings which can be reinvested in the fleet. Tactical effects will include better outreach to Sailors and families, improved programs, and streamlined training that reduces the training burden at the deckplates. Strategic and tactical effects will combine to increase overall readiness to support forward operations and warfighting proficiency in line with the Chief of Naval Operation's guidance.

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# Appendix A – Plan of Action and Milestones

Task Force Resilient Plan of Action and Milestones (POA&M)						
Recommendation Number	Action	Time to Complete	OPR	OSR	Scheduled Completion Date	Status
1.0	VCNO establishes N1 as EA for Navy resilience and suicide prevention efforts via NAVADMIN	T+1 Month	VCNO			
1.1	N1 establishes authorities and responsibilities of 21st Century Sailor Office	T+1 Month	N1			
1.3.2	N1 directs the Office of Hazing Prevention (N137) to be moved under the authority of the TSF office	T+1 Month	N1			
1.1	N1 announces 2-Star line officer to lead 21st Century Sailor Office	T+6 Months	N1			
1.2.2	N11 Develop the organizational structure for the 21st Century Sailor Program o Coordinate with BUPERS for billets for 21st Century Sailor Program o Establish initial doctrine that will outline the authorities and responsibilities of each department within 21st Century Sailor Program	T+6 Months	N11	BUPERS		
1.2.2	N11 Determine the location of, and ensure sufficient administrative and logistic support in place for establishing the 21st Century Sailor Program	T+6 Months	N11	N135		
1.2.2	N11 Name the program offices for 21st Century Sailor Program, assign branch heads and personnel	T+6 Months	N11			
1.2.2	Branch Offices Establish initial office policy and protocols, battle rhythms, etc	T+6 Months	N11	SP Program Office/ BH Office/ TSF Program Office		
2.1	BH Program Office develop and implement targeted suicide awareness training for hospital corpsmen	T+6 Months	BH Program Office	BUMED		
5.4	BH Program Office review policies for caregiver transition management and make recommendations for change to N11	T+6 Months	BH Program Office	BUMED		
5.1	BH Program Office develop a "warm handoff" program instruction using the DoD policy as a guide	T+6 Months	BH Program Office	BUMED		
2.2	TSF Program Office develop the TSF training continuum into all facets of the training continuum with goal of reaching all deployers in year one	T+6 Months	TSF Program Office			
3.5	SP Program Office analyze staffing needs for data analysis and hire personnel	T+6 Months	SP Program Office	BUPERS		
1.2.2	Branch Offices conduct initial analysis of existing programs, including alignment within the N11 organization and their internal measures of effectiveness	T+6 Months	SP Program Office/ BH Office/ TSF Program Office			
1.5.2	SP Program Office promulgate specific guidance on current policies regarding restricting access to lethal means via NAVADMIN	T+6 Months	SP Program Office			
7.1	TSF Program Office develop an aggressive stigma reduction campaign	T+6 Months	TSF Program Office	PAO		
1.2.1	N11 holds conference with DoD and Navy stakeholders (CNIC, Chief of Chaplains, BUMED, NAVSAFECEN, CNRC, Program Offices) to discuss way ahead for developing the strategic framework for 21st Century Sailor Program	T+6 Months	N11	CNIC, Chief of Chaplains, BUMED, NAVSAFECEN, CNRC, Program Offices		
1.2.1	N11 writes strategic plan for 21st Century Sailor Program (coord with DoD and stakeholders)	T+6 Months	N11			
1.2.1	N11 Strategy for 21st Century Sailor Program to stakeholders for chop	T+6 Months	N11			
1.2.1	N11 Strategy for 21st Century Sailor Program to N1 for approval	T+6 Months	N11			
1.2.1	N1 Approves Strategy for 21st Century Sailor Program	T+6 Months	N1			

1.2.1	N11 Strategy for 21st Century Sailor Program promulgated to fleet	T+6 Months	N11			
2.5	TSF Program Office conduct review of current program training products and make recommendations for consolidation/revision to N11	T+6 Months	TSF Program Office	NETC, NAVSAFECEN, FFSC		
3.3	Update the Navy Suicide Prevention Program instruction to include: <ul style="list-style-type: none"> <li>Echelon 2 and 3 responsibilities for tracking DoDSER compliance</li> <li>Requirement to brief first Flag Officer in the chain of command for all suicide events</li> <li>Coordination between the Suicide Prevention Program Office and NAVSAFECEN for dissemination of lessons learned from suicide events</li> </ul>	T+6 Months	SP Program Office	NAVSAFECEN		
4.0	BH Program Office conduct analysis of adequacy of behavioral health manpower pool under projected policies (including requirements from additional screening and checkups, potential expansion of embedded practitioners, etc.) and make tiered recommendations to N11	T+1 Year	BH Program Office	BUMED		
4.0	N11 make recommendations to N1 for additional behavioral health practitioners hirings and anticipated billet structure	T+1 Year	N11	BUMED		
6.0	BUMED assign a Suicide Prevention Program coordinator at each MTF to ensure the adherence to standardized policies and practices	T+1 Year	BUMED			
6.0	Chief of Chaplains assign a Suicide Prevention Program coordinator within the Chaplain Corps to ensure the adherence to standardized policies and practices	T+1 Year	N097			
6.0	CNIC assign a Suicide Prevention Program coordinator to ensure the adherence to standardized policies and practice	T+1 Year	CNIC			
1.4.2	BH Program Office develop format and policies (to include data collection) for periodic behavioral health checkups of all Navy personnel	T+1 Year	BH Program Office	BUMED/OJAG		
1.2.3	Branch Offices Consolidate program listings under their cognizance	T+1 Year	SP Program Office/ BH Office/ TSF Program Office			
5.2	TSF Program Office review adequacy of current Navy sponsor program instruction for transition management by both receiving and departing commands	T+1 Year	TSF Program Office			
1.5.5	SP Program Office develop means and periodicity for promulgating prevention best practices to the fleet	T+1 Year	SP Program Office			
1.2.5	Program Offices conduct in-depth analysis of cognizant programs and make recommendations for reorganizing, combining, or deleting programs	T+1 Year	SP Program Office/ BH Office/ TSF Program Office			
1.2.5	N11 Approve final program registry for each Branch Office	T+1 Year	N11			
1.2.4	N11 Consolidate metrics from branch offices	T+1 Year	N11			
1.2.4	N11 Develop overall program metrics for 21st Century Sailor Program	T+1 Year	N11			
1.2.3	N11 Incorporate Program Registry into the 21st Century Sailor Program Instruction	T+1 Year	N11			
1.2.4	N11 Incorporate metrics into the 21st Century Sailor instruction	T+1 Year	N11			
1.1	N11 Develop and promulgate 21st Century Sailor program instruction	T+1 Year	N11			
1.4.1	BH Program Office develop format and policies (to include data collection) for behavioral health screening of new accessions	T+18 Months	BH Program Office	BUMED/OJAG		

1.4.1	BUMED ensure sufficient behavioral health staff (or outsourced support) at Recruit Training Center and MEPS to accommodate screening efforts of new recruits	T+18 Months	BUMED		
1.4.2	BUMED ensure sufficient behavioral health staff (or outsourced support) to accommodate screening efforts of personnel identified through periodic checkups	T+18 Months	BUMED		
1.5.3	SP Program Office conduct further study on further expansion of reducing access to legal means for at-risk personnel	T+18 Months	SP Program Office	DoD/OJAG	
3.2	SP Program Office review DoD Task Force and BUMED recommendations regarding DoDSER revision and improvement	T+18 Months	SP Program Office		
3.2	SP Program Office review existing DoDSER format with eye on format improvement, database interfaces, and standard reports and make recommendations for changes to N11	T+18 Months	SP Program Office		
3.4	SP Program Office develop comprehensive suicide investigation protocol with a view on identifying and reporting root causes and potential points of intervention	T+18 Months	SP Program Office	NCIS	
2.5	N11 review and approve changes to consolidated/revised training programs	T+18 Months	N11		
2.1	SP Program Office conduct data analysis to periodically (at least annually) assess the need for addition or deletion of targeted training groups and make recommendations to N11 for changes	T+18 Months	SP Program Office		
2.3	N11 develop a family centered resilience and suicide prevention campaign	T+18 Months	N11	TSF Program Office/BUMED/Chief of Chaplains/CNIC	
5.3	BH Program Office OJAG develop limited release procedures enabling caregivers and command leaders to communicate sensitive information regarding Sailors' behavioral health issues	T+18 Months	BH Program Office	OJAG	
6.0	BH Program Office develop Navy specific Clinical Practice Guideline for Suicide Assessment and Treatment/Safety Planning	T+18 Months	BH Program Office	BUMED	
5.5	TSF Program Office develop a policy similar to the USAF Limited Privilege Suicide Prevention (LPSP) Program (AFI 44-109) requiring commands to notify individuals who are being investigated for criminal and other serious offenses of the different behavioral health caregiver assistance programs available.	T+18 Months	TSF Program Office	OJAG	
1.4.1	BH Program Office implement accessions behavioral health screening	T+2 Years	BH Program Office	NRC	
1.4.2	BH Program Office implement periodic behavioral health checkups	T+2 Years	BH Program Office	NRC	
1.5.4	SP Program Office conduct further study on suicide predictive methodologies for suicide prevention efforts	T+2 Years	SP Program Office	CNA	
2.2	N11 ensure mandate for TSF training included in 21st Century Sailor instruction update	T+2 Years	N11		
2.2	TSF Program Office implement the TSF training continuum into all facets of the training continuum.	T+2 Years	TSF Program Office		
2.4	TSF Program Office deliver training product for command triad/Ombudsmen implementation for a family centered resilience and suicide prevention campaign	T+2 Years	TSF Program Office		
5.3	TSF Program Office deliver training on revised caregiver to command communications.	T+2 Years	TSF Program Office	BH Program Office	
7.1	TSF Program Office implement an aggressive stigma reduction campaign	T+2 Years	TSF Program Office	PAO	

2.5	TSF Program Office promulgate revised training continuum to the fleet	T+2 Years	TSF Program Office			
3.2	N11 coordinate with DoD/DoN in recommending changes to DoDSER	T+2 Years	N11			
3.4	SP Program Office revise Navy Suicide Prevention Program instruction to reflect updated investigation protocol	T+2 Years	SP Program Office			
3.4	SP Program Office use revised data from suicide event investigations to make data informed recommendations for training and programmatic improvement	T+3 Years	SP Program Office			
7.2	TSF Program Office reinstitute Personal Readiness Summits	T+3 Years	TSF Program Office			
8.0	TSF Program Office develop and implement policies for command-led Personnel Readiness/Wellness Councils	T+3 Years	TSF Program Office	NAVSAFECEN		
8.0	TSF Program Office integrate Personnel Readiness/Wellness Councils training into the Command Leadership School continuum	T+3 Years	TSF Program Office			

# Appendix B: Program Assessment

## Tier 1 Program Assessment

Tier 1: Mission and desired outcome is specifically stated to influence suicide prevention or stress control.										Alignment and Leadership	Policies and Processes	Resources	Training and Support Programs	Metrics	Communications and Messaging	Developed	Mandatory	Used	Duplicative/Overlap	Effectiveness	
Tier 2: Mission and desired outcome is not specific to suicide prevention but one or more of its objectives may impact suicide prevention or risk/protective factors that influence suicide prevention.																					
Tier 3: Mission and desired outcome is not specific to suicide prevention but it may have tertiary effects that contribute to prevention of suicide.																					
Research: Tier 2 and 3 programs which are research projects only and do not provide any actual services to Sailors .																					
Program	POC	Category	Cost-FY12	FTE	# Served	Instruction Authority	Supported Unit	Supporting Unit	SUMMARY												
Returning Warrior Workshop		1	1,500,000	Varies by contract	11,686	N095	BUMED	CNRF	Meets the "post-deployment" requirement of the yellow ribbon reintegration program through weekend retreats.							FY08	NO	YES	PHOP/WWR LCC/REACH/SPRINT	Wholisticly reorganize mental health care to strategically capture entire Sailor population with appropriate level of resources, then target specifically where needs exist.	
Navy MORE (My Ongoing Recovery Experience) Program, * Has a Subset in Tier 3		1	556,200	9	7,000	DNS	BUMED	BUMED	12-18 month web and phone-based recovery management and aftercare/continuing care support system. Navy MORE will also provide a 24/7 suicide prevention hotline.							FY09	NO	PARTIAL	*	Wholisticly reorganize mental health care to strategically capture entire Sailor population with appropriate level of resources, then target specifically where needs exist.	
Navy Center for Combat Operational Stress Control		1	8,100,000	45	ES	DNS	BUMED	M9 NCCOSC	Comprehensive programs that educate service members, decrease stigma, build resilience and research and promote best practices in treatment of combat and operational stress injuries.							FY08	NA	YES	NOSC/NSWRP/OSC FAMILY	Wholisticly reorganize mental health care to strategically capture entire Sailor population with appropriate level of resources, then target specifically where needs exist.	
Behavioral Health Integration Program-2011		1	5,420,000	*	3,977	BUMED	BUMED	Regions, M3/5, M9, L Clinics	Improve health and well being through the effective and efficient treatment of mental health and health behavior concerns.							FY12	*	YES	RWW/WWR LCC/REACH/SPRINT	Wholisticly reorganize mental health care to strategically capture entire Sailor population with appropriate level of resources, then target specifically where needs exist.	
Heartmath Coherence Advantage Training for Deploying Detainee Operators	BUMED	1	428,152	4	513	DNS	BUMED	Regions, L Clinics	Predeployment sessions using biofeedback, self-regulation, and coherence techniques that support mental health resilience in Sailors deploying in support of Detainee Operations.							FY10	YES - DETAINEE OPS ONLY	YES	COSC/OSC	Wholisticly reorganize mental health care to strategically capture entire Sailor population with appropriate level of resources, then target specifically where needs exist.	
Reintegrate Educate and Advance Combatants in Healthcare (REACH)		1	981,000	*	98	DNS	BUMED	M1	Supports wounded warriors throughout their recovery as they reintegrate back to active duty or transition to veteran status.							FY11	NO	YES	RWW/WWR LCC/BHIP/SPRINT	Wholisticly reorganize mental health care to strategically capture entire Sailor population with appropriate level of resources, then target specifically where needs exist.	
Special Psychiatric Rapid Intervention Team		1	*	*	1100	DNS	BUMED	*	Quick reaction force of mental health professionals and chaplains designed to provide short term mental health support to a command immediately after a traumatic event.							*	NO	YES	RWW/WWR LCC/BHIP/REACH	Wholisticly reorganize mental health care to strategically capture entire Sailor population with appropriate level of resources, then target specifically where needs exist.	
Navy & Marine Corps Reserve Psychological Health Outreach Programs		1	5,713,675	55+	32,240	DNS	BUMED	MTF, Regional Reserve Commands	Behavioral screenings, mental health care referrals/coordination/follow-up for reservists and their families.							FY08	*	YES	RWW/WWR LCC/BHIP/REACH/SPRINT	Wholisticly reorganize mental health care to strategically capture entire Sailor population with appropriate level of resources, then target specifically where needs exist.	
USMC WWR Licensed Clinical Consultants (N95)		1	1,500,000	11	1200	CNO	BUMED	M9 WWR Medical Cell	Assistance to wounded, ill and injured Marines, Sailors assigned to Marine units, and their families throughout the recovery process, specifically in regard to Psychological Health (PH) issues—including PTSD—and Traumatic Brain Injury (TBI).							FY08	*	YES	RWW/PHOP/BHIP/REACH/SPRINT	Wholisticly reorganize mental health care to strategically capture entire Sailor population with appropriate level of resources, then target specifically where needs exist.	
Operational Stress Control (OSC) Program		1	1,400,000	6	*	CNO	N1	N135	Conducts enhanced skills training to navigate the pitfalls of an operationally stressful environment to include avoiding negative coping mechanisms and high risk behaviors.							FY08	YES	YES	NCCOSC/NSWRP/OSC FAMILY	Reorganize entire OSC enterprise under strategic leadership with appropriate controls and MOE's.	
Navy OSC Mobile Training Team	N135	1	*	24	*	N1	N135	NOSC	1 East Coast and 1 West Coast team that conducts OSC training courses. Teaches enhanced skills to navigate pitfalls of operationally stressful environment, including avoiding negative coping mechanisms.							FY08	NO	YES	NCCOSC/NSWRP/OSC FAMILY	Falls under new strategic OSC leadership.	
Navy OSC Leader	N135	1	439,000	Included in OSC MTT #'s	*	N135	NOSC	OSC MTT	Course of training conducted by NOSC MTT. Tains leaders/ representatives who help facilitate OSC initiatives.							FY08	NO	YES	NCCOSC/NSWRP/OSC FAMILY	Falls under new strategic OSC leadership.	
Navy Suicide Prevention Program OPNAVINST 1720.4A		1	1,000,000	6	ES	CNO	N1/VCNO	CNET, N135, BUMED, CMC, CNIC, CO	Provides policy, procedures and assigns responsibilities for the Navy's suicide prevention program.							FY05	YES	YES	VARIOUS	Comprehensive reconstruction under new Navy suicide prevention strategy.	
Navy Wounded Warrior - Safe Harbor		1	4,500,000	43	970	CNO	CNIC	CNIC N95	Navy Wounded Warrior (NWW) - Safe Harbor coordinates the non-medical care of seriously wounded, ill and injured Sailors and provides resources and support to their families to ensure enrollees' successful recovery, rehabilitation and reintegration.							*	NO	YES	RWW/BHIP/WWR LCC/REACH/SPRINT	Wholisticly reorganize mental health care to strategically capture entire Sailor population with appropriate level of resources, then target specifically where needs exist.	
Navy Wounded Warrior Anchor Program	CNIC	1	172,800	1	78	CNO	CNIC	CNIC N95	Navy Wounded Warrior - Safe Harbor's Anchor Program solidifies the Navy's covenant to provide "lifetime support" to seriously wounded, ill and injured Sailors. The Anchor Program matches a Sailor or Coast Guardsman returning to his or her local community with two mentor volunteers that will provide local support and assistance.							*	NO	YES	NO	Volunteer program	
Naval Special Warfare Resilience Program	NECC	1	9,586,047	27	5757	*	*	*	Provides mechanism for individual service and family members to strengthen and build resilience in order to maintain a healthy lifestyle and quality job performance despite experiencing crisis or trauma.							FY08	YES	YES	NCCOSC/NOSC/OSC FAMILY	Reorganize entire OSC enterprise under strategic leadership with appropriate controls and MOE's.	

- Navy Installations Command program
- Navy Marine Corps Health Center program
- MWR program
- Naval Safety Center program
- NETC program
- N1 program
- BUMED program

\*Not Provided or Unknown  
ES = End Strength

Significant obstacles to meeting mission and objectives  
Partially meets mission and objectives  
Meets mission and objectives

Investigate Further  
Capture Efficiencies  
No Change

# Appendix B

## TIER 2 PROGRAM ASSESSMENT

Tier 1: Mission and desired outcome is specifically stated to influence suicide prevention or stress control.									Alignment and Leadership	Policies and Processes	Resources	Training and Support Programs	Metrics	Communication and Messaging	Developed	Mandatory	Used	Duplicative/Overlap
Tier 2: Mission and desired outcome is not specific to suicide prevention but one or more of its objectives may impact suicide prevention or risk/protective factors that influence suicide prevention.																		
Tier 3: Mission and desired outcome is not specific to suicide prevention but it may have tertiary effects that contribute to prevention of suicide.																		
Research: Tier 2 and 3 programs which are research projects only and do not provide any actual services to Sailors.																		
Program	POC	Category	Cost-FY12	# Served	Instruction Authority	Supported Unit	Supporting Unit	SUMMARY										
Families Overcoming Under Stress (FOCUS)	BUMED	2	9,217,653	671	DNS	BUMED	MTF	"Family centered resiliency services." Provides training, skill building and referrals.							FY08	NO	YES	FFS/FAP/FRG/ OMBUDSMAN
Mobile Care Team		2	O&M	1,207	DNS	BUMED	MCT	In theater psychological support/surveillance of IA's.							FY06	YES	YES	
Post-Deployment Health Reassessment		2	*	*	*	*	*	*	Funding stream for various post-deployment programs. List not provided.						*	*	*	
Increased Access to Psychological Health		2	21,000,000	*	DNS	BUMED	MTF	Program supports the ultimate goal of increasing the capacity to provide AD direct mental health care at Navy MTF's for Sailors and family members. Approx 250 FTE's average across multiple years.							FY07	NO	YES	
Divine/Religious Services	N097	2	*	*	CNO	N097	Unit Chaplains	Religious services provided ashore and afloat by Navy chaplains on daily or weekly basis.							1775	NO	YES	
Religious Ministry Support to Individual Augmentees		2	2xFTE	4k	USFFC	USFFC Chaplain	USFFC Chaplains	Initial and ongoing contact by chaplains to IAs to provide support.							FY11	NO	YES	
Navy Chaplains Religious Enrichment Development Operation (CREDO)		2	900,000	3,904	CNO	N097	CNIC	Provides retreats and workshops to strengthen marriages, family relationships, personal resilience, and unit cohesion - includes suicide prevention training and Sailor retention efforts.							1971	NO	YES	
Cooperative Religious Ministry		2	*	ES	N097	USFFC PACFLT CNIC	Unit Chaplains	Establishes minimum standard of care delivered by duty chaplain in response to suicidal behavior, sexual assault, domestic violence, substance abuse, acute combat/operational stress, CACO, IA support, etc.							FY11	NO	YES	
Spiritual Fitness Guide		2	*	*	N097	N097	Unit Chaplains	Self-assessment tool modeled after the COSC continuum which assists Sailors in assessing their own spiritual condition. Accompanying referral tool provides framework for caregivers to determine when to refer personnel to chaplain.							FY11	NO	YES	
ChaplainCare		2	*	ES	N097	CNIC	Space & Naval Warfare	Online portal which provides resources and 24/7 duty chaplain access for Sailors and their families.							1999	NO	YES	
Religious Ministry Team Resiliency Retreat		2	Provided via CREDO Funding	127	USMC REL	MEF	BUMED, USMC Com. Services	Three day weekend retreat designed to provide care and decompression of Religious Ministry Teams who have recently returned from Marine combat deployments. The retreat focuses on issues of reintegration.							FY11	*	YES	NCCOSC/NOSC
Substance Abuse Rehabilitation Program		N1	2	*	7,000	CNO	N1	N135	Rehab for service members.							1960's	YES	YES
Sexual Assault Prevention and Response	2		512,000	ES	CNO	N135	CNIC, COs	Navy task force (under N1). Sexual Assault Prevention Training and response.							1994	YES	YES	
Family Advocacy Program	2		*	ES	CNO	N135	Chaplains, CNIC, BUMED, JAG, PERS-8, COs	Provides a consistent, standardized response to incidents of domestic or child abuse.							*	*	*	
Navy Family Ombudsman Program	2		*	*	CNO	N1	CNIC, COS, CNET, N13	The Navy Family Ombudsman Program is a Navywide program established to improve mission readiness through improved family readiness.							1970	NO	YES	FRG
Personal Financial Management	2		*	ES	CNO	N1	CNIC, COS, FFSC	Provides education, counseling information and referral to Navy personnel and commands in order to increase personal, family, and operational readiness.							*	YES	YES	
Family Readiness Groups	2		*	*	CNO	N1	CNIC, COS, USFF	A private organization, closely affiliated with command, comprised of family members, Sailors, and civilians associated with the command and its personnel, who support the flow of information, provide practical tools for adjusting to Navy deployments and separations.							*	NO	YES	OMBUDSMAN
Health Promotion and Wellness	2		*	*	BUMED	*	*	Innovative and evidence-based health promotion and wellness programs and services that facilitate readiness and resilience, prevent illness and injury, hasten recovery, and promote lifelong healthy behaviors and lifestyles.							FY12	NO	YES	21st Century Sailor/NCCOSC/ NOSC
Military and Family Life Counselor Program	PERS-61		2	*	*	CNO	*	*	Offers short-term, non-medical counseling to service members and their families as well as DoD Civilian Expeditionary Workforce members and their families.						*	*	*	

Navy Installations Command program	NETC program
Navy Marine Corps Health Center program	N1 program
MWR program	BUMED program
Naval Safety Center program	N097 program

\* Not provided or unknown  
ES = End Strength

	Significant obstacles to meeting mission and objectives
	Partially meets mission and objectives
	Meets mission and objectives

# Appendix B

## TIER 3 PROGRAM ASSESSMENT

Tier 1: Mission and desired outcome is specifically stated to influence suicide prevention or stress control. Tier 2: Mission and desired outcome is not specific to suicide prevention but one or more of its objectives may impact suicide prevention or risk/protective factors that influence suicide prevention. Tier 3: Mission and desired outcome is not specific to suicide prevention but it may have tertiary effects that contribute to prevention of suicide. Research: Tier 2 and 3 programs which are research projects only and do not provide any actual services to Sailors.								
Program	POC	Tier	Cost-FY12	# Served	Instruction	Supported	Supporting	SUMMARY
Family Emergency Response & NFAAS	CNIC	3	86,000	ES	CNO	N1	CNIC	Account, manage and monitor the recovery process for personnel and their families affected by a catastrophic event.
Family Employment Readiness Program		3	*	*	CNO	N1	CNIC	Career Resource Center to assist spouses and family members in finding employment.
Navy School Liaison Officer		3	*	*	CNO	N1	*	Subject matter experts for K-12 education issues. SLOs work to connect commanders, educators and parents.
Navy Child and Youth Programs	N1	3	*	*	CNO	N135	CNIC, FFS	Navy child and youth programs provide developmental child care and youth recreational programs and services for eligible children and youths ages 4 weeks to 18 years of age.
Child Development Centers		3	*	*	CNO	N135	CNIC, FFS	Provide full and part day child care for ages 6 weeks to 5 years of age.
Child Development Homes		3	*	*	CNO	N135	CNIC, FFS	Provide full and part day/night and weekend child care for ages 4 weeks to 12 years of age
School-Age Care		3	*	*	CNO	N135	CNIC, FFS	Provides before and after school and day camps for ages 6 years to 12 years of age.
Youth and Teen Programs		3	*	*	CNO	N135	CNIC, FFS	Provide sports programs, leisure classes, youth internet labs and teen programs for ages 6 to 18 years of age.
Child and Youth Education Services		3	*	*	CNO	N135	CNIC, FFS	Helps "level the playing field" for transitioning student, prepares schools and installations to respond confidently to the complexities of transition and deployment.
Child and Youth Outreach Services		3	*	*	CNO	N135	CNIC, FFS	Provides families off-installation CYP opportunities.
Deployed Forces Support		MWR	3	200,000,000	*	CNO	N4	MWR
Navy Operational Fitness and Fueling System (NOFFS)	3		*	*	CNO	N4	MWR	"World-class" performance training resource for Sailors.
Senior Health Assessment Program Enterprise (SHAPE)	3		*	*	CNO	N4	MWR	Program to improve the fitness and quality of life of service members.
All Navy Sports Program	3		*	*	CNO	N4	MWR	Command program allows Sailors a chance to represent the Navy at higher-level athletic competitions.
GMT and NMT	NETC	3	*	ES	CNO	N1	CNET	NETC developed training.
Naval Safety Center	NSC	3	11,000,000	*	CNO	Safety Center	CNIC	COMNAVSAFECEN prevents mishaps to save lives and preserve resources. The advice, policies, services and risk management information and tools COMNAVSAFECEN provides enhance command culture, combat readiness and global war-fighting capabilities.
Mishap and Safety Investigation, Reporting, and Record Keeping		3	*	*	CNO	Safety Center	CNIC	A single policy directive for mishap and safety investigation reporting and record keeping by all Navy and Marine Corps commands, activities, units, installations and facilities.
Recreation and Off-Duty Safety Program		3	80,000	*	CNO	Safety Center	CNIC	Policy to reduce or minimize the probability of mishap occurrence during off-duty and/or recreational activities.
QA Program		3	*	*	CNO	Safety Center	CNIC	Not clearly delineated under a specific NSC program or Navy instruction.

- Navy Installations Command program
- Navy Marine Corps Health Center program
- MWR program
- Naval Safety Center program
- NETC program
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- BUMED program

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Research: Tier 2 and 3 programs which are research projects only and do not provide any actual services to Sailors .									
Program	POC	Tier	Cost-FY12	# Served	Instruction	Supported	Supporting	SUMMARY	
Navy Occupational Safety and Health (NAVOSH) Program	NSC	3	25,000	*	CNO	Safety Center	CNIC	Navy program encompassing all safety disciplines such as aviation safety, weapons/explosives safety, off-duty safety, traffic safety, and occupational safety and health.	
Operational Risk Management		3	13,000	*	CNO	Safety Center	CNIC	Policy, guidelines, procedures, and responsibilities to standardize the operational risk management (ORM) process across the Navy and establish the ORM training continuum.	
Cultural Workshops		3	19,000	*	CNO	Safety Center	CNIC	Workshops that give commanding officers a snapshot of their unit's culture developed by trained facilitators who carefully listen to unit members.	
Command Managed Equal Opportunity (CMEO) Program	N1	3	*	*	CNO	N134	CNIC N1	Promote EO environment, includes DEOCS climate assessment survey.	
Exceptional Family Member Program		3	111	*	CNO	N451	CNIC BUMED N135	N1 Program, assists Sailors with the special needs of their Exceptional Family Members (EFM).	
Work/Life Programs		3	*	*	CNO	N134	N135 FFSC BUPERS	DON Civilian Human Resource Program, open to active duty. Includes: telework, transit subsidy, dependent care and wellness.	
Telework Program		3	*	*	POTUS	OPM	CNO	POTUS directed policy requires the heads of each executive agency to establish and implement a policy under which employees shall be authorized to telework.	
Paternity Leave Program		3	*	*	CNO	N134	FFSC	Policy under which a married member of the armed forces on active duty whose wife gives birth to a child shall receive 10 days of leave to be used in connection with the birth of the child.	
Career Intermission Pilot Program		3	*	*	CNO	N134	BUPERS	Program allowing 20 officers and 20 enlisted per year for four years to transfer out of the AC and into the Individual Ready Reserve for up to 3 years while retaining full health care coverage.	
Coalition of Sailors Against Destructive Decisions		3	*	*	CNO	N1 FMC	N135	Peer-to-peer mentorship program used Navy-wide. The program is geared at Sailors 18 to 25 years old, to reinforce our culture of "Shipmates helping Shipmates".	
Navy Diversity and Inclusion		3	*	*	CNO	N134	FFSC	Attract, develop, and retain a high-quality, diverse workforce that values a culture of inclusion.	
Fleet Diversity Council		3	*	*	CNO	N134	FFSC	Hosted by the Office of Diversity and Inclusion (N134). Trains, inspires and facilitates fleet feedback for diversity.	
Casualty Assistance		3	115,000	*	CNO	N135	BUMED Naval District Washington	Render prompt and compassionate assistance to Navy families during and after their time of need.	
Navy Alcohol and Drug Prevention and Control		3	*	ES	CNO	N1	N135, BUMED, CNETC, NPC	Comprehensive alcohol and other drug abuse prevention and control policy and procedures.	
IMPACT/PREVENT/ADAMS/SFL		3	*	*	CNO	N1	N135	Family of training programs within NADAP.	
Hand Held Detection Device		3	*	*	CNO	N1	N135	Alcohol Detection Program.	
SARP Living in Balance / Co-occurring Disorders		BUMED	3	100,000	40 (staff)	DNS	BUMED	BUMED	Core training for its Navy professional staff responsible for delivering SARP services.
USN Behavioral Health Needs Assessment - N87			Research	618,000	NA	CNO	BUMED	NHRC	Meets with expeditionary Sailors in theater to obtain anonymous and confidential BHNAS survey data on stressors, combat exposure, mental health stigma, and perceptions of leadership, unit cohesion, and morale.
Combat Stress Burden - N115-2010	Research		200,000	NA	CNO	BUMED	NHRC	Series of longitudinal, interrelated projects to better understand risk and resilience in a cohort of Marines.	

- Navy Installations Command program
- Navy Marine Corps Health Center program
- MWR program
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Research: Tier 2 and 3 programs which are research projects only and do not provide any actual services to Sailors .								
Program	POC	Tier	Cost-FY12	# Served	Instruction	Supported	Supporting	SUMMARY
Pharmaceutical Utilization Before and After Combat	BUMED	Research	*	NA	CNO	BUMED	NHRC	Determine whether enough time lag is being allowed between receipt of new psychotropic medication and deployments.
Mental Skills & Hyper-Realistic Combined Readiness Training for Deploying Corpsmen		Research	913,420	NA	CNO	BUMED	NHRC	Evaluate the impact of hyper-realistic training in corpsmen; identify predictors of resilience in a sample of corpsmen.
Validation of Wear and Tear Stress Components of Naval COSC Doctrine		Research	120,000	NA	CNO	BUMED	NHRC	ID sources of stress; ID the relationship between combat, operational and wear and tear stress and their effect on mental health.
Reduced PTSD Risk in Combat Amputees: Role of Early Postinjury Factors		Research	226,000	NA	CNO	BUMED	NHRC	Investigate early postinjury medications or other treatments that might protect against the development of PTSD.
Expanded Psychological Health Tracking of Separating Sailors and Marines		Research	740,000	NA	CNO	BUMED	NHRC	The mission of the program is to (1) determine the factors associated with successful reintegration among veterans, and (2) use this information to develop, in collaboration with Marine Corps leadership and Transition Assistance Program (TAP) managers, psychological health curricula for TAP classes.
Navy-Marine Corps CTR Expeditionary Medical Encounter Database (EMED) & Infrastructure		3	2,400,000	NA	DNS	BUMED	*	Supplements the psychological health care training of graduates of PA/NP programs with an advanced understanding of etiology, assessment, and treatment of psychological health disorders. Leads to improvements in psychological health outcomes for their patients. 34 FTE in FY12.
The Drug Demand Reduction Program	*	3	*	ES	SecDef	DSDR	CNO	The Department of Defense (DoD) Drug Demand Reduction Program (DDRP) mission is to prevent drug abuse through education, outreach, and awareness programs, and detect and deter DoD civilian and military personnel from using illicit drugs and misusing prescription drugs.
Management of HIV Infection	*	3	*	ES	SecNav	ASN (M&RA)	BUMED CHINFO	Navy policy on individuals infected with HIV.
Individual Personnel TEMPO (ITEMPO) Program	*	3	*	ES	CNO	N3/5	FLT CDRs, NSWC	Tracks personnel operational tempo in order to preserve quality of life.
Use of Hand Held Alcohol Detection Devices	*	3	*	ES	CNO	Echelon 2 CDRs	CO's	Intended to help deter irresponsible use of alcohol and assist w/ identifying service members who require support and assistance.
Navy & Marine Corps Tobacco Policy	*	3	*	ES	SecNav	CNO	CNET, BUMED, CO's	Reduce tobacco use, prevent tobacco initiation, provide support and improve personnel health.
Guidelines Concerning Pregnancy and Parenthood	*	3	*	ES	SecNav	CNO	*	Intended to help accommodate the career and welfare needs of service members who are parents.
Navy Guidelines Concerning Pregnancy and Parenthood	*	3	*	ES	CNO	CNO	CO's, HCP, N097, OJAG, BUMED	Intended to help manage service members pregnancy and parenthood in the first year.
Military Spouse Employment Partnership	*	3	*	ES	DoD	CNO	N135, CNIC, FFSC	Help military spouses obtain meaningful long-term employment.
Health and Wellness Instruction	*	3	*	*	CNO	N1	OCHR, N097, NETC, USNA, CHINFO, BUMED, NSC	Updates the comprehensive Navy Health and Wellness Promotion Program that improves and sustains military readiness by focusing on health, fitness, and quality of life for Sailors, Department of Defense (DoD) personnel, and other beneficiaries.
21st Century Sailor	*	3	*	*	SecNav	Program Managers	Varies by Program	Set of objectives, policies and programs designed to maximize Sailor and Marine personal readiness, to maintain the resiliency of the force, and to hone the most combat effective force in the history of the Department of Navy (DoN).
Shipmates to Workmates	*	3	*	*	NAVAIR	NAVAIR	CNIC, SPAWAR, NAVSEA	Information about post Navy career opportunities.

- Navy Installations Command program
- Navy Marine Corps Health Center program
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## Appendix B

### Additional Programs - Not Assessed

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Tier 3: Mission and desired outcome is not specific to suicide prevention but it may have tertiary effects that contribute to prevention of suicide.								
Research: Tier 2 and 3 programs which are research projects only and do not provide any actual services to Sailors.								
Program	POC	Category	Cost-FY12	# Served	Instruction Authority	Supported Unit	Supporting Unit	SUMMARY
Navy Marine Corps Health Center Nutrition Program	*	unk	*	*	*	*	*	
Life Skills Program	*	unk	*	*	*	*	*	
Military and Family Life Care Program	*	unk	*	*	CNO	*	*	Offers short-term, non-medical counseling to service members and their families as well as DoD Civilian Expeditionary Workforce members and their families.
FFSC Clinical Counseling	*	unk	*	*	*	*	*	
Navy Galley Program	*	unk	*	*	*	*	*	
Prevention and Management of STDs	*	unk	*	*	*	*	*	
MWR Food and Beverage Program	*	unk	*	*	CNO	N4	MWR CNIC	Navy Recreational Food Operations include a variety of concepts, ranging from full-service clubs to quick-service restaurants.
Navy Professional Development Resources	*	unk	*	*	*	*	*	
Navy Resource Guide	*	unk	*	*	*	*	*	
Expanded Psychological Health Tracking	*	unk	*	*	*	*	*	
Psychological Health Training for Family Practice Physicians- N7	*	unk	*	*	*	*	*	
Combat Trauma Registry Deployment Health Database - N89	*	unk	*	*	*	*	*	
PH Hire Staff - NPH	*	unk	*	*	*	*	*	
Neurocognitive Combat Stress Toolbox (NCST)	*	unk	*	*	*	*	*	
Suicide Prevention Training for Navy Medical Providers	*	unk	*	*	*	*	*	
Suicide Postvention Plan: A Toolkit for Commanders	*	unk	*	*	*	*	*	
Stress Mitigation and Strategic Operations - N149	*	unk	*	*	*	*	*	
Chaplain Spiritual Support Service	*	unk	*	*	*	*	*	
Force Health Protection	*	unk	*	*	*	*	*	Develops science and technology solutions for the improvement of personnel performance, casualty prevention and combat casualty care.
Wounded Warrior Care Resources	*	unk	*	*	*	*	*	
Navy Center for Personal and Professional Development	*	unk	*	*	*	*	*	Develop and deliver education and training opportunities (personal/professional/leadership) to achieve fleet readiness.
Wounded Warrior Care Resources	*	unk	*	*	*	*	*	Broad category defining other program such as: FOCUS, OSC.
Alcohol and Drug Abuse	*	unk	*	*	*	*	*	Encompassed by SARP.
Go For Green Program	*	unk	*	*	*	*	*	Army/DoD program.
Safe a Life Tour	*	unk	*	*	*	*	*	Not a DoD program.
Suicide Postvention Plan: A Toolkit for Commanders	*	unk	*	*	*	*	*	Document provided on 21st Century Sailor website.
Hiring Our Heroes	*	unk	*	*	*	*	*	US Chamber of Commerce Program.
Spouse Mentoring COMPASS	*	unk	*	*	*	*	*	Standardized team-mentoring program developed by spouses for spouses. Not a Navy program.
Relocation Assistance Through Plan My Move (OSD program)	*	unk	*	*	*	*	*	FFSC program-relocation services to aid in military moves.
The National Intrepid Center of Excellence (NICoE)	*	unk	*	*	*	*	*	DoD Level Program.

## **Appendix C - Chaplain Corps Specific Recommendations**

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The Chaplain Corps (CHC) is one of the principal agents supporting resilience and suicide prevention in the Navy. A total of 573 active and reserve component chaplains supported by 502 religious program specialists (RPs) are currently serving Navy units. Together they deliver life changing religious ministry accompanied by various forms of resilience and suicide prevention programming.

Nearly all chaplains are in billets where they provide or facilitate religious services which have demonstrably positive effects on unit morale and individual readiness. Furthermore, all chaplains provide confidential counseling to Sailors and family members in need. Approximately 66% of chaplains and 35% of RPs deliver suicide prevention training on a routine basis, and an additional 17% of chaplains and 6% of RPs serve as Suicide Prevention Coordinators for their commands. When coupled with the fact that 44% of chaplains teach stress management classes and another 22% of chaplains teach anger management classes, the CHC's contribution to resilience and suicide prevention becomes apparent.<sup>1</sup>

Because of the CHC's role in supporting resilience and suicide prevention, a thorough assessment of CHC programming was performed as part of Task Force Resilient's overall program analysis. Requests for information were staffed through the Chief of Navy Chaplains Office (N097) and the Professional Naval Chaplaincy Board of Directors (PNCEB) to identify:

- CHC sponsored resilience programs
- CHC support for other resilience programs
- CHC involvement in suicide prevention efforts
- CHC systems of measurement

Results of the CHC assessment inform the body of this report, but additional findings specific to the CHC are recorded below. As with the findings and recommendations provided by the overall report, these CHC-specific findings and recommendations are divided into five discrete categories:

- Organization
- Training
- Assessment
- Care
- Learning and Culture

The following findings and recommendations are provided to the Chief of Navy Chaplains to further enhance the CHC's already strong contribution to promoting resilience and preventing suicide.

## **Organization**

### **ChaplainCare Standard Operating Procedure**

The ChaplainCare online ministry portal has a long history of highly effective service. This portal provides online resources and 24/7 chaplain access for Sailors and families in need. On average, ChaplainCare receives 63,000 website visits per year generating 652 cases requiring chaplain contact and response. Despite nearly 15 years of dedicated service, ChaplainCare operates from an informal and unofficial standard operating procedure (SOP). Program effectiveness would likely be improved by developing and promulgating a formal and official SOP.

### **Recommended Actions**

1. Coordinate with stakeholders to develop a formal ChaplainCare SOP delineating all roles, responsibilities, and processes relative to its operation.

## **Training**

### **Standardization of Training**

A review of OPNAV policies indicates that N097 is tasked to support five major resiliency programs: Suicide Prevention, Sexual Assault Victim Intervention, Family Advocacy, Navy Alcohol and Drug Abuse Prevention, and the Health and Wellness Promotion Program. Taskings principally include the establishment of standards and the provision of initial and refresher training on select issues. An assessment of the actions taken by N097 indicates material compliance with most taskings but also discovered the need for greater standardization and regimentation of training to meet the requirements established by policy. N097 must develop a regimented training plan to ensure training is delivered to meet requirements established by policy.

### **Standards of Care**

*Cooperative Religious Ministry* (NTTP 1-05.2), establishes a minimum standard of care to be delivered by duty chaplains in response to suicidal behavior, sexual assault, domestic violence, substance abuse, acute combat and operational stress reaction, casualty assistance calls, IA support, religious accommodation, counseling, facilitation of communication with deployed Sailors, and information referrals. Utilization of this resource for the purposes of training and standardization appears to vary from one domain to another. Adherence to NTTP 1-05.2 would ensure a consistent delivery of crisis care across all domains. Service and family members would benefit if all chaplains were trained to the standards articulated in this publication. N097 should ensure chaplains are trained to this standard.

## Recommended Actions

2. Develop a training plan to ensure initial and refresher training are delivered to meet requirements established by policy.
  - 2.1 Coordinate with N11 and NETC to resource identified training requirements.
  - 2.2 Establish a comprehensive training plan with standardized refresher curricula that meets the specific requirements defined in policies.
  - 2.3 Establish a schedule for refresher training and institute a method to track completion.
  - 2.4 Perform an annual review of policy to identify new training requirements and ensure their incorporation into the training plan.
  - 2.5 Coordinate with BUMED to develop and promulgate policies regarding the proper evaluation of service members who exhibit suicide related behaviors and ensure inclusion of such guidance in all phases of chaplain training.
  
3. Ensure all chaplains are trained to, and deliver, the standards of care articulated by NTTP 1-05.2.
  - 3.1 Review and revise NTTP 1-05.2 as required.
  - 3.2 Establish standardized lesson plans to support the standards of care articulated by NTTP 1-05.2.
  - 3.3 Ensure all chaplains are trained to standard and deliver the established standard of care.
  - 3.4 Incorporate standardized training into the CHC training continuum.

## **Assessment**

### Spiritual Fitness Guide

The Spiritual Fitness Guide is a self-assessment tool modeled after the COSC continuum which assists Sailors in assessing their own spiritual condition. The accompanying Referral Tool provides a framework for other caregivers to determine when to refer personnel to chaplains for spiritual counseling. Phase 1 deployment is now complete. Chaplains and caregivers have received copies of the Spiritual Fitness Guide and Chaplain Referral Tool. In addition, the Spiritual Fitness Guide is included in the Commanding Officer's Tool Kit. Now that these tools have been deployed, additional efforts should be made to evaluate: 1) their validity, 2) how extensively they are used, and 3) whether or not they are effective in helping Sailors and caregivers address issues of spiritual fitness.

### Recommended Actions

4. Perform a study of the Spiritual Fitness Guide and Chaplain Referral Tool to determine their validity, rate of utilization, overall effectiveness, and means for their improvement.
  - 4.1 Establish the presence or absence of evidence to validate the Spiritual Fitness Guide and Chaplain Referral Tool.

- 4.2 Measure their rate of utilization and overall effectiveness in helping Sailors and caregivers address issues of spiritual fitness.
- 4.3 Implement measures to improve overall utilization and efficacy.

## **Care**

### Marriage PREP

Navy data indicates that relationship problems were present in 59% of Navy suicides committed between 1999-2009. Service members frequently turn to chaplains for relationship counseling. The CHC needs to provide a standardized evidence-based program for relationship counseling. The Marriage Preparation Relationship Enhancement Program (Marriage PREP) provides such a standard. Marriage PREP is the only adult-focused relationship education program listed in the U.S. Government's Substance Abuse and Mental Health Services Administration's national registry of evidence-based programs and practices. A recent NETC Human Performance Requirements Review led by Naval Chaplaincy School and Center (NCSC) recommended inclusion of PREP training in NCSC courses. The Navy would benefit by training chaplains in PREP; the prevalence of relationship problems as a risk/causal factor in Navy suicides warrants a standardized CHC response.

### Soundings

The *Soundings* program is a Commander Submarine Forces (COMSUBFOR) endorsed resilience program designed by COMSUBPAC chaplains. The program addresses factors contributing to unplanned loss by incorporating five factors of psychological fitness associated with human performance and resilience. Program curriculum is highly developed and includes separate courses for junior enlisted, supervisors, and khaki. Although the program is posted on Navy Knowledge Online, there's little evidence of usage outside the submarine force. With some modification, this program holds potential for widespread use across the Navy.

### CREDO Program

The Chaplains Religious Enrichment Development Operation (CREDO) program is a highly successful program which supports Service and family member resilience. CREDO provides retreats and workshops to strengthen marriages, family relationships, personal resilience, and unit cohesion. Other programs include suicide prevention training and Sailor retention efforts. Interactive Customer Evaluation (ICE) reports substantiate the popularity and efficacy of CREDO programming. Furthermore, a Task Force sponsored survey of Command Master Chiefs demonstrated their belief that CREDO is a valuable tool for strengthening Sailors and family members. Nevertheless, interest in attendance tends to exceed capacity as most or all CREDO sites must use standby lists to manage interested parties who cannot be accommodated by existing quotas. In addition, geographical location, work schedules, and other factors tend to prevent many Sailors from attending CREDO retreats. Funds have been secured to create addition CREDO sites but this will not completely alleviate these barriers to

attendance. N097 should offer select CREDO content in distributed or distance learning formats to address these barriers to attendance.

### *Benefits of Religion/Spirituality*

A 2001 review of 1,200 separate studies documented the following health benefits rooted in spiritual or religious factors: more hope and optimism, less depression, fewer suicides, less anxiety, less alcohol and drug abuse, greater marital stability, less risky behavior, and lower mortality from various causes.<sup>2</sup> Likewise, in a literature review of studies of post-traumatic growth, i.e. positive growth in the wake of a highly stressful or traumatic event, religion was frequently identified as a significant factor in promoting such growth.<sup>3</sup> The Chief of Chaplains' annual guidance makes meeting the religious needs of Service members the CHC's highest priority and efforts are currently underway to encourage more meaningful, better prepared, and better executed worship opportunities. This practice should be emphasized.

### *Recommended Actions*

5. Establish Marriage PREP as the CHC's standard relationship enhancement program.
  - 5.1 Train chaplains in PREP.
  - 5.2 Ensure chaplains routinely offer PREP throughout the domains.
  - 5.3 Offer PREP via CREDO retreats.
  - 5.4 Continue partnership with FFSCs to provide PREP training.
  
6. Study feasibility of deploying *Soundings* Navy-wide.
  - 6.1 Coordinate with N11 to ensure *Soundings* does not needlessly duplicate other program efforts.
  - 6.2 Evaluate the evidence supporting *Soundings* to ensure it is an evidence-based or evidence informed program.
  - 6.3 Modify curricula for use in any Navy setting.
  - 6.4 Consider use by CREDO.
  - 6.5 Promote use through strategic communication.
  
7. Develop means for offering select CREDO content in distributed or distance learning formats.
  - 7.1 Offer select CREDO resources in online formats for personal use by individuals or professional use by other chaplains.
  - 7.2 Explore options for hosting distributed/distance CREDO workshops and seminars.
  - 7.3 Ensure availability of online content and distributed/distance learning options are incorporated into the Chaplain Corps' (CHC's) comprehensive communication plan.
  
8. Implement plans to strengthen the delivery of divine and religious services, sacraments, ordinances, rites, and rituals.
  - 8.1 Coordinate through the PNCEB to organize local workshops and/or regional training events designed to further enhance the delivery of divine and religious services.
  - 8.2 Encourage chaplains endorsed by common religious organizations to establish communities of interest in order to routinely collaborate on best practices.

8.3 Continue to incorporate messages regarding the value of religious ministry into strategic communications plans.

## ***Learning and Culture***

Confidential communication to a chaplain is a critical enabler for help-seeking behavior that limits stigma, encourages full and complete disclosure by persons seeking assistance, enhances a supportive command climate, and enables authorized users to get the help they need to remain ready or return to readiness as quickly as possible. Anecdotal evidence suggests that confidential communication to chaplains is not well understood by leadership nor fully appreciated by service members. N097 should ensure confidential communication to chaplains is properly understood and publicized.

### **Recommended Actions**

9. Encourage help-seeking behavior by leveraging confidential communication to chaplains as a proven means for avoiding stigma while seeking assistance en route to additional care.

9.1 Collaborate with Navy Chief of Information to ensure confidential communication to chaplains is included in strategic messaging.

9.2 Collaborate with NETC to ensure confidential communication to chaplains is included in the Navy's leadership training continuum.

### ***Endnotes:***

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<sup>1</sup> Statistical data provided by N097 and the Professional Naval Chaplaincy Board of Directors.

<sup>2</sup> Military Medicine, 175, 8:73, 2010, pp. 78-79.

<sup>3</sup> PTSD Research Quarterly, Vol. 21/No. 3, Summer 2010.

# Appendix D – DoD Task Force Recommendations

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*The following is a list of recommendations from the 2010 Final Report of the DoD Task Force on the Prevention of Suicide by Members of the Armed Forces.*

## **Focus Area 1: Organization and Leadership**

*Strategic Initiative 1A: Create, restructure and resource suicide prevention offices at the OSD, Service installation, and unit levels to achieve unity of effort*

1. Build, staff, and resource a central OSD Suicide Prevention Office that can effectively develop, implement, integrate, and evaluate suicide prevention policies, procedures, and surveillance activities. This office should reside within the Office of the Under Secretary of Defense for Personnel and Readiness and be granted the coordinating authority that enables strategic suicide prevention oversight from OSD, through the Services, and down to the unit level.
2. Prioritize resources to adequately staff, fund, and organize the headquarters-level suicide prevention offices, within each Service, to successfully meet all current requirements.
3. Services should require full-time civilian suicide prevention coordinators at all installations identified by major commands. Major commands must facilitate the consistent implementation of Service suicide prevention strategy down to the small unit level and installations must ensure appropriate resourcing of this position in order to fully support both DoD suicide prevention policy, and Service policy and programs.
4. Sufficiently resource suicide prevention coalitions that strategically integrate installation and major command suicide prevention efforts and informs the Service-level program office. This coalition should also function to coordinate support services through collaboration on overarching social/behavioral risk problems on the installation.
5. Require full-time suicide prevention program coordinators at each MTF (or regionalized when covering several non-hospital MTFs) to facilitate the standardized implementation of Service suicide prevention strategy on behalf of the MTF commander and ensure the adherence to standardized policies and practices.
6. Recommendation 6 Direct unit-level suicide prevention program officers to facilitate the implementation of Service policies.

*Strategic Initiative 1B: Equip and empower leaders (provide them tools) to establish a culture that fosters prevention as well as early recognition and intervention.*

7. Strengthen and reinvigorate the fundamentals of military garrison leadership at the unit level with a focus on supervisor-subordinate interactions and mentoring. Ensure that front-line supervisor training is mandatory, occurs prior to assuming a supervisory role, and includes critical skills building in interpersonal relationships.

8. Ensure that professional military education, ranging from basic training to Senior Service Schools, develops leaders with the interpersonal and leadership skills required to fulfill their leadership and mentoring responsibilities, as well as promotes the well-being and total fitness of the Service Members under their charge.
9. Maintain a sufficiently small front-line supervisor-to-subordinate ratio to ensure the person-centered leadership functions can occur.
10. Add validated behavioral risk questions to unit climate surveys to help commanders detect relative elevations in behavioral risk across their military units and respond with appropriate preventive measures. Mandate the use of unit climate and risk surveys annually and upon accepting and relinquishing command.
11. Develop monthly risk reports from a multitude of sources and services to create a snapshot of the unit and the ability to compare a commander's unit with like units across the Service and at the installation, while also allowing for the identification of positive and negative trends with reference to risk behaviors by members in that unit.
12. Disseminate and enforce — zero tolerance policies that prohibit prejudice, discrimination, and public humiliation towards individuals who are responsibly addressing emotional, psychological, relational, spiritual, and behavioral issues; as well as towards those seeking help to increase their psychological fitness and operational readiness. Support these policies by holding leaders and supervisors accountable and by sustained communications campaigns.
13. Develop and implement sustainable training programs for PAOs serving Service leaders, senior leaders, and installation commanders in crafting health-promoting messages that support the goals and objectives of the Services' suicide prevention and health promotion programs; avoid counterproductive or dangerous messages whenever making statements or discussing suicide-related information or statistics.
14. Instruct PAOs to disseminate nationally recognized recommendations for reporting on suicide as they interact with news media on the subject of suicide.
15. Develop and disseminate communication guidelines to commanders for use in the wake of a local suicide event.

*Strategic Initiative 1D: Reduce stigma and overcome military cultural and leadership barriers to seeking help.*

16. Develop an aggressive Stigma Reduction Campaign Plan, communications effort, and implement policies to root out stigma and discrimination. Follow scientifically based health communications principles in these campaigns
17. Promote values that encourage seeking the assistance of chaplains, healthcare, and behavioral healthcare professionals to enhance spiritual, physical, and psychological fitness.
18. Develop and implement campaigns to inculcate values and norms aligned with promoting the well-being, connectedness, and psychological and spiritual fitness of Service Members. Use well-planned, multi-year communications campaigns at the DoD and Service levels, employing the best of health communications science as part of that effort.
19. Target a specific component of the communications campaign to ensure that Service Members who hold security clearances and the mental health providers who see them

are aware of policies that exclude reporting certain instances of mental health care on the SF-86.

20. Adjust manning levels, especially in elite units and certain military occupational specialties, to support developing and maintaining comprehensive fitness by all members.
21. Infuse curricula for all levels of military specialty training with expectations that even the most effective Service Members will occasionally experience difficulties that require temporary interruptions in their qualifications for full duty. Teach that the responsibility of others in the unit is to support them during those times.
22. Discourage and refrain from use of the term —malingering in association with suicide-related behaviors. Ensure DoD and Service suicide prevention policies and guidelines eliminate using the word — malingering.

*Strategic Initiative 1E: Standardize Suicide Prevention Policies and Procedures.*

23. DoD and Service guidance for commanders and military recruit instructors that addresses the management of suicide-related behaviors during basic training.
24. Develop and implement a DoD-wide policy requiring immediate command notification and chain of care (or chain of custody) for individuals who become aware they are being investigated for a criminal or other serious offense, immediately after they confess to a crime, and/or soon after they are arrested and taken into custody.
25. Establish clear DoD, Joint and Service guidance for removal and subsequent re-issue of military weapon and ammunition for Service Members recognized to be at risk for suicide. The guidance should emphasize a collaborative, team approach to the decision-making process and specify documentation requirements.

**Focus Area 2: Wellness Enhancement and Training**

*Strategic Initiative 2A: Enhance well-being, mental fitness, life skills, and resiliency.*

26. Improve access to, and promote utilization of, state-of-the-art training in critical life skills (e.g., financial management, communication, marriage and family relationships, anger management, and conflict resolution).
27. Expand the practice of embedding behavioral health providers in operational units. Conduct studies to determine the range of effective staffing ratios for embedded providers.

*Strategic Initiative 2B: Reduce stress on the force and on military families.*

28. Balance uniformed end-strength with operational requirements by either increasing military end-strength or decreasing operational commitments.
29. Provide sufficient, high-quality dwell time for redeploying Service Members in keeping with the most current military health research. Initial post-deployment dwell time should ensure an initial period (of at least several months) in which Service Members can restore their well-being, and should not include extended temporary duty (TDY) or extended — gear-up training for the next deployment.
30. Reduce operations tempo and day-to-day work requirements on individuals and units to sustainable levels that support the wellness of Service Members and their families. Create white space in training schedules, especially in post-deployment periods.

31. Review in-garrison military training requirements with the goal of eliminating and/or combining training, thereby reducing the time burden on units and Service Members.  
*Strategic Initiative 2C: Transform suicide prevention training of Service Members, leaders, and families to enhance skills.*

32. Develop DoD and Service-level comprehensive suicide prevention training strategies. Develop and disseminate state-of-the-art training curricula addressing the specific knowledge, skills, and attitudes required of each sub-population in the military community. Incorporate industry-standard evaluation practices throughout the development and dissemination phases. Focus efforts on skills-based training.

33. Target and train families (including parents, siblings, significant others, and next of kin) as a suicide prevention training strategy, and consider it an important part of the chain of care for Service Members. Family members should be educated and trained to recognize the signs of stress and distress, to know whom to call for advice, and to understand how to respond in emergencies.

34. Develop strategies to locate and remain in contact with families during every phase of the deployment cycle. Develop and disseminate pre-deployment and reintegration education and training programs germane to suicide prevention for family members.

35. Proactively seek opportunities to collaborate with other federal agencies in their efforts to support military families.

### **Focus Area 3: Access to, and Delivery of, Quality Care**

*Strategic Initiative 3A: Ensure available and reliable access to high-quality*

36. Implement policies that optimize access to care for all Service Members which are specifically designed for behavioral health care, and monitor access standards closely for compliance.

37. Train all caregivers in the governing rules applicable to appropriate and necessary information sharing among providers, outside agencies, and with Service Members' commands.

38. Develop interdisciplinary treatment plans for Service Members at risk for suicidal behavior.

39. Implement coordination of care plans across longitudinal lines (e.g., permanent change of station, temporary change of station, deployment and redeployment transitions, temporary duty with other units, release from active duty, demobilization, confinement, hospitalization, and extended leave periods).

40. Establish multidisciplinary case management teams to ensure the highest quality of coordinated care by the team of commander, clinical provider, and non-clinical care provider.

*Strategic Initiative 3B: Leverage and coordinate military community-based services, as well as local civilian community services (especially with respect to the Reserve Component).*

41. Optimize and coordinate community-based services to leverage their capabilities to enhance protective factors for Service Members.

42. Promote and utilize coordinated community outreach and awareness activities provided by clinicians and other installation-based care providers to improve access to care and reduce stigma.

43. Encourage Service Members to have annual face-to-face — conferences with chaplains for the purpose of resolving questions of guilt and to obtain referrals to appropriate caregivers for other concerns beyond the chaplain's scope of expertise and experience.
44. Develop a comprehensive policy to promote systematic and regular communication among clinical and non-clinical providers.

*Strategic Initiative 3C: Ensure continuity of behavioral healthcare, especially during times of transition, to ensure seamlessness of healthcare and care management.*

45. Manage care across transition points and monitor Service Members identified as being at-risk for suicide.
46. Assess Military OneSource capabilities to ensure a seamless transition of care system is established for suicidal or at-risk Service Members who utilize their services. This transitional care system needs to take into account challenges involving medical documentation, timeline of transition, and maximizing Service Member compliance with the transition plan.
47. Develop, evaluate, and more widely disseminate peer-to-peer and other programs that intentionally promote not only connectedness but also risk identification and response among Reserve Component Service Members.
48. Promote easy access to evidence-based treatments and community support services for post-deployment Reserve Component Service Members.
49. Ensure all Reserve Component Service Members receive face-to-face behavioral health checks post-deployment/post-demobilization and before being remobilized, with an emphasis on connecting them with professional services during the post-deployment phase.
50. Provide guidance on how behavioral health providers and commanders should best communicate with each other to promote effective suicide prevention practices for Service Members.
51. Establish and use interdisciplinary — human factors type boards (emphasizing topics like physical, social, behavioral, psychological, nutritional, environmental, spiritual, and medical health) on all installations to coordinate suicide prevention care for at-risk Service Members.
52. Take steps to make — mental fitness commensurate with — physical fitness within military culture as a core value of military life. Ensure every Service Member receives a mental fitness assessment and appropriate wellness education as part of his or her periodic health assessment.
53. Integrate behavioral health treatment teams into DoD primary care settings to overcome stigma and increase the likelihood of access to care; as well as to establish an early intervention approach to suicide prevention. Where this is not possible, train primary care providers and their staff in the assessment and management (and triage) of acute suicide risk patients.
54. Develop a standard and systematic medical documentation system to identify high-risk patients and track the care provided. Continually review and update the record (documentation).
55. Suicide watch should be used only as a last resort and only until appropriate mental healthcare becomes available. Provide consistent guidance to units for these

exceptional instances, as well as — just in time training (e.g., online training). If units have a suicide prevention coordinator, the management of these rare instances could fall to that individual's responsibility. A suicide watch training program should be developed and similarly instituted.

*Strategic Initiative 3D: Standardize effective crisis intervention services and hotlines.*

56. Provide clear direction and consistent messaging regarding the promotion and usage of the National Suicide Prevention Lifeline 1-800-273-TALK (8255) as a national suicide prevention hotline resource available to all Service Members and their families, as well as the use of local crisis hotlines (or information lines) focusing on specific populations.
57. Formalize existing interconnectedness of the DCoE Outreach Call Center, National Suicide Prevention Lifeline, and Military OneSource to enable each agency too quickly and effectively route calls to appropriate responders. Ensure ongoing quality review and quality improvement efforts focused on emergency rescue situations, follow-up referrals for callers at-risk, and linkages with community providers of crisis services (e.g., mobile outreach teams).
58. Optimize the availability of suicide hotline services to deployed Service Members using the same National Suicide Prevention Lifeline number to ensure best response capabilities.

*Strategic Initiative 3E: Ensure all "helping professionals" are trained in the competencies to deliver evidence-based care for the assessment, management, and treatment of suicide-related behaviors.*

59. Develop clinical practice guidelines to promote the utilization of evidence-based practices for the assessment, management, and treatment of suicide-related behaviors.
60. Dedicate sufficient behavioral health resources to military health facilities to allow for timely mental health assessment and treatment.
61. Train all military healthcare providers (including behavioral health providers) and chaplains on evidence-informed suicide risk assessment, management, and treatment planning. Create and provide continuing education tailored to their specialty and area of expertise.

*Strategic Initiative 3F: Develop effective postvention programs to support families, Service Members, and unit leaders after a suicide.*

62. Incorporate postvention programs targeted at the decedent's military unit, family and community after a tragedy or loss to reduce the risk of suicide. Postvention efforts must address Service Members affected by a significant loss, especially after a fallen comrade's death in combat or in garrison when the unit is impacted. Unit-level postvention efforts must focus on effective debriefing and prevention when they are impacted by a significant tragedy or loss.
63. Train first responders, chaplains, casualty notification officers, and family interviewers on how to best respond to suicide and suicide-related events when working with families or next of kin.
64. Provide families with comprehensive emotional support following the death of a loved one by suicide. All those affected, including significant others and battle buddies, should have access to resources that will help them cope with traumatic grief, such as the peer-based support organization Tragedy Assistance Program for Survivors (TAPS) and the

Department of Veterans Affairs (VA) Vet Centers. These organizations offer free services to all who are grieving, with focused support for suicide loss.

65. Ensure that Service criminal investigation agencies are staffed appropriately with family advocates trained in communicating with family members whose loved ones might have died by suicide. Maintain effective communication with surviving family members during the investigative process.
66. Develop a consistent DoD policy on memorials that encourages remembrance based on how the Service Member lived, rather than the manner of death. Use WHO/IASP guidelines to avoid increasing risk through glamorizing death, and SPRC recommendations for conducting memorial services.

#### **Focus Area 4: Surveillance, Investigations, and Research**

Strategic Initiative 4A: Conduct comprehensive surveillance aimed at identifying individuals at-risk and informing prevention efforts.

67. Structure DoD to implement surveillance efforts in a standardized manner, with a core focus on informing and improving suicide prevention activities. The DoDSER must be matured, expanded, and refocused to fulfill this surveillance role.
68. Standardize DoDSER surveillance throughout the DoD, including specification of qualifications of surveyor and required training.
69. Facilitate consistent and fluid access to DMSS by DoDSER for appropriate surveillance purposes that also allows for automatic filling of select data fields as appropriate. Aggregation of surveillance data reported using the DoDSER is intended to inform suicide prevention efforts across DoD and the Services through centralized offices at both levels, thus access to DMSS is essential.

*Strategic Initiative 4B: Standardize investigations of suicides and suicide attempts to identify target areas for prevention policies, procedure,s and programs.*

70. Standardize the suicide investigation process across DoD with the sole focus being suicide prevention. The investigation process should be non-attributional, all-inclusive of the days and weeks preceding a suicide or suicide attempt, and be reported in a redacted form, from the Services to OSD, to maintain confidentiality.
71. Institute a modified psychological autopsy and root cause analysis protocol with a standardized process of reporting to a centralized office at the Service and OSD-level. The results of modified standardized investigative procedures can be used to refine and modify the DoDSER and improve surveillance methods. A modified investigatory protocol must include a focus on last days of life; development of a pathway to death that enables identification of potential points of intervention; interaction between person and environment; and access to all currently collected surveillance, as well as medical and personnel records.
72. Place investigative responsibilities in the Safety Division offices of each Service to leverage the expertise, external party team management experience, protected (confidential) approach, and effectiveness of aviation mishap investigations.
73. Review legal protections and make recommendations to Congress, as necessary, to ensure protected status of investigations.

74. Recommend legislation to create procedures that facilitate the timely transfer and sharing of civilian autopsy findings on Service Members (Active Duty, Reserve Component, National Guard) with the Armed Forces Medical Examiner's Office. Evaluate the appropriateness and necessity of access to other civilian findings to improve the tracking of members of the Armed Forces at-risk.

*Strategic Initiative 4C: Ensure that all initiatives and programs have a program evaluation component.*

75. Every suicide prevention program initiated by DoD or the Services must contain a program evaluation component.

*Strategic Initiative 4D: Support and incorporate ongoing research to inform evidence-based suicide prevention practices.*

76. Create a unified, strategic, and comprehensive DoD plan for research in military suicide prevention: (1) ensuring that the DoD's military suicide prevention research portfolio is thoughtfully planned to cover topics in prevention, intervention, and postvention; and (2) assisting investigators by creating a DoD regulatory and human protections consultation board that is responsible primarily for moving suicide-related research forward in an expedited manner.

## **Appendix E – BUMED Report Recommendations**

*The following is a list of recommendations excerpted from the U.S. Navy’s Bureau of Medicine and Surgery (BUMED) 2012 Navy Medicine Review of Medical Personnel Suicides.*

	FOCUS AREA #1: ORGANIZATION & LEADERSHIP		
No.	Strengthen/reinforce policies that support suicide prevention efforts	All Navy	Navy Medicine
1.1	Develop a comprehensive policy to promote systematic and regular communication of risk factors (transitions, mental health issues, sleep, etc.) between Commands, and between and among mental health and health care providers and chaplains. The USMC Force Preservation Council concept can serve as one model. (TFR#44, TFR#45, TFR#51)	X	X
1.2	Remove barriers to “help-seeking behaviors” (i.e. Increased evening appointment times, clear messaging about singular point of contact for psychological support) as part of Navy’s stigma reduction strategy. Adhere to evidence-informed communication principles in these efforts. (TFR#16)	X	X
1.3	Ensure Commanding Officers (CO)/Officers-in-Charge (OIC) have awareness of, and support to act on DoD Instruction 6490.08, Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to service members (17 Aug 2011), which provides guidance for the balance between patient confidentiality rights and the Commander’s right to know for operation and risk management decisions (see Appendix F). (TFR#37)	X	X
1.4	On small bases where privacy is challenging for medical personnel seeking treatment, ensure a culture that supports the importance of self-care as well as confidential delivery of services (e.g., use of pre-approved purchased care, time for travel to an MTF).		X
1.5	Expand available appointment hours to include after-hours scheduling to mitigate absence from work and required permission from Leadership. (TFR#36)	X	X

1.6	Standardize reporting for PAOs, Command Leadership, Service Chiefs and unit commanders on suicide to be consistent with nationally recognized recommendations for “safe public messaging” on suicide; safe messaging is a strategy to reduce the incident of increased suicide risk or other adverse event after a suicide. (Suicide Prevention Resource Center, 2010; OSD Suicide Prevention Public Affairs Guidance). (TFR#14)	X	X
1.7	Educate Commands to attend to individuals facing serious legal/disciplinary events and institute direct referral to MH for evaluation with warm hand-off from command or referring POC. Explore use of Buddy System for those undergoing legal investigations. (TFR#24)	X	X
1.8	Provide mental health and/or legal guidance to service member in case of legal investigations prior to final charges.	X	X
1.9	Reinforce the value and execution of Welfare Checks/Buddy Checks – know where Sailors are if not reporting for duty or UA.	X	X
1.10	Consistent with the USMC Force Preservation Council model, coordinate communication between the Family Advocacy Program (FAP) and medical providers. Improve communication between Command, FAP, CNIC, Chaplains, and other personnel to provide an opportunity for informed decisions regarding disposition of cases, to identify risks and danger signs, and to provide support.	X	X
1.11	Implement the DoD Task Force recommendation to control access to lethal means of self-harm. (TFR#25) The availability of fire arms control is crucial to suicide management (Ramchand, et al., 2011; Kubrin & Wadsworth, 2009; Mann et al., 2002).	X	X
No.	Equip and empower leaders to establish a culture that fosters prevention as well as early recognition and intervention	All Navy	Navy Medicine
1.12	Institute the issuance of a welcome letter to the service member’s family/significant other by the Commander each time the member transitions (letter to include: specific POC for raising issues of concern, recommended family resources and websites, warning signs Commander wants them to know about). (TFR#34)	X	X

1.13	Institute intermittent caring contact (Comtois, 2002) by Leadership as described in the COSC doctrine (hands “on” care) and the Navy OSC Lead (COSC Doctrine, 2010) to manage care across transition points. (TFR#34, TFR#44)	X	X
1.14	Implement OSC Lead training for leaders at all levels and expand Combat Operational Stress First Aid (COSFA). For example, use the Navy Stress Control Guide-Second Ed-CS5_NLL Version Aug 2012.	X	X
1.15	Institute front-line supervisor training prior to assuming any supervisory role. (TFR#7)	X	X
1.16	Expand and strengthen Leadership skills. Tools should be promoted: (TFR#8) Navy and Marine Corps Public Health Center (NEHC) Leader's Guide for Managing Personnel in Distress Web page: <a href="http://www.med.navy.mil/sites/nmcphc/Documents/LGuide/index">http://www.med.navy.mil/sites/nmcphc/Documents/LGuide/index</a>	X	X
1.17	Educate Commands to refer individuals to counseling who are in transition, facing serious duty status consequences of Force Shaping, School failure, or other actions leading to significant change. Times of transition are correlated with increased stress and risk of suicide. The Career Options and Navy Skills Evaluation Program (CONSEP) could be valuable as a “reality check” for service members and Leadership. (TFR#44)	X	X
No.	Leaders take direct action in maintaining awareness of suicide- related issues	All Navy	Navy Medicine
1.18	Ensure leadership is accountable for completion and timeliness in meeting Suicide Prevention Instructions (e.g., Referral to TAPS, SPC assigned, SP training provided, and DoDSER submitted).	X	X
1.19	Monitor closely and act on findings of surveillance data (i.e. Command Climate Survey, Behavioral Health Quick Poll (BHQP) (see Appendix G) that shed light on stigma, stress levels, perception of Command Leadership and awareness of suicide prevention strategies.	X	X

1.20	Mandate suicide prevention training at all levels and evaluate opportunities to combine trainings to reduce redundancy and ineffective delivery of training. (TFR#31)	X	X
1.21	Monitor Navy Medicine personnel data on deployment, TAD, and time away from families for indicators of potential risk, and to ensure compliance with the protective intent of dwell-time policy. (TFR#29)		X

FOCUS AREA #2: PREVENTION & TRAINING			
No.	Improve access to, and promote utilization of, evidence-informed prevention programs and training methodologies for all helping professionals (medical, psychological, chaplain services)	All Navy	Navy Medicine
2.1	Mandate training and the use of the Veterans Administration Safety Plan and Safety Plan Manual to Reduce Suicide Risk (Stanley and Brown 2008) (see Appendix I). (TFR#59)	X	X
2.2	Mandate training and the use of evidence-informed clinical measures such as the Columbia Suicide Severity Rating Scale (Holloway, 2011) (see Appendix J).	X	X
2.3	Mandate provider (mental health and primary care) use of Assessing and Managing Suicide Risk (AMSR). (Suicide Prevention Resource Center, 2010). (TFR#59, TFR#61)	X	X
2.4	Revise the current Navy suicide prevention program to be evidenced-informed. Consider adding social media warning signs from real cases and stressing the importance of taking action on social media posts. (TFR#32)	X	X
2.5	Generate suicide prevention specific information for Care Giver Operation Stress Control (CgOSC) and Combat/Operational Stress First Aid (COSFA) courses.	X	X
2.6	Given the evidence that sleep deprivation is correlated with risk for suicide, emphasize the importance of sleep hygiene and sleep disturbance as a “warm” sign – a yellow rating on the COSC continuum.	X	X
2.7	Most firearm safety educational materials focus on the prevention of accidents rather than on suicide. Firearm safety could include a statement regarding the importance of being alert to signs of suicide in Sailors.	X	X
No.	Improve communication with, and training for, family members and significant others	All Navy	Navy Medicine
2.8	Revise and increase family/significant other scenario-based training on identifying stress and distress (including ongoing social media posts of concern, sleep problems, etc...). (TFR#33)	X	X
2.9	Modify messaging about crisis hotlines to be clear that anyone who is concerned can call for information - a crisis does not have to be imminent.	X	X
2.10	Increase Command and line education awareness about the Family Advocacy Program (FAP) and its benefits.	X	X

2.11	Incorporate compassion fatigue training into current training available to family members. (Sprang, Clark, & Whitt-Woosley, 2007).	X	X
No.	Promote utilization of evidence-informed and skills-informed suicide prevention programs and skills training for sailors	All Navy	Navy Medicine
2.12	Institute skill-rehearsal and discussion based training for critical life skills for Sailors (relationships, coping, self-care, managing expectations & disappointment, communication, conflict resolution) (Brown, 2005; Knox, 2003; Eggert, 2002; LaFromboise, 1995). (TFR#26)	X	X
2.13	Revise current ACT and OSC training to include scenario-based (role playing) training.	X	X
2.14	Emphasize that social media posts from peers may provide opportunities for discussion and follow up.	X	X
No.	Increase awareness of prevention resources and improve compliance with DoD instruction on public messaging about suicide	All Navy	Navy Medicine
2.15	Disseminate positive messages that focus on recovery and hope to help reduce the biases and prejudices associated with psychological and substance use disorders.	X	X
2.16	Increase awareness of and compliance with OSD Suicide Prevention Public Affairs Guidance on speaking/writing/reporting on suicide (Suicide Prevention Resource Center, 2010; OSD Suicide Prevention Public Affairs Guidance). (TFR#14)	X	X

FOCUS AREA #3: ACCESS TO, & DELIVERY OF, QUALITY CARE			
No.		All Navy	Navy Medicine
3.1	Ensure through policy and training that evidence-informed clinical interventions are used such as cognitive behavior therapy (Brown GK, Ten Have T, Henriques GR, Xie SX, Hollander JE, Beck AT., 2005) This may require changes to the length and availability of clinical appointments. (TFR#36, TFR#59)	X	X
3.1.1	Columbia Suicide Severity Rating Scale. Posner, et al (2011)	X	X
3.1.2	Clinical intervention using evidenced-informed treatment such as cognitive therapy. (Brown, et. al)	X	X
3.1.3	Mandate Safety Plans: VA Safety Plan Manual to Reduce Suicide Risk (Holloway, 2011; Stanley and Brown, 2008). Provide training to providers and other specialties including non-medical counselors, chaplains, and Family Advocacy Program (FAP) personnel. Any person with depression, PTSD, Suicide Risk should have a safety plan.	X	X
3.1.4	Institute provider (mental health, primary care, and non-medical counselors and chaplains) use of Assessing and Managing Suicide Risk (AMSR).	X	X
3.1.5	Distribute, train, coach, monitor application of DoD/VA Clinical Practice Guidelines (CPGs) on depression, PTSD, anxiety, and substance abuse to Navy personnel. Disseminate DCoE pocket guidelines.	X	X
3.2	Physician protocols should include:		
3.2.1	Recognition and treatment of depression by primary care provider.	X	X
3.2.2	Provider alert to increased medication-seeking behavior.	X	X
3.2.3	Provider alert to duration of maintenance of sleep and/or pain medications.	X	X
3.2.4	Routine screening for sleep problems (parallel to pain protocols). Include a sleep scale in Vitals module to be filled out at every medical appointment. This will prompt provider engagement on the topic and educate that sleep disturbance is not merely a factor of a bigger condition (Picchioni, et al., 2010; Hopf, 2011).	X	X
3.2.5	Encourage use of sleep journals as standard practice.	X	X
3.2.6	Aviation community has software that determines “toxicity” of sleep deprivation; explore use for Navy Medicine.	X	X

3.3	Develop a Clinical Practice Guideline for Suicide Assessment and Treatment; other guidelines might serve in the interim (American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, April 2004) (TFR#59). Provide training on the guideline to medical and behavioral health personnel as well as Chaplains and non-medical counselors (e.g. FAP, CNIC).	X	X
No.	Improve access to confidential and coordinated care	All Navy	Navy Medicine
3.4	Expand hours for MTF/Medical Clinic care to include off-duty hours/evenings and weekends, with a focus on increasing privacy and accessibility for care at small clinics and/or small bases. (TFR#36)	X	X
3.5	Expedite use of uniform case management tracking tool to coordinate care across longitudinal lines (e.g., permanent change of station, temporary change of station, release from Active Duty, confinement, hospitalization, forced rate conversion, and extended leave status.). (TFR#39) (TFR#40)	X	X
3.6	Ensure Reserve Component service members have access to evidence-informed treatments and community support services, especially during transitions. BUMED Reserve Psychological Health Outreach Program can provide commands with local resources and provide support.	X	X
No.	Develop additional strategies to screen, identify, and address at-risk service members	All Navy	Navy Medicine
3.7	Screen at beginning of transfer to a new command or 3-4 months after checking in because the protective factor of the USN is not in place yet.	X	X
3.8	Flag frequent medical encounters: AHLTA algorithm for identifying people who have an increased number of medical visits in a certain timeframe.	X	X
3.9	Develop, evaluate, and more widely disseminate peer-to-peer programs that intentionally promote not only connectedness, but also risk identification and response for AD and Reservists. (TFR#47)	X	X
No.	Protect those impacted by suicide through effective interventions	All Navy	Navy Medicine
3.10	Incorporate post-vention programs at the unit, command, and family level so that those close to/impacted by a suicide or suicide-related event have support to reduce the risk of suicide. Effective debriefing and prevention must be central to the efforts. (TFR#62)	X	X

FOCUS AREA #4: SURVEILLANCE			
No.	Increase surveillance of risk behaviors	All Navy	Navy Medicine
4.1	Research indicates increased usage of health care prior to suicidality. Institute routine surveillance of primary care visits with AHLTA flags to alert medical providers. (TFR#54)	X	X
4.2	Institute routine surveillance of sleep problems and sleep prescriptions with AHLTA flags to alert medical providers.	X	X
4.3	Add mental health assessment (as has been added to the MHA) to the Periodic Health Assessment (PHA) process as was done with the PDHA and PDHRA. (NAVMED 6100/8 (3/2012). (TFR#10)	X	X
4.4	Monitor Navy Medicine personnel data on down time and TAD to ensure compliance with the dwell-time policy after deployment and/or time away from home. (TFR#29)		X
No.	Increase awareness of, and compliance with the OPNAV Instruction 3100.6H for the DoDSER reporting requirement	All Navy	Navy Medicine
4.5	Continue effort to enhance fidelity and completeness of the DoDSER and improve Command compliance, especially at MTFs. The SG could issue a BUMED directive about the importance of the DoDSER fidelity, completeness, and timeliness. (TFR#67)	X	X
4.6	Issue instructions to assist Command in selection of personnel completing each DoDSER to increase objectivity and responsibility for the investigation. (TFR#67)	X	X
4.7	Pre-populate DoDSER with information from standard data sources (e.g., Defense Manpower Data Center (DMDC), Comprehensive Ambulatory/Professional Encounter Record (CAPER).	X	X
4.8	Adopt the Center for Disease Control's definitions for suicide nomenclature (i.e., suicide attempt) in DoDSER.	X	X
No.	Support and expand efforts to obtain baseline psychological health and health data	All Navy	Navy Medicine
4.9	Adopt for Navy the pilot Recruitment Assessment Program (RAP) underway at Naval Health Research Center (NHRC) for the Marine Corps Recruit Center (San Diego) for newly enrolled service members to establish base line of pre-induction risk factors (see Appendix L).	X	X



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## ***Appendix G – Critical Interviews***

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ADM William E. Gortney, Commander, U.S. Fleet Forces Command.

ADM (retired) Michael Mullen, CJCS

Brig Gen Eden J. Murrie, Director, Air Force Services.

BG Barry L. Price, Director, Human Resources Policy Directorate.

CAPT Bruce Cohen, Navy Expeditionary Combat Command (NECC).

CAPT Mark N. Copenhaver, Office of the Navy Inspector General.

CAPT Gerard Cox, Office of the Navy Inspector General.

CAPT Steve Holmes, BUPERS-3.

CAPT Scott Johnston, MC, Director, Navy Center for Combat & Operational Stress Control.

CAPT Lori Larraway, NC, NECC.

CAPT Melanie O'Brien, NRC N3.

CAPT John Sears, OPNAV N13B.

CDR Barry Adams, MSC, Director, Deployment Health Program Manager, Code M9-2, Wounded Ill and Injured (WII), Bureau of Navy Medicine and Surgery.

CDR Elena Ingram, OPNAV N814M.

Dr. Joie Acosta, Behavioral Scientist, RAND Corp.

Dr. Jay Churchill, Ph.D, Director, National Institute of Mental Health (NIMH).

Dr. Keita Franklin, Behavioral Health Branch Head, United States Marine Corps

Dr. Chris Gilchrist, Ph.D., Psychotherapist and Licensed Clinical Social Worker (LCSW), "Out of the Darkness".

Dr. Ann P. Haas, Director of Education & Prevention, American Foundation for Suicide Prevention (AFSP).

Dr. Thomas R. Insel, M.D., NIMH.

Dr. Harold Dennis Kade, NECC.

Dr. Jan Kemp, Ph.D., Department of Veterans Affairs National Suicide Prevention Coordinator.

Dr. Kevin Quinn, NIMH.

Dr. Rajeev Ramchand, Ph.D., Behavioral Scientist, RAND Corp.

Dr. Karen Reivich, Ph.D., Co-Director, Penn Resiliency Project.

Dr. M. David Rudd, Ph.D., Dean, College of Social & Behavioral Science, Clinical Psychology, University of Utah.

Dr. Edmund Schmitz, CNA.

EODC Mike Greenwood, NECC.

FLTCM Scott A. Benning, USN, Manpower, Personnel, Training, & Education Fleet Master Chief.

GEN Peter Chiarelli (ret.), CEO, ONE MIND for Research.

GEN Carter F. Ham, Commander, U.S. Africa Command.

GEN Raymond T. Odierno, Army Chief of Staff.

LTG Howard B. Bromberg, Deputy Chief of Staff G-1.

Hon. Juan M. Garcia, Assistant Secretary of the Navy for Manpower & Readiness Affairs.

LCDR Rose Goscinski, OPNAV N814.

LCDR Claude McRoberts, NRC N37.

Maj Jason Bogden, USMC Representative.

Maj Kathleen Crimmins, USAF Suicide Prevention.

Maj Gen Douglas J. Robb, Joint Staff Surgeon.

MGen(sel) Robert F. Hedelund, Director, Marine and Family Programs.

MCPON Mike D. Stevens, Master Chief Petty Officer of the Navy.

MG Gary S. Patton, Director, Sexual Assault Prevention and Response Office.

Mr. Bill Crowley, Director Program Evaluation & Analysis, Defense Suicide Prevention Office.

Mr. Dennis Dingle, Special Assistant to the Director, Office of the Deputy Chief of Staff, G-1, Human Resources Policy Directorate (DAPE-HR).

Mr. Robert T. Gebbia, Executive Director, AFSP.

Mr. Chris Gilchrist, LCSW, practicing psychotherapist in Norfolk, VA

Mr. Bryan Hixson, CEO Neurotopia.

Mr. Steve Iselin, AFSP.

Mr. John Madigan, Senior Director of Public Policy, AFSP.

Mr. David J. McIntyre, Jr., President and CEO, TriWest Healthcare Alliance.

Mr. Victor Schwartz, Medical Director, JED Foundation.

Ms. Nicole Bartlett, Program Specialist, Functional Systems IT (Case Management System).

Ms. Leanne J. Braddock, Operational Stress Control/Suicide Prevention Project Manager (N135).

Ms. Bonnie Carroll, President and Founder of Tragedy Assistance Program for Survivors (TAPS).

Ms. Rosye Cloud, Director of Policy for Veterans, Wounded Warriors and Military Families, White House.

Ms. Luanne Ellingson, retired Navy Chief of 25 years, Edward Jones Investment Office Manager; actively involved with anti-suicide efforts in Norfolk, VA.

Ms. Kim Ruocco, Director for Suicide Outreach and Education Support Programs at TAPS, LCSW.

Ms. Marguerite (Peg) Tackett, Fleet and Family Support Program Manager, Mid-Atlantic Region.

Ms. Terri Tanielian, Ph.D., Senior Social Research Analyst, RAND Corp.

Ms. Lisa Teems, United States Coast Guard Representative.

RADM Maura K. Dollymore, Director of Health, Safety & Work-life, United States Coast Guard.

RADM Clinton F. Faison, MC, Commander, Navy Medicine West/Naval Medical Center, San Diego.

RADM Michael T. Franken, Chief of Legislative Affairs.

RADM Mark D. Guadagnini, Director, Maritime Headquarters.

RADM William H. Hilarides, Special Assistant to the Deputy Chief of Naval Operations for Information Dominance for Research, Strategy, and Integration.

RDML John F. Kirby, Chief of Information.

RADM Anthony M. Kurta, Director, Military Personnel Plans & Policy.

RADM(sel) Michael C. Manazir, Commander, Carrier Strike Group EIGHT.

RADM Michael H. Mittelman, MSC, Deputy Chief, Bureau of Medicine and Surgery.

RADM William F. Moran, Director, Air Warfare Division.

RADM Elizabeth S. Niemyer, NC.

RADM Mark L. Tidd, CHC, Chief of Chaplains/Director of Religious Ministries.

RADM Michael P. Tillotson, Commander, NECC.

RDML Martha Herb, Director, Personnel Readiness & Community Support.

RDML(sel) Alex L. Krongard, Director, Combating Terrorism, National Security Council.

RDML Kenneth J. Norton, Commander, Naval Safety Center and CMDCM Susan A. Whitman, Naval Safety Center Command Master Chief.

VADM Allen G. Myers, Deputy Chief of Naval Operations for Integration of Capabilities and Resources.

VADM Kendall L. Card, Deputy Chief of Naval Operations for Information Dominance/Director of Naval Intelligence.

VADM Mark I. Fox, Deputy Chief of Naval Operations for Operations, Plans, and Strategy.

VADM Matthew L. Nathan, MC, Surgeon General of the Navy.

VADM Philip H. Cullom, Deputy Chief of Naval Operations for Fleet Readiness & Logistics.

RADM(sel) Kevin R. Slates, CEC, Director, Energy and Environment.

VADM Rick Hunt, Director, Navy Staff.

VADM Scott R. Van Buskirk, Deputy CNO for Manpower, Personnel, Training & Education/Chief of Naval Personnel.

VADM William D. French, Commander, Navy Installations Command.

# ***Task Force Resilient***

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## **Rear Admiral Walter E. “Ted” Carter, Jr., USN Commander**

### **Task Force Resilient Flag Staff**

- CAPT Peter Galluch, USN, Surface Warfare Officer, Chief Of Staff
- LT Chip Evans, USN, Naval Special Warfare, Flag Aide
- ITCS(SW) Aaron Henson, USN, Senior Enlisted Advisor
- YN1(SW) Amber Suggs, USN, Administrative Assistant

### **Task Force Resilient Team Leads**

- CAPT Nancy Hight, USN, PhD., Medical Service Corps (Non-DoD Programs)
- CDR Daniel Sullivan, IV, USN, Naval Aviator (Navy Programs)
- CDR David Walt, USN, Naval Aviator (Research Analysis / Final Report)
- LCDR Chris Gilmore, USN, Submarine Officer (Operational Environment)

### **Task Force Resilient Members**

- CDR Lynne Blankenbecker, USNR, Medical Service Corps
- CDR Michael Gore, USN, Chaplain Corps
- LCDR Carolyn Crary, USN, Naval Flight Officer
- LCDR Jason Grower, USN, Naval Aviator
- LCDR Mike Nordeen, USN Naval Aviator
- LCDR Joshua Sanders, USN, Information Warfare Officer
- LCDR Jonathan Williams, USN, Naval Intelligence Officer
- LT Quincy Hochard, USN, Naval Aviator
- LT Scott Sharrow, USN, Submarine Officer
- LT Brent Shrader, USN, Submarine Officer



**Task Force Resilient  
Final Report**

**April 2013**