INSTITUTE FOR DEFENSE ANALYSES

Strengthening the Contributions of the Defense Suicide Prevention Office to DOD's Suicide Prevention Efforts

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November 2016
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IDA Paper P-8248
Log: H 16-001218

INSTITUTE FOR DEFENSE ANALYSES
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Alexandria, Virginia 22311-1882

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About This Publication

This work was conducted by the Institute for Defense Analyses (IDA) under contract HQ0034-14-D-0001, Task BA-6-3848, "Research and Analysis in Support of the Defense Suicide Prevention Office," for the Under Secretary of Defense for Personnel and Readiness. The views, opinions, and findings should not be construed as representing the official position of either the Department of Defense or the sponsoring organization.

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Acknowledgments

The authors wish to thank Sheila Earle, John Whitley, and Robert Zirkle for their review of this document. They also wish to thank all of those who were interviewed in the course of this research for their time and insights.

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Executive Summary

The Defense Suicide Prevention Office (DSPO) tasked the Institute for Defense Analyses (IDA) to conduct a wide-ranging, independent review of its activities and organization. Specifically, DSPO asked IDA to: review its strategic plans; assess its organizational structure and effectiveness; examine data and analyses capabilities and challenges; review program evaluation approaches; and provide recommended improvements.

The focus on suicide prevention within the Department of Defense (DOD) has grown over the last decade. Since 2008, the suicide rate of the active duty military population has consistently exceeded that of a comparable civilian population, adjusted for age and sex. While each Service has long had its own suicide prevention program, the 2010 Report of a DOD Task Force recommended the creation of a policy office within the Office of the Secretary of Defense (OSD) to unify suicide prevention efforts across the DOD.[1] DSPO was established in 2011 in response to that recommendation.

A. IDA's Research Approach

IDA's research draws on an extensive literature review and interviews with over 70 stakeholders both within and outside DOD. The IDA study team employed a multi-step organizational assessment framework addressing three major questions:

- Are DSPO's current mission, vision, functions, and deliverables consistent with DOD's needs?
- Is DSPO employing the most effective and efficient management mechanisms?
- Is DSPO properly organized, staffed, and resourced?

Commonly when using this methodology, fairly diverse perspectives can begin to coalesce around what could be categorized as schools of thought. Different schools might emerge because those interviewed have different stakeholder roles, such as being part of the organization's customer base or being a subject matter expert external to the organization. Traditionally, the analysis then assesses the strengths and weaknesses of each identified school of thought. In the case of this research on the DSPO organization, however, IDA found that stakeholder perspectives largely converged on the central issues. There was strong commonality of views on DSPO's purpose, its functions and deliverables, how well it is doing its job, the management mechanisms and staff resources it needs to perform well, and some of the improvements that still need to be made.

[1] Report of the DOD Task Force on Prevention of Suicide by Members of the Armed Forces, *The Challenge and the Promise: Strengthening the Force, Preventing Suicide, and Saving Lives* (Washington, D.C.: DOD, August 2010).

This report is organized into four parts, the first three of which address these three questions; the fourth part summarizes IDA's recommendations. The first part provides an overview of DSPO's mission and describes how DSPO has evolved as an office. Part One also provides IDA's assessment of DSPO's value-added functions. Part Two focuses on the mechanisms DSPO is developing as it moves toward an evidence-based approach. These include mechanisms for: program evaluation; suicide data management and DSPO's reporting obligations; and shaping research on suicide prevention and translating emerging evidence into action. Part Three assesses DSPO's organization and staffing. A final chapter (Part Four) presents the study's conclusions and summarizes IDA's recommendations.

B. Findings and Recommendations

IDA finds that DSPO's mission is appropriate, consistent with its position as an OSD policy office, and is understood by DSPO's staff and external stakeholders. Our interviews show that stakeholders believe DSPO has become better focused since it began its second phase of operations in early 2015 under the leadership of a new Director. DSPO has adopted a public health approach that is widely embraced in the suicide prevention community. In parallel, DSPO is continuing to work toward an evidence-based management framework including concerted efforts to improve its mechanisms for program evaluation, data management, and research support. DSPO's capability to perform its functions and provide value-added deliverables has also improved appreciably. DSPO has hired additional staff members with requisite subject matter expertise. More generally, DSPO has placed increased focus on collaboration and communication with all suicide prevention stakeholders.

DOD suicide rates have declined from 2012 levels, but remain above comparable civilian rates. By this measure, it cannot be proven that DSPO has "bent the curve" and measurably reduced the incidence of suicide. Still, beneath the surface, there is reason to expect that dissemination of innovative practices, such as the U.S. Marine Corps' "Marine Intercept Program" and the adoption of specific actions identified in ongoing research will lead to measurable improvements in the coming years.

While the IDA study team's overall assessment of DSPO's status and direction is positive, this report, nevertheless, provides 80 recommendations on actions to continue progress and to improve further DSPO's functions and deliverables.

1. Mission and Functions

IDA's study team defined seven broad value-added functions that are being performed by DSPO: strategy and policy; collaboration and advocacy; outreach and education; program evaluation; data management; support for research; and resource management. It is IDA's assessment, and the feedback from the entire stakeholder community, that the focus on these functions is appropriate given DSPO's mission and position as an OSD policy office.

The priority action needed in this area is for DOD to close the guidance gap on roles and responsibilities through prompt completion of the Department of Defense Instruction (DODI) for suicide prevention. In addition, to further strengthen its collaboration with stakeholders, DSPO should work to expand participation in the DOD suicide prevention governance structures — the action officer-level Suicide Prevention and Risk Reduction Committee (SPARRC) and the Suicide Prevention General Officer Steering Committee (SPGOSC) — to include both Reserve Component and Active Component Service stakeholders. It should also ensure that these bodies are structured to drive decisions informed by evidence-based research. Finally, DSPO should leverage its newly hired outreach staff to fulfill its clearinghouse role for the community through actions such as maintaining a repository of suicide prevention resources on its website.

2. Management Mechanisms

DSPO has made significant investments in developing the mechanisms for adopting an evidence-based approach in executing its functions.

Program evaluation. Program evaluation is one of DPSO's most important and challenging mandates, given the difficulty of assessing prevention programs for such a complex human phenomenon. With the guidance of a conceptual model informed by recent research from the World Health Organization (WHO), DSPO is developing, in close collaboration with the Services and other stakeholders, metrics for quantifying program effectiveness.

As DSPO solidifies an evaluation framework, one key area for clarification will be determining who should be performing the evaluations: DSPO or the Services? The IDA team believes that DSPO's approach of identifying specific programs using an agreed-upon assessment framework for the Services to use in reporting annually on their programs is an appropriate model. This evaluation framework has been developed with an awareness of existing external tools and best practices and in coordination with relevant community stakeholders, DOD and non-DOD, to explore the applicability of such tools and practices to the DOD context.

To complement these metrics, DSPO could also work with the Services to develop a structured approach for DSPO's participation in installation field visits to contribute to its fact-finding efforts. Such visits could improve DSPO's understanding of ground truth on suicide prevention successes, challenges, and practical considerations. These visits could provide an avenue to share expertise and best practices and increase field awareness of resources available through DSPO. Field visits would not take the form of program inspections; rather they would be focused on information-sharing.

Data. Much progress has been made in the realm of data management since 2015, especially in DSPO's access to current DOD data. Several additional actions are needed. First, DSPO and the Department of Veterans Affairs (VA) should craft a strategic plan to improve the Suicide Data Repository's (SDR) content and structure. In parallel, DSPO and the VA should ensure research teams are aware of the availability of SDR data. At the same time, research

utilizing SDR data should be aligned to DOD/VA research priority areas, and results of that research should be provided routinely to DSPO and the VA. Second, beyond the SDR, DSPO should establish avenues for sharing the results of the Services' deep dives on suicide cases as well as explore the feasibility of requesting observer status at those deep dives. Finally, DSPO and the Services must address a new Congressional requirement for reporting on suicides among military dependents. DSPO has proposed a path for collaborating with the Services and the Defense Manpower Data Center (DMDC) to explore the feasibility of using the Defense Enrollment Eligibility Reporting System (DEERS) as a mechanism for obtaining relevant family data. This approach should be explored through a trial assessment of these data in DEERS.

Research. DSPO's evidence-based management approach emphasizes the role of research as a foundation for informing program planning. Through its methodology of translating research into evidence-based practices), DSPO seeks to establish a mechanism that will consistently bridge the gap between research and practice, resulting in programs that are informed by emerging evidence from researchers and practitioners.

Given the limited funding available, DSPO should direct its efforts toward identifying research gaps and providing financial support to address those gaps, such as in prevention. It should also support, coordinate, and shape the work of the major research funding activities across the Federal Government. Most importantly, DSPO could provide a major pathway for facilitating the translation of that research into practice. In the first role, DSPO should continue to work collaboratively with existing research governance bodies as well as other key entities in the DOD research community to identify research gaps and priorities in support of goals laid out in the *Defense Strategy for Suicide Prevention*, issued in December 2015. DSPO's Research Summit series is a key collaborative mechanism toward that end. To augment this role as research facilitator and clearinghouse, DSPO should promote stakeholder awareness of and access to research via the Defense Suicide Prevention Research Analysis Tool (DSPRAT) and the DSPO website. This allows DSPO to fulfill its clearinghouse role of sharing valuable resources and information about those involved in suicide prevention research.

In the second role of translating research into action, DSPO should continue the collaborative efforts it has established with other stakeholders. Some additional avenues to foster translation of research include: focusing available DSPO funding on initiatives to pilot test and field new approaches based on emerging research; building the expertise needed to assist DSPO and stakeholders in translating current research; helping shape future research proposals and projects so that they are better geared toward translation; and utilizing the SPARRC to engage Service program managers on this goal.

3. Organization and Staffing

IDA finds that the recent changes to DSPO's organizational structure and greater transparency of this structure have significantly enhanced its operations. The DSPO staff is not a large one and as it further develops the needed management mechanisms described above, the

office will likely require some additional talent. During the conduct of most of this research, DSPO was organizationally aligned under the Office of the Executive Director for Force Resiliency (OEDFR). While this alignment theoretically offered many potential benefits, such as greater integration and collaboration among its offices to enhance the resiliency portfolio, they were never fully realized during OEDFR's brief tenure before its elimination in late 2016. It will be important for the latest P&R reporting structure, including DSPO's placement under the Assistant Secretary of Defense for Readiness, to encourage collaboration across the resiliency portfolio.

The IDA team has identified some organizational actions that would improve DSPO's performance of its current functions. For example, DSPO would benefit from a more comprehensive military presence representing both Active and Reserve Components. DSPO has benefitted greatly from past military billets filled by Active Component (AC) subject matter experts and has sought transfer of unfilled Personnel and Readiness (P&R) billets to bring on additional military expertise. DSPO should seek to add a Reserve Component (RC) position to inform the office's various functional areas (policy, research, data, outreach) on Reserve/National Guard-unique issues to help identify gaps, work to identify evidence-based programs to fill those gaps, and facilitate the sharing of best practices on ways to adapt suicide prevention programs and training to better serve RC needs. Other areas of staff augmentation DSPO should consider include additional experts in the program evaluation and data surveillance portfolios, as well as legislative liaison staff support for DSPO responses to Congressional inquiries.

A new organizational function that DSPO should consider piloting to fulfill both postvention and outreach mandates is the establishment of one or more deployable postvention teams. Drawing on a roster of certified experts from DOD and other government/non-government entities, these teams could provide surge support to installations in need in the aftermath of multiple suicide incidents. Such teams could assist installation leadership with strategic communications, advise on policy, and provide surge counseling capacity. The OUSD Military Community & Family Program (MC&FP) Family Advocacy Community Assistance Team (FACAT) model could serve as a template to draw on for this concept.

DSPO's placement and reporting structures within P&R have shifted several times since its inception. DSPO would benefit from more consistency and stability. The OEDFR structure within P&R was designed to offer a more coherent umbrella for DSPO and counterpart offices which share responsibility in support of DOD's Total Force resiliency mandate. OEDFR's intent, which the new P&R organizational structure may continue, was to facilitate collaboration and sharing of best practices among the offices charged with personnel wellness initiatives. DSPO should take advantage of the Prevention Wellness Collaboration forum and explore collaboration opportunities with other P&R counterparts such as the Operation Live Well's (OLW) Building Health Military Communities (BHMC) pilot. DSPO's collaboration with BHMC could leverage existing programs to improve military community awareness of suicide prevention resources and

coordinate planned surveys to collect data relevant to assessing the impact of suicide prevention programs and interventions.

C. Conclusion

DSPO has evolved markedly since it was formed in 2011. Despite many challenges, it has made considerable progress developing into an office poised to carry out its mandate to provide an overarching policy framework and a more standardized, evidence-based approach to suicide prevention in the DOD. The current DSPO leadership is on the right trajectory to foster strategic alignment on suicide prevention programming across the DOD enterprise. The recommendations in this report provide DSPO with options to improve further its operations and organization to drive continued progress.

Contents

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1. Introduction

A. Overview of IDA's Tasking

The Defense Suicide Prevention Office (DSPO) within the Defense Human Resource Activity (DHRA) of the Office of the Undersecretary of Defense for Personnel & Readiness (OUSD(P&R)) requested the Institute for Defense Analyses (IDA) to conduct an organizational analysis and programmatic review of its office. The principal objective of this research is to identify opportunities to improve DSPO's operations and organization while ensuring that the office is well-organized and positioned to drive continued progress across the Department of Defense (DOD) toward strategically aligned efforts that support an environment where suicide prevention is integrated into DOD's policies and programs. The timing for this review is propitious as DSPO has now existed for five years and has had an opportunity to establish itself and its functions. This review assesses the organization's progress, identifies opportunities for adjustments to its activities, and provides additional independent feedback on the organization's operations.

DSPO asked the IDA research team to focus on aspects related to organizational effectiveness and program efficacy. Specifically, it tasked IDA to review DSPO's strategic plans; assess its organizational structure and effectiveness; examine data and analysis capabilities and challenges; review program evaluation approaches; and provide recommended improvements. This report conveys the findings and recommendations from IDA's research into these topics.

B. DOD Suicide Prevention Programs and Suicide Trends in the Military

As a backdrop to the programmatic review, it is useful to review briefly the evolution of DOD's suicide prevention efforts and to examine how suicides in the military forces compare to and differ from those in the civilian community. One of the first signals of a nation-wide recognition to pay more attention to suicide and suicide prevention came with the 1999 publication of the *Surgeon General's Call to Action to Prevent Suicide.*[2]

1. Nascent DOD Collaboration

DOD suicide prevention efforts were initially addressed within each of the Military Services through Service-specific programs, but they were absent an overarching DOD policy framework, had only limited coordination mechanisms across the department, and, in many cases, lacked standardized approaches.[3] The beginning of some DOD-wide efforts to address suicide, albeit still without an overarching DOD policy office to provide necessary oversight and coordination, began in 1999. For example, the Suicide Prevention Risk Reduction Committee

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2 U.S. Public Health Service, *The Surgeon General's Call to Action to Prevent Suicide* (Washington, D.C.: 1999).

3 A synopsis of each Service's program is offered in Appendix A.

(SPARRC) was formally established in September as a result of a White House initiative in July of that year. The SPARRC consisted of members from the military and the Department of Veterans Affairs (VA) and fostered collaboration among the Services, DOD, and other agencies.[4] In 2002, DOD held the first annual Military Suicide Prevention Conference. Subsequently, in response to senior leadership calls for greater standardization, the SPARRC established working groups to address certain goals: Suicide Rate Standardization (2005), Suicide Nomenclature Standardization (2006), and Data Collection (2007) (later called the Department of Defense Suicide Event Report (DoDSER) working group). Outside of DOD, the International Association for Suicide Prevention set up a Task Force on Defense and Police Forces in 2007 and, in that year, the North Atlantic Treaty Organization (NATO) also stood up an exploratory team to look at military suicide in its member nations.

Given multiple Federal efforts to develop common nomenclature by the Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA),[5] VA, and DOD, the SPARRC working group deferred establishing policy on standard terms until they could reach agreement with the VA to ensure continuity of care as the military population transitioned to civilian life. In 2010, the DOD, VA, CDC, and SAMSHA all agreed to adopt the same nomenclature.[6]

With regard to data, the SPARRC working group developed the DoDSER standardized format for suicide event reporting in 2007, which was implemented across the Services on January 1, 2008, replacing Service-specific forms previously used. The data repository for the Service DoDSER inputs was established at the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE), National Center for Telehealth & Technology (T2).[7] DCoE was stood up in November 2007 in response to recommendations from the 2006-2007 DOD Task Force on Mental Health to establish "a tri-Service center of excellence with the goal of promoting resilience, recovery and reintegration of warriors and their families."[8] In 2008, DCoE produced the first annual report on military suicides for the Assistant Secretary of Defense for Health Affairs (ASD(HA)) drawing from the DoDSER database.[9]

In 2008, DOD-level suicide prevention efforts - to include the SPARRC, its working groups, and the annual suicide prevention conference - moved under DCoE. In 2009, the annual conference was sponsored by the DOD and the VA, and interagency stakeholders from

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4 Department of Defense (DOD) Task Force on Prevention of Suicide by Members of the Armed Forces, *The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives* (Washington, D.C.: DOD, August 2010), 12-13. (Hereafter: DOD Task Force, *The Challenge and the Promise*.)

5 Both the CDC and SAMHSA are part of the Department of Health and Human Services.

6 DOD Task Force, *The Challenge and the Promise*, 12-13.

7 Ibid., 13-14.

8 Ibid., 14.

9 Ibid.

SAMHSA and the CDC were added as "adjunct" SPARRC members.[10] These DOD-level efforts continued under these auspices until DSPO was established.

2. The Creation of DSPO

DSPO was established in 2011 in response to the 2010 Report of the DOD Task Force on Prevention of Suicide by Members of the Armed Forces, *The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives* (hereafter, the DOD Task Force), and legislation in the National Defense Authorization Act (NDAA) 2012, *Public Law 112-81, Section 533*, December 31, 2011. One of the Task Force's findings was: "The absence of an adequately staffed and resourced OSD policy office on suicide prevention leads to significant challenges to the unity of effort. Service programs are not benefiting from the guidance of a Department-wide strategic approach." It, therefore, recommended that DOD:

> 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.[11]

In the policy realm, DOD has drawn from the work of the National Action Alliance for Suicide Prevention (NAASP), established in 2010 as a public-private partnership to advance the *National Strategy for Suicide Prevention* (NSSP). The NAASP stood up an expert task force which developed the 2012 update of the original 2001 NSSP.[12] In 2015, DSPO prepared and DOD issued the *Defense Strategy for Suicide Prevention* (DSSP), based on the NSSP, to guide defense-wide implementation of the national strategy.

3. DSPO was Created to Address the Growth in Suicide Rates

It is helpful to understand how DOD suicide rates and their changes over time compare to the broader picture of suicide numbers across the United States. In 2014, the rate of suicide among U.S. civilian adults was 15.2 per 100,000.[13] That rate represented a total of 41,425 Americans who died by suicide in 2014.[14] More recent analysis by the CDC, released in April 2016, indicates the United States is experiencing "a sustained increase in suicide rates across all age groups for both sexes" with a 24 percent rate increase from 1999-2014, as compared to a

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[10] Ibid.

[11] Ibid., 49, 51.

[12] Department of Health and Human Services (HHS) Office of the Surgeon General and the National Action Alliance for Suicide Prevention, *2012 National Strategy for Suicide Prevention (NSSP): Goals and Objectives for Action* (Washington, D.C.: HHS, September 2012), 10-11, 95.

[13] VA Suicide Prevention Program, *Facts about Veteran Suicide*, July 2016, 2.

[14] Ibid., 2.

downward trend from 1986-2000.[15] Similarly, there have been increases in the military rate compared to civilian rates. In 2008, the military suicide rate surpassed that of the general civilian population for the first time since 1977.[16] Since 2008, the suicide rate of the active duty military has consistently surpassed that of a comparable civilian population, based on age and sex.[17] However, it should be noted that, per the 2014 DoDSER (which is the primary DOD data report issued each year), "there were no *statistically significant* differences between the calendar year (CY) 2014 military suicide rate and the CY2013 U.S. population suicide rate after adjusting for differences in age and sex."[18]

Comparisons between military and civilian populations should be made carefully because, unless explicitly specified, general civilian populations and military populations have not been adjusted to match. While comparisons between civilian and military populations can be made to identify very general trends, specific comparisons should only be made when a matched (comparable) population is used. Before the 2014 DoDSER Annual Report, military suicide rates adjusted to be comparable to civilian populations in age and sex were not reported. In the 2014 report, adjusted rates for the years 2012-2014 were provided.[19] Figure 1 illustrates the adjusted rates for those years.

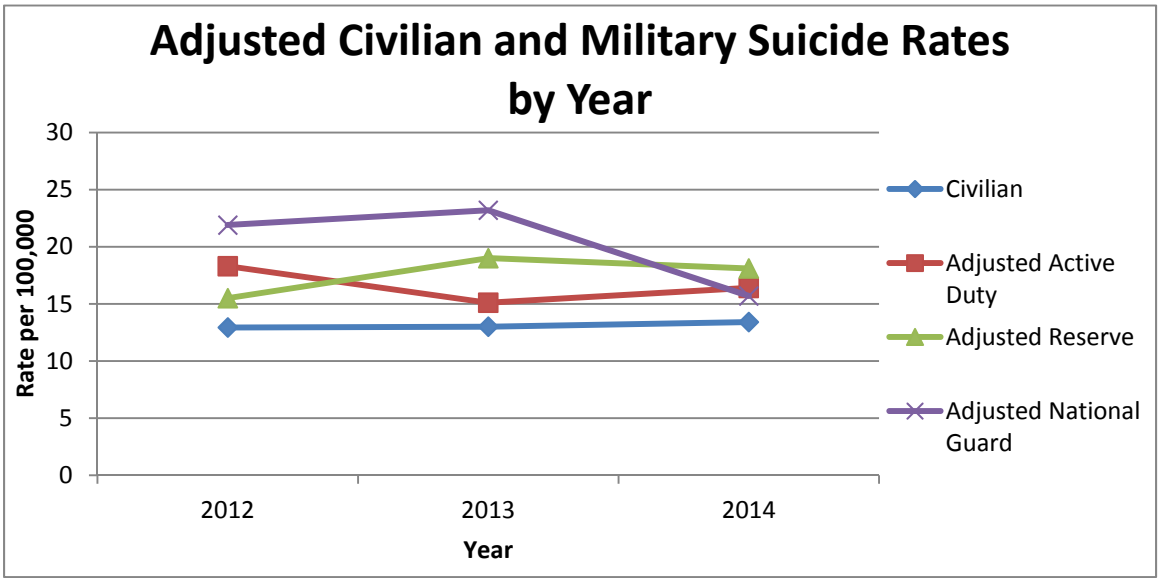

Figure 1. Comparison of Adjusted Civilian and Military Suicide Rates, 2012-2014

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15 "Suicide: The Saddest Trend," *The Economist*, April 30, 2016, 29.

16 Bruce Bower, "As Suicide Rates Rise, Researchers Separate Thoughts from Actions," *Science News*, https://www.sciencenews.org/article/suicide rates rise researchers separate thoughts actions.

17 Ibid.

18 National Center for Telehealth & Technology (T2), *Department of Defense Suicide Event Report (DoDSER) Calendar Year 2014 Annual Report* (Washington, D.C.: DOD, January 2016), vii. Emphasis added. (Hereafter T2, *DoDSER 2014 Annual Report*.)

19 These data trends are discussed more fully in Chapter 5.

The differences between (and similarities across) military and civilian suicides can be important for understanding, for example, what outreach and training may be most effective and what research gaps need to be addressed. To summarize some of these differences and similarities: those dying by suicide in the military are younger than in the civilian population.[20] Males die by suicide at a much higher rate than females in both military and civilian populations.[21] However, among women, the suicide rate is higher in the military community than in the civilian community.[22] In both military and civilian populations, firearms are the most common suicide method used.[23]

Some trends just within the military include: active duty suicide rates decreased from 2012 to 2013 but then climbed again in 2014, the last full year for which data are available.[24] The Army has historically had the highest active duty suicide rate of all the military branches.[25] At 18.1 per 100,000, the Reserves had the highest adjusted suicide rate of all the Components in 2014.[26] More detail about these trends can be found in Appendix B.

C. IDA Study Approach

The IDA study team employed a multi-step organizational assessment framework addressing three major questions:

- Are DSPO's current mission, vision, functions, and deliverables consistent with DOD's needs?
- Is DSPO employing the most effective and efficient management mechanisms?
- Is DSPO properly organized, staffed, and resourced?

To assemble the necessary information, IDA pursued the following lines of effort:

- Literature Review
  - Baseline documentation
    - National guidance (e.g., NSSP, NDAA legislation)
    - DOD/DSPO documents (e.g., DOD Task Force, Department of Defense Directive (DODD), Department of Defense Instruction (DODI), DSSP, Training

[20] American Association of Suicidology (AAS), *U.S.A. Suicide: 2014 Official Final Data*, and T2, *DoDSER 2014 Annual Report* and *DoDSER 2010 Annual Report*.

[21] Ibid.

[22] VA Suicide Prevention Program, *Facts about Veteran Suicide*, July 2016, 3.

[23] Ibid.

[24] T2, *DoDSER 2014 Annual Report* and *DoDSER 2010 Annual Report*.

[25] Ibid.

[26] Ibid.

Competency Framework, and charters for the Suicide Prevention General Officer Steering Committee (SPGOSC), SPARRC, and Suicide Data Repository (SDR))

  - General literature review
    - Program evaluation literature, RAND Corporation reports, other organizations' websites, academic papers

- Interviews
  - Internal DSPO
  - DOD stakeholders (DOD leadership, program managers, others in the suicide prevention community)
  - External stakeholders (non-DOD government as well as non-government and academic suicide prevention communities)
- Observation of relevant events
  - DOD suicide prevention program governance meetings: November 2015 SPARRC and April 2016 SPGOSC
  - DSPO-sponsored meetings: Cost Analysis Data Collection Workshop, Research Summit
  - Congressional hearings: House Armed Services Committee, Subcommittee hearing: Update on Military Suicide Prevention Programs
  - Broader suicide prevention community conferences and meetings: VA Preventing Veteran Suicide: A Call to Action and the American Association of Suicidology (AAS) 49th annual conference

Commonly when using this methodology, fairly diverse perspectives can begin to coalesce around what could be categorized as schools of thought. Different schools might emerge because those interviewed have different stakeholder roles, such as being part of the organization's customer base or being a subject matter expert external to the organization. Traditionally, the analysis then assesses the strengths and weaknesses of each identified school of thought. In the case of this research on the DSPO organization, however, IDA found that stakeholder perspectives largely converged on the central issues. There was strong commonality of views on DSPO's purpose, its functions and deliverables, how well it is doing its job, the management mechanisms and staff resources it needs to perform well, and some of the improvements that still need to be made.

At the request of the sponsor, the IDA research team has maintained an interactive relationship with DSPO, providing regular in-process review briefings to share interim findings and receive further guidance and clarification on desired areas of investigation. At the suggestion

of the sponsor, the IDA team also extended its interviews and literature review to benchmark similar DOD offices and their approaches to similar functional areas, to explore potential applicability to DSPO.

The research began in August 2015, with interviews conducted September 2015-August 2016. IDA conducted all interviews on a not-for-attribution basis to encourage openness. Appendix C lists the names and organizations of all those interviewed, but with no specified date. References to those interviews in this report refer only to "DSPO interview," "DOD stakeholder interview," and "non-DOD stakeholder interview," along with the date of the interview to preserve this anonymity.

D. Report Structure

This remainder of this report is organized into four parts. Part One contains Chapters 2-3 and focuses on "what" needs to be done. Chapter 2 provides an overview of DSPO's mission, describes how DSPO has evolved as an organization, and offers IDA's identification of DSPO's value-added functions. These functions are: strategy and policy; collaboration and advocacy; outreach and education; program evaluation; data management; support for research; and resource management. Notably, both IDA's assessment and feedback from the entire stakeholder community consistently support the focus on these important functions, along with DSPO's public health approach, as an appropriate mission and activities for DSPO. Chapter 3 then assesses each of these value-added functions, their associated deliverables, how well DSPO is performing each of them, and offers recommendations as appropriate.

Part Two contains Chapters 4-6, each of which focuses on mechanisms needed, i.e., "how" things need to be done, as DSPO moves toward an evidence-based approach. Chapter 4 examines needed program evaluation mechanisms and metrics. Chapter 5 addresses the importance of access to suicide data and DSPO's reporting obligations with respect to these data, while Chapter 6 describes possible mechanisms for DSPO to guide and apply research on suicide prevention. DSPO has recognized the role of research as a foundation for informing program planning. In collaboration with other stakeholders, DSPO is focusing on translating research into practice so that programs are increasingly based on evidence from the published literature. With the guidance of a logic model, DSPO has developed metrics for quantifying program effectiveness. IDA finds that DSPO has already identified further worthwhile efforts to engage in related to metrics, data, and research support. Chapter 7, comprising Part Three of this report, assesses DSPO's organization and staffing, taking all of the preceding into account. Finally, the fourth part of the paper is featured in Chapter 8 and offers IDA's findings and summarizes its recommendations for DSPO's proposed next steps. These findings and recommendations are incorporated throughout the report.

Part One

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2. DSPO's Mission and Evolution

A. Background

Part one of this report contains two chapters. This chapter describes DSPO's mission, i.e., purpose, and how it has evolved over time since the office's creation. An important part of this evolution has been the organization's transition from a focus on addressing the 2010 Task Force's recommendations to one focused on adopting a more comprehensive public health model. This chapter also identifies what IDA finds to be DSPO's value-added functions. IDA's assessment incorporates three factors. First, is DSPO's alignment with DOD's strategy, the *Defense Suicide Prevention Program* published in December 2015. Second, is DSPO's consistency with DOD's definition of the appropriate roles for OSD activities. And, third, the assessment incorporates IDA's fact-finding with the Military Departments and other stakeholders about the DSPO functions they believe would provide the greatest added value. The next chapter in part one explores the IDA-identified value-added functions in detail and offers recommendations for further improvement.

B. First Phase of Operations: Addressing the DOD Task Force Report

DSPO has had two executive Directors since its creation in 2011, representing two distinct phases of operations. The initial phase of operations, from 2011-January 2015, focused on addressing the Task Force Report recommendations. The second phase of operations, from February 2015 to present, has shifted focus from Task Force implementation to the creation of a new office strategy and organizational restructuring to guide operations.

The 2010 Task Force Report issued 76 recommendations, binned under 18 strategic initiatives in four focus areas:

1) Organization and Leadership

2) Wellness Enhancement and Training

3) Access to, and Delivery of, Quality Care

4) Surveillance, Investigations, and Research

The report also identified 13 foundational recommendations, each addressing several targeted recommendations, the implementation of which is deemed critical for success.[27] The top foundational recommendation corresponding to Focus Area 1 was the creation of a new DOD suicide prevention policy office.

[27] These 13 foundational recommendations are listed in Appendix D.

Based on Task Force recommendations, OUSD(P&R) developed an implementation plan in a report to Congress in 2011 to guide the DOD suicide prevention effort.[28] The plan indicated that of the Task Force's 76 recommendations, 36 required new DOD actions; 34 had actions planned, underway, or complete; and the six remaining did not merit any action by DOD.[29]

After delivery of the implementation plan to Congress, DSPO was established within P&R in 2011, thereby addressing the first foundational recommendation. P&R then tasked a senior steering committee, the SPGOSC, to prioritize and group the 36 recommendations requiring action.[30] The SPGOSC developed nine priority groups based on the implementation plan; the corresponding Focus Areas are noted in parentheses after each group:[31]

1) Group (G)1 – Issue Policy directive (*Focus Area 1)*
2) G2 – Increase fidelity of data and data processing (*Focus Area 4)*
3) G3 – Develop a program evaluation process (*Focus Area 4)*
4) G4 – Improve strategic messaging and resilience (*Focus Areas 1, 2)*
5) G5 – Develop means reduction policy (*Focus Area 1, Recommendation 25)*
6) G6 – Conduct a comprehensive training evaluation (*Focus Areas 2, 4)*
7) G7 – Evaluate access and quality of behavioral health care (*Focus Area 3)*
8) G8 – Review and standardize investigations (*Focus Area 4)*
9) G9 – Develop a comprehensive research strategy (*Focus Area 4)*.

The work of each of these groups, as well as the relationships among the Task Force Focus Areas, Foundational Recommendations, Implementation Plan Targeted Recommendations for Action, and Implementation Priority Groups, are described in greater detail in Appendix D.

By 2015, DOD had addressed or had set forth a path to address all of the Task Force Report recommendations identified in the implementation plan. Many recommendations are being addressed by ongoing efforts within the department. Based on this progress, and with the arrival of a new Director, DSPO pivoted its work to focus on a second phase of operations, developing an office strategy and organizational restructuring to guide its operations into the future.

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28 Jacqueline Garrick, *Briefing on Defense Suicide Prevention Office Initiatives*, November 18, 2013.

29 Department of Defense, *Response to Congress on Section 733 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009, Phase 2 Response to Department of Defense Task Force Report on Prevention of Suicide by Members of the Armed Forces*, September 2011, 1.

30 Defense Suicide Prevention Office (DSPO), *Annual Report for Fiscal Year 2013*, 9.

31 Jacqueline Garrick, *Briefing on Defense Suicide Prevention Office Initiatives*, November 18, 2013.

C. The Second Phase of Operations: Current Mission, Goals, and Strategy

At the beginning of DSPO's second phase of operations, the office held a series of strategic offsite events in 2015 to re-examine its direction and priorities. From these endeavors, DSPO developed an office strategy in September 2015 that identified its vision, mission, and five strategic goals with corresponding objectives that informed its operational structure.[32] These goals are: data management; program assessment; advocacy; policy; and outreach and education. During DSPO's 2015 review and pivot, the previously assigned resilience portfolio was removed from its mission.[33] A new OSD organizational home for resiliency was not identified until OEDFR was created, with responsibility for both resiliency and prevention oversight. DSPO, along with the Sexual Assault Prevention Office (SAPRO), the Office of Diversity Management and Equal Opportunity (ODMEO), Personnel Risk Reduction, and the DOD-VA Collaboration Office were placed under its policy oversight. During its existence, OEDFR's mission was:

> …to strengthen and promote the resiliency and readiness of the Total Force through the development of integrated policies, oversight, and synchronization of activities in the areas of diversity management and equal opportunity, personnel risk reduction, suicide prevention, sexual assault prevention and response, and collaborative efforts with the Department of Veterans' Affairs.[34]

As defined on its website, DSPO's vision and mission as of 2016 are as follows:

> **Vision:** Through data surveillance, program assessment, research, advocacy, policy oversight, outreach, and education, the Department's efforts remain strategically aligned to support an environment where suicide prevention is integrated into military, civilian, and family policies and programs.
>
> **Mission:** The Defense Suicide Prevention Office (DSPO) provides advocacy, program oversight, and policy for Department of Defense suicide prevention, intervention and postvention efforts to reduce suicidal behaviors in Service members, civilians and their families.[35]

Beyond DSPO's internal strategy and re-organization, the office also led the development of the DSSP in collaboration with DOD Component and Service stakeholders. The DSSP mirrors the NSSP structure, incorporating DOD-specific language and enhancements for each of the NSSP's four strategic directions and 13 goals.[36] It was approved by DOD leadership and formally issued in December 2015, providing an overall framework for the department's suicide

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32 DSPO, *2015 DSPO Strategy*, draft as of September 11, 2015.

33 There were at least two reasons for the removal of resiliency from DSPO's mandate. First, because resiliency pertains to several issues (not just suicide prevention), it was logical to raise this mission to a higher level. Second, the DSPO staff did not have the bandwidth to address adequately resiliency.

34 Office of the Under Secretary for Personnel and Readiness website, *Force Resiliency Mission*, http://prhome.defense.gov/ForceResiliency/Mission.aspx, as accessed in mid-2016. As of October 2016, this link is no longer available. OEDFR has ceased to exist and DSPO now reports to ASD (Readiness).

35 DSPO website, *DSPO Mission and Vision*, http://www.dspo.mil/AboutDSPO/MissionVision.aspx.

36 See *NSSP*, 81-91.

prevention efforts. Table 1 lists the DSSP's 13 goals, three of which are highlighted in bold; these are the three goals that DSPO and the SPGOSC identified and prioritized to focus on in FY2016.

Table 1. The Four Strategic Directions and 13 Goals of the Defense Strategy for Suicide Prevention[37]

Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities
Goal 1: Integrate and coordinate suicide prevention activities across the Department of Defense.
Goal 2: Implement research-informed communication efforts within the Department of Defense that prevent suicide by changing knowledge, attitudes, and behaviors.
Goal 3: Educate the Military Community on the protective factors against suicide that also promote resilience, and recovery in the Department of Defense.
Goal 4: Encourage responsible media reporting and portrayals of Military Community suicide and mental illnesses and promote the accuracy and safety of online content related to suicides in the Department.
Strategic Direction 2: Clinical and Community Preventive Services
Goal 5: Develop, implement, and monitor effective Department of Defense programs that promote resilience, and prevent suicide and related behaviors.
Goal 6: Promote efforts within the Department of Defense to reduce access to lethal means of suicide among individuals with identified suicide risk.
Goal 7: Provide Military Community service providers and Military Healthcare service providers evidence based training on the prevention of suicide and related behaviors.
Strategic Direction 3: Treatment and Support Services
Goal 8: Promote suicide prevention as a core component of Military Healthcare services.
Goal 9: Promote and implement effective clinical and professional practices in the Military Healthcare System for assessing and treating those identified as being at risk for suicidal behaviors.
Goal 10: Provide support and quality services for those in the Military Community affected by suicide deaths and attempts and implement community-wide postvention strategies to help prevent subsequent suicides.

[37] Ibid.

Strategic Direction 4: Surveillance, Research, and Evaluation

Goal 11: Improve the timeliness and usefulness of Department of Defense surveillance systems relevant to suicide prevention, and improve the ability to collect, analyze, and use this information for improving Department suicide prevention efforts.

Goal 12: Promote and support Department of Defense research on suicide prevention.

Goal 13: Evaluate the impact and effectiveness of Department of Defense suicide prevention interventions and systems in order to synthesize and disseminate the findings.

Besides the DSSP, DSPO's other major effort to provide improved policy guidance and greater definition on roles and responsibilities for the DOD Suicide Prevention Program is the development of a DOD Instruction (DODI). When completed, the DODI will supersede DODD 6490.14. As of the writing of this report, DSPO has solicited informal feedback from the Service and Component stakeholders and is working toward completing the DODI as soon as possible. The purpose of the DODI is to establish policy and assign responsibilities for the DOD Suicide Prevention Program, establish procedures for oversight and reporting of that program, and establish policy for reporting suicides and suicide attempts of Service members from the Regular Component and Selected Reserves, as well as for Service members' dependents, per DOD Directive 5124.02 and Section 567 of Public Law 113-291.[38] This latter requirement presents a new set of challenges for annual reporting.

Additional DOD policy developed to govern suicide prevention-related efforts include:

- USD(P&R) Memorandum, *Guidance for Commanders and Health Professionals in the Department of Defense on Reducing Access to Lethal Means Through the Voluntary Storage of Privately-Owned Firearms*, August 28, 2014.
- USD(P&R) Memorandum, *Standardized Department of Defense Suicide Data and Reporting*, March 11, 2015.
- Directive-Type Memorandum (DTM) 16-001, *Policy for Reporting Suicides and Attempts of Service Members and Suicides of Service Members' Dependents*, January 7, 2016.

[38] Draft Department of Defense Instruction (DODI), *Defense Suicide Prevention Policy and Program Procedures*, April 25, 2016 version (unpublished) and DOD Directive (DODD) 5124.02, Under Secretary of Defense for Personnel and Readiness (USD(P&R)), June 23, 2008. Section 567 of the Carl Levin and Howard P. "Buck" McKeon *National Defense Authorization Act for Fiscal Year 2015* stipulates that DOD must now track and report suicides or suicide attempts not only of all Service members but also of their dependents. In response to this requirement, OUSD(P&R) issued Directive-type Memorandum (DTM) 16-001, *Policy for Reporting Suicides and Attempts of Service Members and Suicides of Service Members' Dependents*, enacted on January 7, 2016. This memorandum stipulates that military dependent suicide events must begin to be reported by July 2016.

These policy documents will be incorporated into and superseded by the DODI once it is finalized and issued.

D. Value-Added Functions

Having reviewed DSPO's strategy, goals, and mission as outlined in the section above, IDA has identified the following functions as important ones for DSPO to fulfill as the DOD integrator for suicide prevention programs. These functions were also consistently supported by stakeholders during IDA's interviews for this research.

- Establish a DOD strategy and policy for suicide prevention
- Promote collaboration and advocate for the Services
- Conduct outreach and education with DOD and non-DOD stakeholders
- Create processes for evaluating the value and impact of DOD suicide prevention programs and activities
- Have access to data to respond to Congressional and other inquiries, as well as to help inform functions such as identifying gaps in research
- Help to identify research gaps relevant to DOD and supporting research, to the extent feasible, to address those gaps
- Manage resources

Each of these is explored in detail in the following chapter.

3. DSPO's Value-Added Functions

This chapter explores the roles and responsibilities of DSPO from three perspectives: 1) DSPO's role in executing the DSSP; 2) the appropriate roles for an OSD organization; and 3) the stakeholder community. It examines how DSPO has identified its roles and responsibilities, particularly drawing upon the strategic goals and objectives outlined in its draft *2015 DSPO Strategy* document.[39] IDA then incorporates feedback from the stakeholder community, both within and outside DOD, regarding what it thinks DSPO's roles and responsibilities are and/or should be, and how well they are being executed today. Based on these perspectives, IDA identified the office's value-added functions, along with recommendations to improve or modify them as appropriate.

As an OSD office, DSPO exercises "policy development, planning, resource management, fiscal, and program evaluation responsibilities."[40] To perform its functions effectively, an OSD policy office must strive to work cooperatively with the Military Departments and other stakeholders while exercising the authority granted by its OSD charter. Particularly since 2015, DSPO has been appropriately moving away from a more operational focus, as dictated by the Task Force, toward a greater focus on strategy and policy. Broadly speaking, DSPO's role is to serve and support the Services and to engage with other stakeholders, setting the overall policy for DOD on suicide prevention. DSPO has taken important steps in issuing not only the DSSP but also a concise office strategy document, and is in the process of reviving and modifying its annual report. The *2015 DSPO Strategy* identifies five strategic goals which closely mirror the functions that IDA has identified as DSPO's value-added contributions: DOD policy and strategy; collaboration and advocacy; outreach and education; program evaluation; data management and reporting; research support; and resource management. Each is addressed in turn in this chapter.

A. DOD Policy and Strategy

1. Findings and Observations

DSPO's stated policy goal is to "[s]erve as the primary originator and coordinator of suicide prevention policy throughout DoD."[41] It further recognizes the importance of collaborating with the Services to identify potential gaps and revisit policy as needed. DOD's suicide prevention policy is established in the DSSP which, as noted earlier, is strategically linked with the NSSP. Stakeholders widely embrace the view that DSPO has done an excellent job of adapting the

[39] *2015 DSPO Strategy*.

[40] As defined in http://www.defense.gov/About-DoD/Office-of-the-Secretary-of-Defense.

[41] *2015 DSPO Strategy*, 15.

NSSP for the defense community.[42] DSPO's suicide prevention policy is, therefore, on a solid foundation; what is still evolving is a plan for its execution and implementation.

As with many OSD offices, DSPO can face challenges in trying to set overall DOD policy because each Service argues that it has a unique culture and needs to tailor its programs to fit that culture. Suicide prevention is no exception and, indeed, its task is made more difficult because DSPO was created after each of the Services had already established its own suicide prevention program. Still, stakeholders widely recognize that DSPO does have an important function to play. Without DSPO, there would be no leader to coordinate across the Services or to integrate efforts. There is certainly still work to be done, but DSPO's current emphasis on a collaborative approach and its initiatives to re-invigorate collaborative mechanisms such as the SPGOSC and the SPARRC are appreciated by stakeholders and are seen as moving the enterprise in the right direction. For example, one suggestion DSPO offered at the November 2015 SPARRC meeting was to use the SPARRC to lay out a plan for how each of the Services will implement the DSSP. Such collaborative efforts are an important means to help unify approaches across the DOD community.

The way in which DSPO is currently approaching its mission has also improved markedly since 2015. As described in the *2015 DSPO Strategy* and the office's draft 2015 annual report, DSPO has adopted a public health approach, moving away from what many perceived to be too great a focus on the clinical aspects of suicide prevention.[43] This model resonates well and reflects the more holistic view of suicide prevention seen in research and clinical communities, which recognize the linkages between suicidal behavior and issues such as financial, relationship, and alcohol problems. In addition to this important shift, stakeholders also affirmed the need for DSPO to focus its attention on providing a vision for the entire DOD community, keeping its thinking and initiatives at the strategic level. In one interview, for example, it was suggested that DSPO sometimes risks focusing too much on suicide symptoms and means, rather than on trying to determine causes.[44]

The most glaring gap in policy guidance currently is the absence of a DODI for suicide prevention. While the DODD on suicide prevention has been in place since June 2013 and was updated in April 2016,[45] the DODI remains a work in progress; although, under the current DSPO Director, there has been notable progress its development. Based on a review of a draft of this document in early 2016, IDA concluded that the DODI will, once finalized and issued,

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[42] For example, non-DOD stakeholder interview, February 8, 2016.

[43] This view was articulated in many of IDA's interviews with stakeholders, including non-DOD stakeholder interview, March 11, 2016.

[44] This interviewee offered a tangible example of trying to get at the causes: what is different now compared to the 1980s, when the DOD suicide rate was much lower.

[45] DODD 6490.14, *Defense Suicide Prevention Program*, June 18, 2013; change 1 incorporated effective April 1, 2016. A DODD is a broad policy document, whereas a DODI describes how the policy will be implemented and by whom.

address many, if not all, of the concerns about lack of sufficient guidance and absence of clarity in suicide prevention roles and responsibilities among various DOD stakeholder organizations. Importantly, however, even once the DODI has been published, it will be vital for DSPO to put mechanisms in place to ensure that the responsibilities are executed as stipulated. For example, the DODI specifies timelines for the Services and others to report data and other information to DSPO. These timelines will need to be tracked so that products can be produced on schedule and answers to queries can be provided in a timely manner.

DSPO is responsible for providing DOD-wide reports and responding to queries from Congress and other organizations who seek to understand military suicide trends and the activities and priorities DOD is pursuing to try to reduce the military suicide rate. This is another arena in which DSPO plays a vitally important role as a coordinator and integrator. To produce the required documents, DSPO must have timely access to the latest available data. However, this has often not been possible in the current operating environment, either due to responsiveness of the organization owning the data or delays in data being available or verified. At least some of these difficulties should also be alleviated once the DODI is issued.

As DSPO has articulated in its policy goal, it envisions a role in resolving policy gaps so that a standardized approach is established. During IDA's interviews with DOD stakeholders, at least two examples of policy gaps were identified. The first was the need for a standardized policy on memorial services.[46] This is, in fact, addressed in the draft DODI, so once the DODI is enacted, that standardization will be in place. The second example offered was the creation of a uniform set of regulations for completing a DoDSER report.[47] This, again, is addressed in the draft DODI, which should create a more uniform approach. At present, each Service publishes its own regulations to include what is reported, e.g., suicides, ideations, attempts, and who completes the report; these regulations are similar, but not identical, across the Services. If a DOD standard were developed, it was argued, the Services could opt to exceed that standard, but all would need to adhere to at least the base standard.

2. Recommendations

Above all in the policy realm, it is vital that the issuance of the DODI be pursued with the utmost vigor. It will provide the necessary and still missing clarification of roles and responsibilities as well as guidance about what needs to be provided or produced by whom when. It also has embedded in it DOD standardized approaches to issues such as lethal means safety,[48] DoDSER reporting, and memorial services, so these will then be better codified than they are currently.

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[46] DOD stakeholder interview, February 22, 2016.

[47] Non-DOD stakeholder interview, February 3, 2016.

[48] Lethal means safety refers to ways of controlling access to the means that can be used for completing a suicide (such as medications or guns).

Once the DODI takes effect, DSPO leadership should designate specific DSPO staff, in line with their areas of responsibility, to ensure that reporting and other requirements are fulfilled on the specified timelines. The DODI will be a tremendous step forward for DSPO's policy function, but its implementation must be actively pursued and tracked.

The *2015 DPSO Strategy* and draft 2015 annual report both offer cogent insights into DSPO's activities, priorities, and accomplishments. Thus, in addition to the annual report being updated each year, IDA recommends that the strategy document be reviewed periodically to address any gaps and to ensure it reflects the office's latest thinking. As one example of the former, the current version has no mention of DSPO's important role in providing coordinated DOD responses to Congressional and other inquiries. It would also be beneficial to post the *2015 DSPO Strategy* on the DSPO website, as it is a useful reference tool that might answer some of the inquiries that DSPO receives.

B. Collaboration, Communication, and Advocacy

1. Findings and Observations

DSPO defines its goal for advocacy as follows: "serve as a lead change agent and champion for all suicide prevention efforts with our internal and external partners."[49] The objectives falling under this goal include fostering a collaborative environment; providing mechanisms for sharing information; and centralizing, coordinating, and disseminating best practices.

Central to fostering a collaborative environment are maintaining open lines of communication, being receptive to others' opinions and ideas, and searching together for solutions to common problems. In virtually every interview that IDA conducted for this study, stakeholders expressed the opinion that DSPO's collaboration and communication have improved markedly since early 2015, when Dr. Keita Franklin became its Director. There is widespread appreciation for this new approach and a recognition that DSPO is genuinely interested in trying to help solve identified problems.[50] In addition to the change in leadership, DSPO's hiring of new personnel with relevant skill sets has contributed to this changed environment, making it possible to have more interactions between DSPO staff and other stakeholders with similar levels of subject matter expertise.[51]

When asked what roles they saw as important for DSPO to perform, DOD stakeholders consistently identified and embraced the notion of DSPO acting as the Services' advocate, since

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[49] *2015 DSPO Strategy*, 24. Of note, DSPO's relationships with the Services and other DOD elements do not fall under "advocacy," but rather under its goal of "outreach and education." Consequently, this report addresses those relationships in the latter section, to mirror DSPO's categorization.

[50] Among those who specifically raised the topic of helping to solve problems, DOD stakeholder interview, March 4, 2016.

[51] Chapter 7 addresses staff issues in more detail.

one responsibility of an OSD office is to represent DOD at large. While many see this as an evolving role, and one that is still a work in progress, they also consistently note that these efforts are moving in the right direction. The Services consider the handling of external taskings, such as requests for information from Congress, part of DSPO's advocacy role. In this case, areas identified that could still be improved include:

- Conveying to Congress that there is no one "silver bullet" solution to suicide prevention
- Obtaining better clarification when there is ambiguity in a request for information before tasking the Services to respond
- Advocating that, if the issue pertains overwhelmingly to only one Service (or some other subset), a response from that entity suffices to answer the question without having to expend efforts on a DOD-wide basis

In a similar vein, the Services believe DSPO is the appropriate organization to advocate for changes to policies and laws that could improve suicide prevention efforts. While by no means an easy undertaking, two specific initiatives that were identified in stakeholder interviews are pressing for the easing of Congressional restrictions on research into gun safety, which could be pursued in collaboration with other entities such as the VA; and arguing for a change to Title 10 so that members of the National Guard and the Reserves would be provided access to psychological medical care.[52] In the case of the former, it is notable that DSPO leadership has now established a working relationship with the National Rifle Association.[53] This kind of collaboration with non-DOD stakeholders is illustrative of DSPO's commitment to open lines of communication and working toward common objectives.

In terms of communication, a number of DOD stakeholders expressed the feeling that there are still too many taskings emanating from DSPO and that appropriate tasking mechanisms and timelines are not always observed. The use of emails rather than the tasking system and requiring responses in less than the time stipulated in the tasking system were cited as examples.[54] The fact that there are multiple information technology (IT) systems throughout DOD that do not communicate with each other adds another frustrating level of complexity to this process for all involved. It should be noted that these complaints have eased in recent months as DSPO has more rigorously used the formal tasking process, but concerns do linger to some extent. Some interviewees expected that an increasingly knowledgeable DSPO staff may well be able to respond to more information requests on its own, which would help reduce the frequency of the requests.[55] It is also important to put this issue into the context of the overall OSD-Service

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[52] The former point was discussed, for example, during DSPO's *Research Summit: Identifying Gaps in Practice*, November 10, 2015. The latter point was raised, for example, in DOD stakeholder interview, December 9, 2015.

[53] DSPO interview, August 4, 2016.

[54] E.g., DOD stakeholder interviews, March 4, 2016, and December 2, 2015.

[55] See, for example, DOD stakeholder interview, December 2, 2015.

relationship: there are inherently tensions between those who need information and those who have it. As such, this may not be so much a reflection of DSPO's performance as a reflection of the general OSD-Service dynamic.

a. Mechanisms for Internal Collaboration

Two key mechanisms for collaboration and information sharing within DOD are the SPGOSC and SPARRC. Each organization has an approved charter, which includes a mission statement and eligible membership. In reviewing these charters, IDA has identified an issue related to membership for each of these groups. In the case of the SPGOSC, the representative or designated alternate is required to be a General Officer/Flag Officer (GO/FO) or a member of the Senior Executive Service (SES). This stipulation means that, at least for some of the organizations, no alternate is possible because there is only one GO/FO/SES in that office.[56] As a result, if the one eligible person is unable to attend, then the office either has no representation at that meeting or is noncompliant in sending a non-GO/FO/SES representative. The composition of the SPARRC, as outlined in the charter, does not include a representative from any of the Service Reserve Component suicide prevention programs, either Reserves or National Guard; rather, there is one representative from the suicide prevention program office from each of the Services and the National Guard Bureau. While other Reserve and National Guard representatives have attended the SPARRC meetings that IDA observed, they are technically not official members of the SPARRC. And, in neither case (SPGOSC or SPARRC) is the U.S. Coast Guard (USCG) listed in the charters, even as an optional member. Despite the lack of a documented mention in the charters, USCG has been invited by DSPO to observe SPARRC meetings and has requested to observe the SPGOSC; USCG would like to be listed in charters for both bodies.[57] Finally, in both cases, IDA found that participation in recent meetings has been affected by sudden changes to the meeting schedules.[58]

Importantly, in 2015, DSPO undertook efforts to re-invigorate both the SPGOSC and the SPARRC. Of the two, changes in the SPARRC have been more noticeable and particularly well-received. Previously convened for a monthly meeting of one-to-two hours, the emphasis was generally on DSPO imparting information to the other participants. Now, the SPARRC meets on a quarterly basis for one-and-one-half days, with the emphasis on sharing best practices and learning about new initiatives. Not surprisingly, IDA found that there is a much greater appreciation for these changes among those who participate and who do so in person. While it is hard to justify attending a one-to-two hour meeting for those not in the Washington, D.C. area, these schedule changes should allow for their in-person participation in the future. Participants

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56 At a minimum, this is the case for the Joint Staff and the Navy.

57 Non-DOD stakeholder interview, March 17, 2016.

58 For example, the October 2015 SPARRC was cancelled on short notice due to budget issues, which were not unexpected, and rescheduled and relocated for November; the September 2015 SPGOSC was cancelled; and the January 2016 meeting was postponed.

look to DSPO and the SPARRC to help identify ways for one Service or organization to adapt a successful program into its own repertoire. DSPO, using the SPARRC, can play a useful role in looking across the Services to identify commonalities, capabilities, potential redundancies, and gaps in knowledge. This information sharing is seen as a major contribution of the SPARRC and one that supports DSSP goals and DSPO's mandate as articulated in the DODD and forthcoming DODI; although, some have suggested that they would also like to see a process developed to be able to take action on the information shared.[59] Of note, SPARRC participants are less convinced about the value of spending (as much) time reviewing the latest suicide data from each of the Services, as they are typically aware of these numbers already. While there is certainly some value in briefly reviewing each Service's suicide numbers and key trends, participants place more value on discussing ideas that could help decrease suicide rates. Finally, as the SPARRC continues to evolve, DSPO could consider a more direct linkage between its activities and those of the SPGOSC, for reasons discussed more in depth below.

The SPGOSC originally focused on DOD's response to the Task Force's report on suicide prevention. The success of DSPO's efforts to enhance the effectiveness of the SPGOSC has been more mixed to date than that of the SPARRC. In terms of its composition, several stakeholders expressed reservations about the exclusivity of attendance at the SPGOSC, arguing that the group's utility could be enhanced by the presence of subject matter experts (SMEs), such as the suicide prevention program managers (SPPMs), rather than just the programmatic leads.[60] In effect, they questioned whether there was an over-emphasis, embodied in the charter, on who is allowed to speak or not, to the detriment of a more fruitful exchange of views and, ultimately, the ability to make the best-informed decisions. In terms of its agenda, several of its members indicated that when meetings are largely focused on information sharing, they are not an appropriate use of the senior-level group's time, given their broad portfolios and pressures on their time.[61] Agenda items that require a decision to be made are viewed much more favorably. Two examples of such decisions in 2016 are approving the recommendations made by a team of SMEs on which projects DSPO should support with some of its Congressional add funding (described in more detail in section G of this chapter); and the selection of three DSSP goals for particular DOD attention in 2016:

- Integrate and coordinate suicide prevention activities across DOD
- Implement research-informed communication efforts within DOD that prevent suicide by changing knowledge, attitudes, and behaviors
- Promote efforts within DOD to reduce access to lethal means of suicide among individuals with identified suicide risk

[59] DOD stakeholder interview, December 15, 2015, among others. IDA supports the notion that the SPARRC's main purpose is information-sharing.

[60] DOD stakeholder interview, March 1, 2016.

[61] DOD stakeholder interviews, March 7, 2016, and April 5, 2016.

These are the types of decisions that are useful for the SPGOSC to make, thereby conferring DOD-wide endorsement, that do not require extensive preparation or staffing prior to the meeting.[62]

There are other areas in which the SPGOSC could offer its recommendations as well, but they would entail a great deal more work. One suggested topic fitting this category is to identify ways to affect the culture within the Services, including ways to overcome the stigma surrounding mental healthcare.[63] To take on such a task, the SPGOSC would need a strong working group structure below it, like the one SAPRO has through its Integrated Planning Teams (IPT).[64] The open question is whether the SPARRC could, or should, fill such a working group role for the SPGOSC. Some members feel that there should be a direct linkage between the two groups, so that the SPARRC feeds items up to the SPGOSC for decision and the SPGOSC, in turn, instructs the SPARRC to delve into the details of a topic.[65] However, in the case of stigma reduction, this is a topic that touches many other areas, not only suicide prevention. As described in Chapter 7, it would more appropriately be the responsibility of the OEDFR (now, its successor) to convene a group, which should certainly include DSPO representation, to address stigma as a mental health issue affecting a range of DOD programs.

b. Disseminating Best Practices

DOD stakeholders look to DSPO to perform the function of centralizing, coordinating, and disseminating best practices across the DOD; in effect, they would like to see DSPO serve as a "clearinghouse" for this information. IDA finds that DSPO is making considerable progress in this area. Examples include:

- The reconfiguration of the SPARRC to serve as a mechanism for sharing best practices
- DSPO's development of DSPRAT, which aims to serve the clearinghouse function for suicide prevention research initiatives[66]
- DOD and the VA annual conferences on suicide prevention which, in 2016, moved to a webinar approach
- DOD participation in AAS annual conferences

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62 It is important, nevertheless, for DSPO to identify these issues in advance of the meeting, as it did on both these occasions, to ensure the members are sufficiently informed by their staffs in advance.

63 The culture issue was raised, for example in DOD stakeholder interview, February 22, 2106; the stigma issue was discussed in DOD stakeholder interview, March 1, 2016.

64 DOD stakeholder interviews, February 22, 2016, March 1, 2016, and March 7, 2016.

65 DOD stakeholder interview, March 1, 2016.

66 See Chapter 6 for a more detailed discussion on DSPRAT.

As OSD at the highest levels has begun to ease the approval process to encourage greater participation in scientific conferences, DSPO may be able to expand its collaboration with the VA, AAS, and other organizations.[67] During IDA's interviews, at least two other concrete examples of sharing best practices were identified:

- Dissemination throughout DOD of the DOD-VA Clinical Practice Guidelines for Suicide Prevention[68]
- Extrapolating from the experience gained by Military Community and Family Policy (MCFP) in developing a social media campaign (in that case, to enhance awareness of child abuse and neglect) to launch a similar effort aimed at suicide prevention[69]

Logically, a place to store information on best practices is the DSPO website, whose structure has recently been made more user-friendly. There is still work to be done, but the framework has been put in place to allow for better information dissemination.

Another remaining challenge lies in translating identified "best practices" into "shared practices" across the Services.[70] One suggestion is that, once something is identified as a "best practice," DSPO provides that imprimatur on behalf of DOD, which would facilitate, although not necessarily guarantee, a Service's ability to adopt it. Indeed, as one stakeholder expressed it, there is a fine line between "standardization," which is seen as something DSPO should provide, and "Service autonomy," i.e., being able to tailor a program to the Service's specific culture. Stakeholders expressed the belief that DSPO is aware of this distinction and is moving in the appropriate direction of standardization, rather than trying to impose a "one-size-fits-all" approach.[71]

2. Recommendations

Generally, in the area of collaboration, communication, and advocacy, IDA recommends that DSPO:

- Raise awareness about and improve communication of the *2015 DSPO Strategy* and any other guidance documents
- Advocate for improved access to mental healthcare for members of the Reserve Component who are not on a 30-plus day activated status

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67 See Secretary of Defense Ashton Carter, *Memorandum on Updated DoD Conference Guidance*, September 23, 2015, and Office of the Deputy Chief Management Officer, *DoD Conference Guidance: Version 3.0*, September 23, 2015.

68 Non-DOD stakeholder interview, January 27, 2016.

69 DOD stakeholder interview, March 30, 2016.

70 DOD stakeholder interview, December 1, 2015.

71 DOD stakeholder interview, March 4, 2016.

- Ensure that taskings to the Services and other DOD stakeholders are clearly articulated, use the appropriate tasking mechanisms, and allow sufficient time for responses to the extent that DSPO has received sufficient response time

a. Mechanisms for Internal Collaboration

To improve the functioning and utility of the SPGOSC and SPARRC, DSPO should:

- Establish a schedule of meetings at the beginning of the CY or FY. This will provide members, especially those not in the Washington, D.C. area, sufficient notification to plan for their participation.
- Ensure that meeting materials are delivered to all members no less than one week prior.
- Report back on actions identified at the meeting within 10-15 business days rather than at the beginning of the next meeting. While ultimate resolution of all issues will not be practicable within this time period, a more routine follow-up process will enhance the communication flow.
- Review the membership of the SPGOSC and SPARRC, as codified in their charters, to confirm all appropriate stakeholders are included. Given the importance of understanding both Active and Reserve Component perspectives, for example, expanding the membership beyond just one representative per Service, covering both Active and RC, would be valuable. Consider also the value of including non-DOD participants. For example, there are precedents for including USCG representation in DOD working groups, even though it is part of the Department of Homeland Security (DHS).
- Consider more external presentations in the SPGOSC and SPARCC in the interests of sharing best practices. For example, AAS conducts studies for individual Services, but has no mechanism for sharing that expertise and raising awareness of the products created with the other Services, which would likely be beneficial.
- Reduce time spent reviewing Service-specific suicide numbers at the SPARRC.

b. Disseminating Best Practices

Finally, DSPO's function of disseminating best practices would be enhanced by continued efforts to improve the DSPO website. The website has an important function to play as a central repository for sharing best practices related to DOD suicide prevention guidance, research initiatives, training, etc. At a minimum, the website should include documents such as the DSPO Strategy, the Training and Competency Framework, the DOD-VA Clinical Practice Guidelines for Suicide Prevention, descriptions of the SDR and DSPRAT, as well as links to webinars and other relevant organizations' websites. DSPO might also consider creating a password-protected

side of its website that would be open only to members of the DOD suicide prevention community. This controlled side could facilitate the sharing and archiving of documents such as those generated for or by the SPGOSC and SPARRC, pre-publication research findings from SDR research or DSPO-funded studies, and other information that could benefit the DOD community but that is not appropriate for public dissemination.

C. Outreach and Education

Inherent to many OSD offices is the need for collaboration with the corresponding offices in the Military Departments. An important mechanism for doing so is through outreach initiatives. DSPO has identified the following goal for outreach and education: "advance the field of suicide prevention within the DoD through strategic partnerships and targeted messaging."[72] Objectives under this goal include improving relations with key stakeholders both within and outside DOD, in part by fostering a collaborative environment; promoting training on suicide prevention; and developing and disseminating messages and educational materials to increase awareness, reduce stigma, and promote self-help.[73]

Within DOD, key stakeholders are not only the Services' suicide prevention program offices and the Defense Health Agency (DHA), but also other OSD offices such as Public Affairs, MCFP, and other offices that had been part of OEDFR. The relationships and collaboration amongst DOD organizations is outlined in DSPO's draft DODI on suicide prevention. Outside DOD, the VA, SAMHSA, National Institute of Mental Health (NIMH), and the CDC number among the key government stakeholders. DSPO relationships with non-governmental organizations also play an important role in ensuring a holistic approach to suicide prevention collaboration.

1. Findings and Observations

The current DSPO leadership has been actively working to engage with other DOD and non-DOD partners, improving relationships by stressing a collaborative approach to the full range of suicide prevention initiatives: data collection, research support, identification of best practices, training and education, and strategic messaging. In addition to the SPGOSC and SPARRC, which are two of the main communication mechanisms that DSPO controls, DSPO is also now actively participating in others' working groups and committees, such as the Military Operational Medicine Research Program (MOMRP), Army Study to Assess Risk and Resilience in Service members (Army STARRS) Longitudinal Study (LS), and the Federal Working Group on Suicide Prevention (an advisory body to NAASP), to name but a few. Through such participation, DSPO is better able to act as a central point of contact for DOD, sharing

[72] *2015 DSPO Strategy*, 15.

[73] Ibid., 15-16.

information across the enterprise. Many interviewees indicated the desirability of DSPO performing such a "clearinghouse" role, as discussed in previous sections of this chapter.[74]

Offering guidance about strategic messaging – from working with the media on responsible reporting to identifying ways to address the stigma issue within the military to advocating for means safety – is an important function for DSPO's outreach and education mandate. Evaluations of the media's suicide reporting show that more training needs to be done with reporters, despite the fact that international guidelines for such reporting already exist.[75] One example of DSPO's outreach on this topic is its discussions with the Iraq and Afghanistan Veterans of America on providing training to journalists to improve media reporting.[76]

In the area of training, an important recent DSPO contribution is the issuance of the Training Competency Framework, developed collaboratively with the Services, which provides a template for consistent training content across DOD using a core competency framework. Several stakeholders cited this document as an example of the kind of product and coordinated effort they welcome from DSPO.[77] An admittedly ambitious initiative identified by one stakeholder would involve DSPO reviewing all suicide prevention training across DOD to determine which have the most evidence-based approach. For example, it has become widely acknowledged that skills-based training that includes practice of the skills taught, e.g., through role-playing exercises, is more useful than traditional briefings and videos in which engagement with the participants is negligible or nonexistent.[78] Another component of such an effort would be identifying ways to translate "best practices" into "shared practices."

DSPO's role as a bridge between the DOD and non-DOD community was often also cited by stakeholders as a valuable contribution of the organization. In general, stakeholders appreciated being given opportunities to understand better what other organizations are doing; noting the key role that the SPARRC has recently played in such information exchanges. While one individual expressed the belief that DSPO continues to focus too much on what the Services are doing and not enough on building bridges to external stakeholders, this may be partly a reflection of the person's membership in the SPGOSC rather than the SPARRC; the latter has been more focused on such information sharing than the former.[79] Nevertheless, it should be noted that other non-DOD stakeholders also expressed a desire to see enhanced communication and collaboration, especially to ensure that they understand fully what DSPO (and DOD) is

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74 DOD stakeholder interviews, December 1, 2015, December 2, 2015, December 8, 2015, and non-DOD stakeholder interview, March 17, 2016.

75 World Health Organization, *Preventing Suicide: A Resource for Media Professionals* (Geneva, Switzerland: World Health Organization, 2008), http://www.who.int/mental_health/prevention/suicide/resource_media.pdf.

76 DSPO interview, January 8, 2016.

77 DOD stakeholder interviews, December 1, 2015, December 2, 2015, and December 3, 2015.

78 As noted, for example, in DOD stakeholder interview, February 22, 2016.

79 DOD stakeholder interview, March 3, 2016.

doing.[80] While there have been dramatic improvements in integrating DOD and the civilian community's work over the last year or so, there remain opportunities for expanding these initiatives; several suggestions are offered in the recommendations section below. Different in nature, but just as important as communication and relationship-building with other members of the suicide prevention community, is DSPO's relationship with Congress. Beginning in 2015, DSPO made particular efforts to enhance communication with Members of Congress, keeping the body better informed about what DOD is doing to prevent military suicide and helping identify the most useful kinds of information DOD can furnish about these efforts.[81]

Overall, DSPO has made notable improvements in its outreach initiatives, including the re-design of its website to make it easier to find documents and other information. There are at least two areas in which continued outreach work is warranted, but DSPO cannot implement these particular changes on its own. One is a seam issue: the need to address gaps as personnel transition from military to veteran status. DSPO and the VA's work with the In Transition office is helping fill those gaps. Notably, one proposed change would promote greater enrollment in the VA. If implemented, instead of the Military Service member actively having to opt in to VA coverage, they would now actively have to opt out. In addition, the In Transition program offers counseling for those deemed at greater risk, having a coach to help ensure they continue to get the necessary support. Another improvement is the change in access to psychiatric medications. The medications previously available only from DOD can now be obtained through the VA as well.[82] The second area is having the necessary leadership support within the P&R structure to be able to make use of other proven best practices. As one example, IDA was told about a communications and outreach program used by the Military Crisis Line/Veterans Crisis Line (MCL/VCL). While DSPO advocated for being able to contract for this program so that it could be tailored to suicide prevention, the request was rejected by the DHRA contracting office because of a sole source requirement.[83]

2. Recommendations

DSPO has been actively and effectively pursuing outreach with both internal (within DOD) and external stakeholders. IDA recommends the continuation of such practices, including participation in working groups and committees, which enhance DSPO's understanding of what other organizations are doing and allows DSPO to share this information with the DOD community. Continuing to improve the content and structure of DSPO's website will also encourage desired collaboration and partnering. Within DOD, several specific areas in which DSPO could improve its outreach, training, and education include:

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[80] Non-DOD stakeholder interview, April 27, 2016.

[81] DOD stakeholder interview, January 11, 2016.

[82] As mentioned in non-DOD stakeholder interview, January 27, 2016.

[83] DOD stakeholder interview, March 30, 2016.

- Ensuring the use of uniform terminology in all DOD suicide prevention materials. One identified example was the use of the CDC definition of a suicide attempt, for which DSPO has advocated but has not been applied in the DoDSER.
- Working with the DOD community to develop a consistent suicide prevention curriculum that would serve as the basis for all to use and could be modified as necessary for the particular Service culture.
- Seeking to translate "best practices" into "shared practices"; in other words, helping the DOD community identify what works well and facilitating the ability for other Services to adopt those practices.[84]

One other initiative that IDA recommends DSPO consider is the creation of "postvention SME teams" comprised of staff from DSPO and other DOD staffs or SMEs to help an installation at a time of need, such as when it is overwhelmed in trying to provide necessary assistance to survivors. Importantly, DSPO cannot be expected to furnish such a team in its entirety with existing staff; other personnel would need to be solicited from the Services or non-DOD personnel, such as retirees, with the necessary understanding of military culture. Such an initiative could be structured similarly to the Family Advocacy Community Assistance Teams (FACAT) created by OSD's Family Advocacy Program (FAP), as described in more detail in Chapter 7.

There are also opportunities for DSPO to expand its collaboration with non-DOD entities, building on the groundwork that DSPO has already laid. Among such opportunities, IDA identifies the following for consideration:

- More frequent inclusion of external stakeholders in SPARRC meetings to promote even greater information sharing and knowledge about best practices. SPGOSC members could also be polled about their interest in a similar effort during some of their meetings.
- More routine inclusion of USCG in DSPO's outreach initiatives.
- Additional partnerships in professional meetings, such as a resumption of the DOD-VA annual suicide prevention conference (but perhaps biennially) and the resumption of a DOD track at the AAS annual conference similar to past participation.
- Continued work with NIMH to maximize database integration between DSPO's DSPRAT and NIMH's research survey tool. The creation of a memorandum of understanding (MOU) between the two organizations could facilitate more

[84] One success along these lines is an effort by other Services to develop programs similar to the U.S. Marine Corps' Marine Intercept Program.

automatic inclusion of DOD grants into the NIMH database and grant permission for DSPO to access NIMH's system.

Finally, current cooperation between the VA and DSPO on suicide prevention has improved dramatically, in large part owing to the positive relationship between the two respective suicide prevention office leaders, Dr. Caitlin Thompson and Dr. Franklin. For example, they have both demonstrated a commitment to working together to address the challenges arising during a Service member's transition from active duty to veteran status. The changes described above are good examples of the positive steps being taken. As with its other outreach initiatives, IDA recommends the continuation of these and similar efforts.

D. Program Evaluation

DSPO's strategic goal of program assessment encompasses an evaluation of "the effectiveness and strategic integration of suicide prevention programs and research throughout DoD."[85] This is in line with the DOD Task Force's recommendation that all suicide prevention initiatives and programs have a program evaluation component.[86] This strategic goal is particularly challenging because it includes both evaluation and research. IDA views these as two separate (albeit linked) functions and, as such, addresses each separately below. Among the identified objectives of DSPO's goal of program evaluation are the following:

- Working with the Services to ensure they are evaluating suicide prevention programs, focusing on quality assurance and continuous improvement
- Executing a DSPO program evaluation plan to provide standardized guidance to increase the effectiveness of programs[87]

The scope and complexity of these two topics – program evaluation and research – merits a more detailed analysis than can be covered in this chapter on overall DSPO value-added functions. Thus, this chapter offers some general findings, observations, and recommendations; while Chapter 4 addresses a specific aspect of program evaluation: proper metrics, including not only DSPO's role in evaluating suicide prevention programs but also ways to assess the DSPO office itself; and Chapter 6 addresses research mechanisms.

1. Findings and Observations

Program evaluation is arguably the most challenging of DSPO's mandates; in large part because assessing any program aimed at "prevention" is so difficult. In short, how can one determine whether a program has caused something *not* to happen? Additionally, suicide is a complex phenomenon with numerous potential contributing factors. Program evaluation is an

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85 *2015 DSPO Strategy*, 14.

86 DOD Task Force, *The Challenge and the Promise*, 105.

87 *2015 DSPO Strategy*, 14.

area in which DSPO had a low baseline from which to start when it began phase two of its operations in 2015.[88] During 2016, DSPO has made concerted efforts in program evaluation and is generally on the right track. An important first step is determining whether DSPO should be performing the evaluations of DOD's suicide prevention programs or whether these evaluations should be conducted by the Services or others and then briefed to DSPO. Indeed, stakeholders voiced the concern that multiple entities had recently been conducting evaluations with considerable and perceived overlap.[89] They noted that DCoE T2 had been conducting one evaluation on cost, NIMH conducted assessments at the installation level, and, in the case of the Air Force, its audit agency was also performing an assessment.

IDA finds that DSPO has recently adopted an effective approach for evaluating the Services' suicide prevention programs, balancing its programmatic oversight duties with an appreciation for not creating an unnecessary burden on the Service staffs. Specifically, DSPO is in the process of obtaining "Service Self-Assessments" (SSAs) of one or more Service-run programs from each of the four Military Services. These SSAs will facilitate program evaluation as described in DSSP Goal 13. Following the first data call, DSPO plans to review initial SSAs and request additional data as warranted. This will provide a learning experience for future data calls. The specific programs that DSPO has identified for SSAs are listed in Table 2. Of the specific programs that DSPO has identified for the first data call, most are training programs. Thus, SSAs will also be a way to monitor training efficacy for both universal and specialized training.

Table 2. Programs Identified for Service Self-Assessments

Service	Program
Army	Ask, Care, Escort (ACE) Unit Risk Inventory (URI)
Air Force	Small Group Suicide Prevention Training
Marine Corps	Unit Marine Awareness Integrated Prevention Training (UMAPIT)
Navy	Defense Equal Opportunity Management Institute Organizational Climate Survey (DEOCS) Quick Poll Ask, Care, Treat (ACT) Operational Stress Control

[88] Several interviewees pointed out that, of the DOD Task Force recommendations, this was the area in which DSPO had made the least progress in its first phase of operations. For example, non-DOD stakeholder interviews, January 27, 2016, and February 5, 2016.

[89] DOD stakeholder interviews, March 3, 2016, and March 4, 2016.

A number of tools have been developed that can guide program evaluation. These include the Suicide Prevention Resource Center's (SPRC) Best Practices Registry (BPR) for Suicide Prevention, Pennsylvania State University's Clearinghouse for Military Family Readiness, and RAND Corporation's Suicide Prevention Program Evaluation Toolkit.[90] One way to ensure that the community is aware of such resources is by posting them on the DSPO website.

Field visits to individual bases offer a different type of evaluation tool, providing snapshots and on-the-ground input about what works in practice. The main objective of such visits would be information-sharing: hearing what is working in the field and raising awareness of recent DOD-level initiatives. To date, DSPO's use of field visits has been fairly ad hoc, taking advantage of other scheduled travel, and have sometimes been seen by the Services as DSPO overstepping its function. A more regularized and targeted approach to field visits that is coordinated as needed with the Services could provide useful insights, including input on the perceived utility of suicide prevention training programs, especially universal ones.[91] In general, too many times when a problem arises, the military and Congressional mindset is to impose additional training requirements. It is not clear, however, that this is the most beneficial response in the case of prevention programs.

2. Recommendations

DSPO's main effort in assessing programs should take the form of an evaluation framework, philosophy, and needed capabilities. By requesting that the Services report annually on their programs using an established framework, as DSPO has now begun to do, DSPO will perform the necessary oversight function of an OSD office without being perceived as impinging on the Services' roles. IDA recommends that DSPO continue to develop the Service self-assessment process as its primary method of program oversight.

Because the Services and the programs they implement operate differently, there is no one-size-fits-all Service self-assessment process. For example, though annual SSAs should be the default, the appropriate frequency of SSAs may vary by program. However, there are standard elements that DSPO can request for all self-assessments. The DSSP identifies three "major assessments of Program Evaluation": strategic integration, resourcing, and effectiveness. These assessments provide the general framework by which DSPO should collaborate with the Services. Thus, IDA recommends DSPO standardize SSAs according to those three major assessments.

As part of this process, first, the Services should be able to describe how the program relates to the DSSP goals and objectives. Second, the Services should be able to report the total

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[90] These tools are described in Appendix H.

[91] For example, DSPO already identified Cherry Point as an important site visit to help gauge what was working so well there compared to other bases. At the other end of the spectrum, Fort Hood would appear to be a logical choice for an on-site program evaluation.

cost of the program, cost per unit or Service members affected, and the sources of the funds used to pay the cost. Some programs are beyond that of suicide prevention, such as resilience or mental health treatment, which complicate the determination of program costs specific to suicide prevention. For such programs, the Services should report costs to the greatest level of specificity possible for suicide prevention. Third, the Services should be able to report outcomes relevant to the program. The relevant outcomes will be program-specific and development of these outcomes will require the expertise of DSPO and program implementers.

The Prevention Forum within P&R could be a vehicle for developing a generic template for SSAs. Another vehicle could be a DSPO-hosted off-site session to brainstorm best practices and evaluation tools. This session could involve not only relevant DOD stakeholders, but also those from the NAASP, VA, SAMHSA, and non-governmental organizations such as Penn State's Military Clearinghouse for Military Family Readiness and the SPRC, as appropriate. IDA recommends DSPO explore these two vehicles as mechanisms to develop a generic template as well as brainstorm best practices and evaluation tools.

While DSPO should have the Services report to it on their program evaluation efforts, a more structured approach to visit specifically identified bases could provide useful inputs on what aspects of the programs work well in reality. DSPO could work with each Service to determine the most appropriate sites, ensuring their support for these visits. These visits could also provide important opportunities for DSPO to share its expertise and increase the knowledge of those in the field about the resources available through DSPO. IDA recommends DSPO work with the Services to develop a structured field visit approach to complement the annual Service program evaluation reports.

E. Data Management and Reporting

DSPO identifies data management, specifically its role in serving "as the authoritative source for suicide data in the DoD," as one of its five strategic goals.[92] The most significant data repositories are the DoDSER and the SDR; these are described in detail in Chapter 5. In its data management role, DSPO staff has identified two important functions: using data to respond to requests for information and using data to help inform future DSPO and Services suicide prevention activities and research.[93] Because of the importance of the data management strategic goal, the expansion of data reporting requirements over the years, and the challenges DSPO has experienced to date in accessing the necessary data, Chapter 5 focuses on data in greater detail. This section highlights a few ancillary data considerations.

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92 *2015 DSPO Strategy*, 13.

93 DSPO interview, March 28, 2016.

1. Findings and Observations

As the central point of contact for DOD's suicide prevention programs, DSPO has taken important steps to enforce standardized policy and guidance so that reporting is consistent across the DOD community. For example, both a 2014 memorandum and the forthcoming DODI outline how the Services are to count and report suicides.[94] This is a marked improvement over the pre-DoDSER and pre-DSPO days when each Service had its own guidance and reporting methodology. DSPO continues to work with the DOD community to identify common data needs and reporting requirements.

DSPO issues a quarterly report of DOD-wide suicide numbers. This currently involves gathering data provided by the Armed Forces Medical Examiner System (AFMES) and sending it to the respective Services for validation. However, the Services each prepare their own weekly or monthly reports for their chains of command. If DSPO were copied on these reports, it could eliminate or significantly reduce discrepancies that appear, not infrequently, between the Services' latest numbers and those DSPO furnishes to them for validation.

The creation of OEDFR should have offered opportunities to improve data integration and inform decision making, not just within DOD's suicide prevention community, but also with other DOD programs touching on personnel issues, such as those dealing with alcohol, family programs, and sexual assault. It is important that such integration efforts be pursued under the new P&R reporting structure as well. As factors are common across several personnel risk areas, being able to identify common data interests and share those across offices can help DOD's overall risk reduction efforts. One existing mechanism for such collaboration is the Prevention Collaboration Forum.[95]

One area DSPO has already identified for further improvement is access to and use of the SDR.[96] Both the VA and DSPO have invested considerable time and funding in the creation of the SDR.[97] Leaders in both organizations embrace the need for a strategic plan to make better use of this data repository. Part of this effort could be to raise awareness of the SDR's existence. Its utility can also be enhanced by requiring debriefs of research results from studies conducted using SDR data to both offices. Of note, the creation of a charter and Board of Governors for the SDR is already a step in the right direction.

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94 The memo is on the DSPO website at http://www.dspo.mil/Prevention/Data-Surveillance/Standardized-Data-and-Reporting.

95 The Prevention Collaboration Forum was initiated by SAPRO with a focus on culture, training, awareness, and leadership influence. It has since expanded its membership (albeit still just within OSD) to identify ways to integrate prevention initiatives better across offices in areas such as training and surveys. DOD stakeholder interview, February 11, 2016.

96 As noted in Objective 2 under the goal of Data Management in the *2015 DSPO Strategy*, 13.

97 Note: DSPO and VA provide payments to the CDC for one of the data sources in the SDR.

2. Recommendations

DSPO should continue its role of enforcing standardized policy and guidance regarding data across the DOD; this effort will be better codified when the DODI is issued. To potentially reduce the frequency of taskings to the Services to validate data, IDA recommends that DSPO mandate that it be provided copies of each Service's weekly or monthly data.[98] This will allow DSPO to compare data it receives from AFMES and identify in advance potential discrepancies.

In its efforts to improve the SDR, DSPO should consider:

- Raising awareness of the SDR's existence, as well as its content, through various mechanisms to include the DSPO and VA websites as well as relevant scientific workshops and conferences
- Requiring, at a minimum, a briefing on the research results from projects that use the SDR, with an emphasis on the research's relevancy to DOD and/or VA suicide prevention interests

A number of other detailed data-related recommendations are offered in Chapter 5.

F. Research Support

1. Findings and Observations

DSPO has identified roles in the realm of research as part of its "program assessment" function, as noted in section D of this chapter. Specifically as it relates to research, DSPO lists the following objectives:

- Having a prioritized research agenda aligned with a broader national strategy and updated as needed
- Identifying translational opportunities and embedding an evidence-based approach into programs and services
- Promoting the development of pilot projects with at-risk populations[99]

During its interviews with stakeholders, IDA found general agreement about the value of DSPO ensuring that research is being done, including through financial support for this research; disseminating research; and helping to identify research gaps.[100] With some exceptions, DSPO's hosting of a research summit in November 2015 was well received; stakeholders embraced its

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98 Such a mandate should be included in the DODI.

99 *2015 DSPO Strategy*. The original draft also included the objective of "becoming the DOD leader in suicide research"; this was subsequently modified to clarify better DSPO's intent to support such research, but not to perform the research function as a leader in the DOD community.

100 DOD stakeholder interviews, December 10, 2015, and January 11, 2016; Non-DOD stakeholder interview, January 27, 2016.

intent to bring them together, share ideas, gain exposure to some ongoing research, and to help identify gaps in research.[101]

Criticism of DSPO's role in research focused particularly on three topics. First, and one fully under DSPO's control to resolve, stakeholders want DSPO to do a more effective job of disseminating research. Numerous interviews with DOD stakeholders affirmed their interest in having DSPO act as a "one-stop-shop" or "clearinghouse" for this information. The development of DSPRAT and efforts to raise awareness about its existence help to fulfill that desired function. However, as described in the next section, there remain challenges in avoiding duplication of efforts.

Second, there are differing views about the extent to which DSPO should be seeking to set DOD's research agenda in this area. Organizations such as MOMRP, Army STARRS, and DSPO all play a role in identifying military research priorities and goals. Some stakeholders have voiced concerns about DSPO either trying to lead the setting of the research agenda too much and/or doing too much on its own without collaborating with other organizations. The IDA research team found that DSPO has an important role to play in helping to set the DOD suicide prevention research agenda, including identifying gaps and priorities and helping to fund research studies, especially addressing gaps such as in suicide prevention research. IDA further finds that DSPO has developed a much more collaborative approach, including working with entities such as MOMRP and the Army STARRS LS to jointly set the research agenda; this change should help assuage some of these concerns. In addition, the differentiation between Research, Development, Test, and Evaluation (RDT&E) and Operations and Maintenance (O&M) funding available to different organizations can help clarify research-related roles and responsibilities. For example, MOMRP is funded using the former, while DSPO uses the latter.

Third, some stakeholders think that DSPO has been too focused on supporting academic research and not focused enough on bringing best practices to the field. The latter is a natural fit for O&M funding; evaluating what already exists. Indeed, beginning in 2016, DSPO has placed a high priority on efforts to translate research into practice. Stakeholders would also like to see more efforts on underlying issues, such as cultural change and ways to address stigma surrounding mental healthcare.[102] It should be noted that, despite these concerns, all stakeholders – both inside and outside DOD – welcomed DSPO's efforts to understand better what research is being done by whom through its more widespread participation in various working groups and committees.[103] The IDA research team recommends that DSPO continue to participate in the advisory boards, working groups, and steering committees of other research organizations, speak

[101] Supporters of the summit and its aims included DOD stakeholder interview, March 4, 2016, and non-DOD stakeholder interview, February 5, 2016. A DOD stakeholder interview, December 16, 2015, disagreed with the idea of DSPO's role in setting the research agenda.

[102] DOD stakeholder interviews, December 10, 2015, and February 22, 2016.

[103] These are outlined in Chapter 6.

at or attend panels or conferences to raise awareness of what is being done in the suicide prevention research arena, and continue to avoid duplication of effort in research. Commendably, this participation has expanded considerably since 2015. In addition, DSPO leads the SPARRC, SPGOSC (as co-chair), and Defense Means Safety Working Group and holds summits and meetings focused on research. DSPO's stakeholders see DSPO as an overarching facilitator and champion of suicide prevention research in DOD.

2. Recommendations

IDA recommends that DSPO continue to participate in the advisory boards, working groups, and steering committees of other research organizations, speak at or attend panels or conferences to raise awareness of what is being done in the suicide prevention research arena, and continue to avoid duplication of effort in research. This participation has, indeed, expanded considerably since 2015.

Another IDA recommendation is that DSPO continue its open and consistent communication with MOMRP and other stakeholders in DOD regarding research priorities, gaps, and funded projects in order collaboratively to set a research agenda. Working with stakeholders and organizations in the suicide prevention research community to set a research agenda ensures that voices are heard, a consensus is met, and duplication of effort is avoided. IDA also recommends that DSPO help fund research studies, especially in those areas that are not currently being addressed.

IDA further recommends that DSPO retain its focus on documenting research relevant to DOD in collaboration with others inside and outside the department; maintaining currency of the suicide prevention research agenda by identifying research gaps in collaboration with key stakeholders; and providing funding support to help address those gaps. As with so many other roles that DSPO plays, continued improved collaboration with other stakeholders is central to the success of this approach. Continued improvements in the content of DSPO's website, to include posting information from the 2015 research summit, the Defense Research Action Plan for Suicide Prevention (DRAP), the DSPRAT database, assessments on translating research into practice, and results from SDR and DSPO-funded studies, will contribute to the office's role as a clearinghouse for research-related information.[104] As such, DSPO's website should serve to centralize DOD-specific research information. As part of its focus on research initiatives, DSPO's website should also provide a link to NIMH's Portfolio Coding (PFC) and the numerous best practices registries and evaluations of evidence-based research.

G. Resource Management

IDA identifies resource management as an additional important DSPO role and responsibility. DSPO's budget goes through DHRA rather than as its own Program of Record;

[104] DRAP, DSPRAT, and TIERS are all discussed in more detail in Chapter 6.

thus, DHRA can, should it choose to do so, reallocate some of this funding to other offices falling under DHRA.[105] DSPO has an annual baseline budget of $6.9 million in O&M funds, meaning that any unused funds expire at the end of each fiscal year. Notably, DSPO has consistently received Congressional adds (also O&M), often on the order of $20-25 million, but these Congressional adds are not guaranteed from year to year nor are they available at the start of the fiscal year.[106] These constraints present challenges to maximizing the utility of these funds. The baseline budget is used for office operations, while the Congressional adds have been used for contracts, other suicide prevention initiatives that DSPO identifies, and as Congressionally directed.[107]

1. Findings and Observations

a. Budgetary options

The uncertainties associated with Congressional adds – whether they will happen, when the funds will be available, how much they will be, and how they can be used for what purposes prior to the end of the fiscal year – pose challenges for DSPO as it seeks to ensure a steady state of operations. There are at least two alternatives to the current structure that might be pursued, each of which has advantages and disadvantages.

One option is for DSPO to advocate for a higher baseline budget, with no Congressional add. The advantage to this approach is that DSPO would have a known amount of funding that could allow for some contract work outside its base requirements and against which long-term plans could be made. Under the current construct, however, this budget would still be subject to internal reallocation decisions by DHRA since DSPO is not recognized by the program objective memorandum (POM) as a program of record. In addition, the argument for a higher base budget would need to be made on the basis of existing requirements; it should not be expected, given the way Congress operates, that this will eliminate future Congressional adds.

An option to address the challenge of having to expend all funds within the fiscal year is to investigate whether some or all of the Congressional add funding could be in the form of RDT&E rather than O&M funds. To do so would not necessarily be an easy process. First, DSPO would need to make a convincing argument with either DHRA or P&R that these funds are being used for R&D-type work rather than, for example, pilot studies. If that argument is successfully made, then it could add these funds to DHRA's existing RDT&E line of accounting, so long as they could be protected from other RDT&E requirements that DHRA might have.

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[105] DSPO interview, September 15, 2015.

[106] In FY2016, DSPO received a $20 million Congressional add, with another $5.5 million specifically marked for peer-to-peer support.

[107] DSPO interviews, September 15, 2015, and September 25, 2015.

Another route would be to seek the OSD Comptroller's support for advocating that the research efforts are R&D-focused, with P&R or DHRA backing. If the Comptroller agrees, then the office of Cost Assessment and Program Evaluation (CAPE) would assign a Program Element (PE) for suicide prevention research. The PE would be issued under a Resource Management Decision (RMD) during the budget and program review process. It should be noted, however, that while the creation of a PE would confer greater visibility on this research, the PE might not remain under DSPO's control. An additional consideration, if this route were pursued, is the potential for blurring the line between what MOMRP supports in its suicide prevention efforts and what DSPO would then be supporting, since MOMRP's funding is RDT&E and DSPO's has always been O&M.

What remains unclear, as of the writing of this report, is how the OSD Comptroller's current initiative, beginning in FY2017, to transfer money from OSD accounts to others only via Military Interdepartmental Purchase Requests (MIPRs), and no longer by sub-allocation, might impact DSPO. The advantage of using a MIPR is that it automatically obligates the funds once they are transferred from OSD to the recipient organization. Depending on the recipient organization, in certain cases the funds can then be used beyond the end of the given fiscal year. The disadvantage of a MIPR is that the recipient organization cannot further transfer those funds. Hence, in the case of DSPO's financial support to the DOD community using its Congressional adds, the funds might be able to be used beyond the fiscal year, but if the research proposal anticipated forwarding the funding to another organization, it would now be a more time-consuming process within DHRA to distribute those funds.

Finally, DSPO has indicated some uncertainty about whether the Congressional adds can be used generally for suicide prevention initiatives or whether they must be used for purposes of the DSPO office itself. One way to clarify this is for DSPO to work with Congressional staff on more specific wording to reflect the intent that funding be used across the DOD suicide prevention community. DSPO is aware of a similar effort by SAPRO and would plan to use this as a model, as appropriate, in its interactions with Congressional staff.

b. A Process for Maximizing the Utility of Congressional Adds

Until recently, DSPO used Congressional adds largely to support research and other projects within its office. The current Director has questioned the importance of some of these efforts and indicated a preference for sharing much of this funding with the Service's suicide prevention offices to help address gaps in research that they are unable to fund. During the course of this study, IDA outlined a process for making better use of these funds, one designed to foster innovation, solidify DSPO's intellectual leadership, and contribute to solidarity within the community. DSPO adopted this process in late-CY2015 to help determine how to spend much of the $20 million FY2016 Congressional add. IDA's proposed process was as follows:

- DSPO determines who would be eligible to submit a proposal. IDA recommended that all SPGOSC and SPARRC members, including DSPO staff, should be eligible. DSPO

could also consider whether to use this proposal process for reviewing various private sector initiatives that have been brought to its attention.[108]

- For each proposal:
  - The structure should be a two-to-three page white paper which outlines the project's objectives, anticipated results, participants, and costs (to include any manpower, data access, or travel), all of which must be able to be obligated by the end of the fiscal year
  - An after action report (AAR) or briefing must be furnished that demonstrates the results or interim findings obtained by the end of the fiscal year. Such information should be housed in a database, such as DSPRAT, to enhance the sharing of ideas and to serve as a central repository for the work
  - DSPO might consider setting minimum and maximum cost bounds for each proposal
  - The proposal cannot be an extension or supplement to already funded work
- DSPO develops criteria to rate each proposal. DSPO would decide on the specific criteria to be used as well as the relative weight of each. IDA suggested the following for consideration:
  - Contribution to understanding better the suicide prevention mission (60 percent). This could include contributions such as:
    - Addressing gap areas identified in the DSSP
    - Addressing gap areas identified by DSPO's November 2015 Research Summit, the SPGOSC, or the SPARRC
    - Promoting cross-Service collaboration to foster common DOD approaches
    - Focusing on suicide prevention's connection to other risk factors
    - Making data more usable and relevant to the DOD mission
  - Likelihood of success or tangible results (20 percent)
  - Capabilities of the project team members (10 percent)
  - The value of the project in relation to the investment being made (10 percent)
- The DSPO Director issues the call for proposals and announces the eligibility and rating criteria, planned review process, and the timelines for submission (approximately four weeks) and decision-making

[108] If a private sector initiative were approved by the review board, additional steps, such as a Broad Agency Announcement (BAA), would be necessary. This could make obligation of the funds by the end of the fiscal year more challenging, depending on the type of funding mechanism used.

- DSPO creates a three-member board to review and rank the proposals, supported by DSPO staff as needed

In large part, DSPO followed the proposed process, which was favorably viewed by the DOD stakeholders. Stakeholders appreciated the opportunity to obtain financial support for their ideas, felt that the process was not overly burdensome, and thought it was well worth the effort. As one interviewee put it, "This is the kind of collaborative effort that we need and will bring people on board."[109] DSPO received proposals totaling $30 million; the review board (which was larger than the three-member composition proposed and included representatives from the Services and other stakeholder organizations) recommended funding 12 projects. In its subsequent discussions with several stakeholders, IDA asked whether it would be worthwhile to have this as an established process, even before the availability of funding is known. Some felt that, despite the compressed timeframe, it was best not to solicit the white papers until DSPO knows that it will be receiving a Congressional add.[110] This perspective must be balanced, however, against the fact that others would like to have a longer lead time to prepare the papers. The importance of timing and the ability to generate the paper can also depend on whether organizations already have an idea for a project but simply no identified funding stream. Finally, while some involved in the process welcomed the fact that any idea could be proposed as long as it met the criteria imposed by the use of O&M funds, others would have preferred for DSPO to provide more guidance on priority areas and topics.[111] DSPO has also identified the need, in future iterations, to require that submissions list not only the name and contact information for the principal investigator, but also for the financial officer.

In sum, this process demonstrated the potential to make good use of supplemental funds. So, while the uncertainty about whether the funds will be available in any given year is not ideal, Congressional adds can present opportunities to support gaps in research as well as other initiatives, such as the creation of tools and training materials or perhaps enlisting social media expertise to help DOD identify new ways of reaching those at risk.

2. Recommendations

While IDA was not mandated to do a comprehensive examination of DSPO's budget and the office's funding requirements for this study, DSPO did ask for IDA's opinion on its idea of advocating for a higher baseline budget with no Congressional add. The findings section above lays out various options and considerations. However, a fully informed recommendation on this topic would require considerably more information and data than is currently available to the IDA team. Important to keep in mind is that an increase in the baseline budget would not protect these funds from being reallocated by DHRA; in contrast, the Congressional adds are specifically

[109] DOD stakeholder interview, March 4, 2016.

[110] For example, DOD stakeholder interview, March 4, 2016.

[111] DOD stakeholder interview, March 4, 2016.

noted for suicide prevention and, therefore, cannot be touched. In any event, IDA recommends that DSPO pursue its plan to clarify better the language Congress uses in providing additional money so that it is clearly understood that these funds are designated for use by the DOD-wide suicide prevention community, not just DSPO.

Based on IDA's analysis of DSPO's current activities using Congressional adds, IDA does not believe that the pursuit of RDT&E funding for some or all of these adds is warranted, at least at this time. Most of the activities that DSPO supported, for example, in FY2016, are a better fit for O&M funds than RDT&E. Retaining the status quo also helps maintain the distinction between the different research portfolios supported by MOMRP and DSPO. Finally, OSD's planned shift, beginning in FY2017, to the use of only MIPRs for transferring funds may well eliminate some of the constraints on expending all funds before the end of the fiscal year since they will be obligated as soon as they are transferred from OSD. It is worth seeing how the FY2017 process proceeds before expending significant effort on the possibility of obtaining some RDT&E funding.

IDA recommends that DSPO continue to use the new process for vetting and financially supporting projects – whether pilot studies, research, or other activities – assuming the continued receipt of Congressional adds. Having adopted the approach IDA recommended in November 2015 for the first time for FY2016 funds, the following modifications to the white paper structure should be considered:

- Make more explicit the need for projects to have a program evaluation component
- Stipulate the requirement for contact information not only for technical cognizance (the SME) but also for the financial person who will facilitate the transfer of funds from DSPO to the recipient organization; of course, if the project involves multiple recipient organizations, it will be necessary to provide the financial point of contact for each of those organizations

IDA also encourages DSPO formally to request input from SPGOSC and/or SPARRC members regarding at least two questions:

- Should the process of soliciting white papers begin earlier to allow more time for their preparation; i.e., prior to DSPO being certain about funding amount and availability?
- Should DSPO identify priority topics each year or should priorities be left to the proposers?

Finally, while it cannot be expected that DSPO staff would supervise these efforts, it is important that DSPO provide an archive for the projects funded. Its DSPRAT database might be able to serve this role. At a minimum, the project proposal white paper and final product(s), such as AARs, briefings, draft journal articles, interim findings, or pilot study results, should be

included. If such information cannot be integrated easily into DSPRAT, DSPO could consider developing a section on its website under its research section for this information.

Part Two

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4. Metrics for Program Evaluation

DSPO has had a significant evaluation responsibility throughout its existence. As noted previously, the Task Force proposed a set of initial evaluative functions when it created DSPO. Specifically, the Task Force positioned evaluating "the effectiveness of the suicide prevention, resilience, or preventative behavioral health programs" as a central DOD policy.[112] Historically, DSPO was unable to fulfill fully its evaluation responsibilities due to a host of organizational and logistical hurdles, including data access issues and difficulty coordinating with the Services. Recently, DSPO has begun to mitigate some of those challenges and to provide a path forward for future evaluation efforts.

As outlined in Chapters 2 and 3, DSPO has three main responsibilities in this area: the evaluation of individual prevention programs, the evaluation of the overall effectiveness of suicide prevention efforts, and the self-evaluation of its roles and contributions. This chapter focuses on the definition and implementation of metrics that would inform these three responsibilities.

A. Findings and Observations

1. Logic Model

DSPO, in collaboration with stakeholders, has created a logic model to guide the development of metrics. The logic model is built on recent research by the World Health Organization (WHO) and Optimizing Suicide Prevention Programs and Their Implementation (OSPI) in Europe. This logic model reproduced in Figure 2, connects the DSSP goals to desired outcomes.[113]

[112] DOD Task Force, *The Challenge and the Promise.*

[113] The figure is taken from the Defense Suicide Prevention Office, *Defense Suicide Prevention Office Measures of Effectiveness*. Note: OSPI European model refers to the initiative *Optimizing suicide prevention programs and their implementation in Europe*. "SP" in the figure refers to suicide prevention.

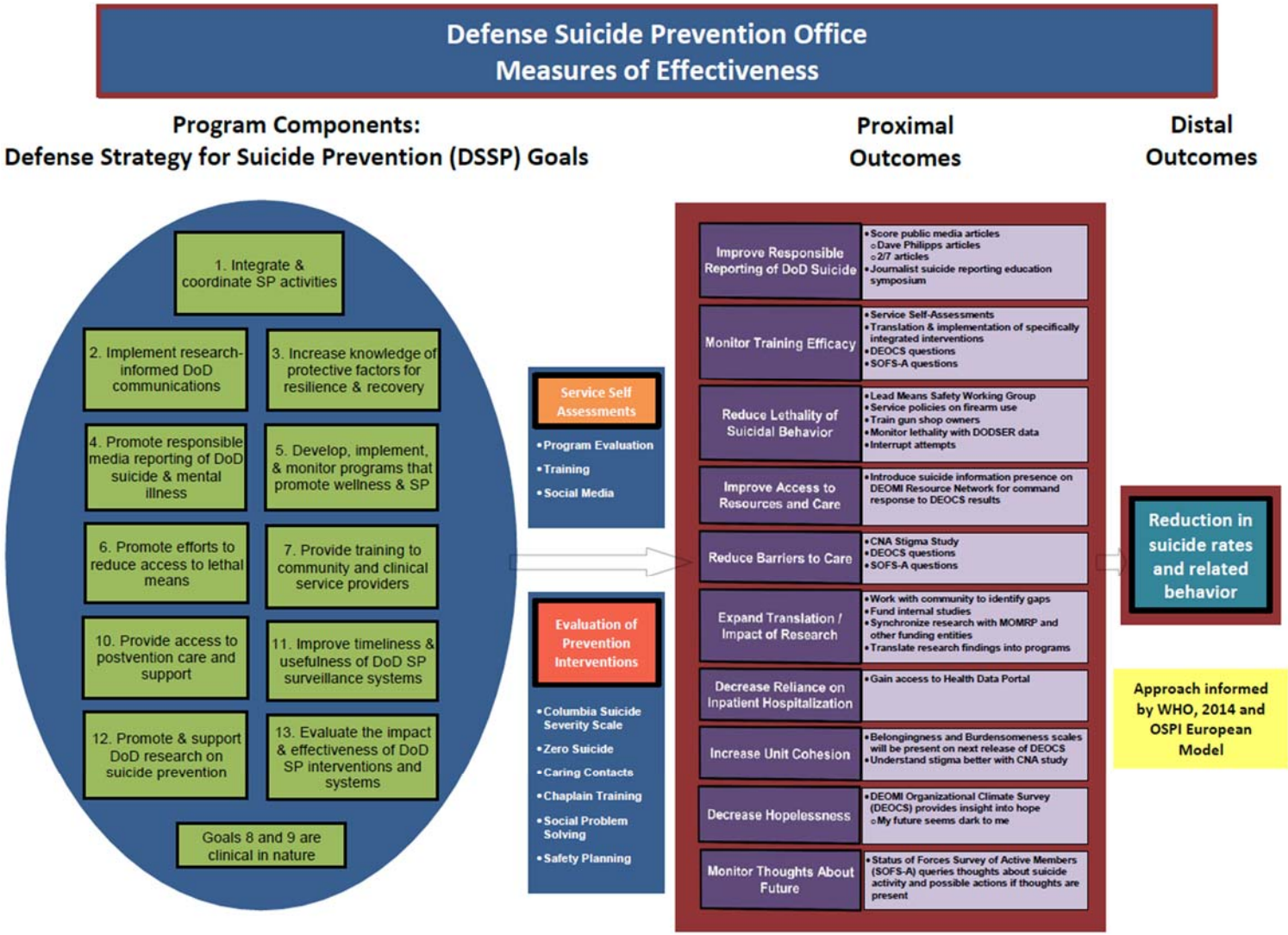

Figure 2. DSPO Logic Model for Measures of Effectiveness

DSPO and the suicide prevention community have defined two categories of outcomes: "distal" and "proximal."[114] The ultimate metric is to reduce suicidal behaviors in Service members, civilians, and their families; known as the "distal outcome."[115] Direct measurement of this goal is enabled by the DoDSER. Suicide attempts and deaths by suicide among Service members are comprehensively recorded in the DoDSER database. However, because observable suicidal behaviors are rare and prevention programs have long-lasting effects, determining the effect of a prevention program on suicidal behaviors is a difficult, long-term effort.

Measuring DSPO's overall success as an organization in reducing suicidal behaviors is even more difficult than assessing any single program. From 2011 to 2012, the first year of DSPO's existence, the suicide rate among active duty Service members rose 21 percent, from 18.7 per 100,000 to 22.7 per 100,000.[116] The active duty suicide rate returned to 18.4 per 100,000 in 2013 and rose in 2014 to 19.9 per 100,000.[117] Theoretically, DSPO's primary effect as an organization is the difference between observed suicide rates and the unobservable suicide rates that would have arisen in DSPO's absence. Perhaps active duty suicide rates would have kept rising in 2013 and 2014 without DSPO's contributions. However, many other factors, observable and unobservable, could have accounted for the higher suicide rate in 2012 and subsequent decline. Therefore, any evaluation of DSPO as an organization that relies on direct measure of suicide rates alone is speculative and unreliable.

To facilitate the evaluation of suicide prevention efforts on an annual or sub-annual basis at either the organizational or program level and to communicate progress in suicide prevention better with stakeholders, DSPO has developed ten proximal outcomes. These outcomes are individually linked to the goals described by the DSSP as shown in Table 3; refer to Table D-1 (in Appendix D) for a description of these goals. DSPO has a team dedicated to translating these outcomes into quantitative Measures of Effectiveness (MOEs). These MOEs will vary widely by source and data type. The remainder of this chapter details the linkages between the DSSP goals, proximal outcomes, MOEs, and data sources. The development of this methodology marks a significant advancement in DSPO's program evaluation work.

2. Proximal Outcomes

Some proximal outcomes directly relate to a single DSSP goal. For example, improving responsible reporting of DOD suicide embodies DSSP Goal 4. Other outcomes, such as decreasing hopelessness, are more broadly applicable. To show how the outcomes are distributed over the DSSP, Table 3 matches each outcome to the most relevant DSSP goal(s). Three DSSP

[114] Proximal outcomes are those that can be impacted in a shorter time frame than a distal outcome that is further up the same causal chain. Proximal outcomes, therefore, allow more immediate measurement of program effectiveness.

[115] DSPO, *About DSPO: Mission & Vision*, http://www.dspo.mil/AboutDSPO/MissionVision.aspx.

[116] T2, *DoDSER 2013 Annual Report.*

[117] T2, *DoDSER 2014 Annual Report.*

goals are not represented among the ten proximal outcomes. These goals concern: coordinating suicide prevention activities across DOD, Goal 1; providing support for those affected by suicide events, Goal 10; and improving the timeliness and usefulness of DOD surveillance systems relevant to suicide prevention, Goal 11.

Table 3. DSPO-Identified Proximal Outcomes in Relation to DSSP Goals

DSSP Goal(s)	Proximal Outcome(s)
1	None
2	Reduce barriers to care Monitor thoughts about the future Increase unit cohesion Decrease hopelessness
3, 5	Increase unit cohesion Decrease hopelessness
4	Improve responsible reporting of DOD suicide
6	Reduce lethality of suicidal behavior
7	Monitor training efficacy
8	Improve access to resources and care
9	Decrease reliance on inpatient hospitalization
10, 11	None
12, 13	Expand translation/impact of research

DSSP Goal 2, which involves changing knowledge, attitudes, and behaviors through research-informed communication efforts, is especially well-represented among the proximal outcomes. DSPO can evaluate communication efforts by observing changes in barriers to care, thoughts about the future, unit cohesion, and hopelessness. DSPO might show, for example, that a smaller share of Service members than in the past feel that negative reactions from peers would prevent a Service member from seeking mental healthcare. This would provide evidence that communication efforts have been successful in changing knowledge, attitudes, and behaviors through reduced stigma.

DSSP Goals 3 and 5 concern the promotion of resilience in DOD through education on protective factors against suicide and community programs, respectively. Increased unit cohesion and decreased hopelessness can provide evidence that suicide prevention efforts have made Service members more resilient.

Goals 4, 6, and 7 directly relate to their respective proximal outcomes, which concern suicide reporting, suicide lethality, and suicide prevention training. Goals 8 and 9 concern the

promotion of suicide prevention as a core, effectively practiced component of Military Healthcare. DSPO can show progress toward these clinical goals through improved access to care and decreased reliance on inpatient hospitalization as a method of treatment. Goals 12 and 13 concern research and evaluation. DSPO can show progress toward these goals through the extent to which the information gained from research and evaluation is synthesized, disseminated, and translated into action.

3. Measures of Effectiveness and Data

The quantitative nature of MOEs allows for comparison of outcomes across units, programs, Services, and time. Thus, they are vital tools for evaluating suicide prevention efforts in the context of the DSSP and budgetary considerations. MOEs require the appropriate form of data depending on the nature of the measured outcome. For each proximal outcome, Table 4 identifies sources of data that DSPO can use to develop MOEs, including the specific questions from these sources. These data sources are described in the remainder of this section.

Table 4. Data Sources for Measures of Effectiveness

Proximal Outcome	Data Source(s)
Reduce barriers to care	DEOCS Question (Q.) 3; SOFS-A[118] Q. 84, 94-97
Monitor thoughts about the future	DEOCS Q. 4; SOFS-A Q. 89-97
Increase unit cohesion	DEOCS Q. 1, 2, 3
Decrease hopelessness	DEOCS Q. 4; SOFS-A Q. 85
Improve responsible reporting of DOD suicide	News articles
Reduce lethality of suicidal behavior	DoDSER
Monitor training efficacy	SOFS-A Q. 82-83; SSAs; Service Reports
Improve access to resources and care	MHS[119]; SOFS-A Q. 84, 94-97; Service Reports
Decrease reliance on inpatient hospitalization	MHS; DoDSER
Expand translation/impact of research	DSPRAT; SSAs

[118] SOFS-A: Status of Forces Survey of Active Duty Members.

[119] MHS: Military Health System.

a. The DoDSER and SDR

The core "distal" metrics for DOD's suicide prevention activities are reported in the DoDSER and SDR.[120] The DoDSER is the authoritative and comprehensive source of data on suicide attempts. Deaths by suicide within DOD are reported in both the DoDSER and SDR. While the SDR has a longitudinal focus, it does not contribute to the measure of proximal outcomes because it only includes individuals who died by suicide. That is, the SDR offers no opportunity to compare individuals who died by suicide to those who survived a suicide attempt. For example, the lethality of a suicide method is the share of attempts using that method that result in a death by suicide. Therefore, the DoDSER allows for the calculation of lethality while the SDR does not.

The DoDSER also provides insight on methods of treatment prior to and immediately following suicide attempts by Service members. This means that the DoDSER can be used to measure the number of hospitalizations resulting from suicide attempts, categorized by geography or demography. This also means that the DoDSER has a direct application to program evaluation, in that each DoDSER reports the individual's prior exposure to suicide prevention and related programs. This allows for a comparison of suicide events among Service members exposed to a specific program, such as the Marine Intercept Program (MIP), to those not exposed to the program. Computation of odds ratios is one method of quantifying this comparison for both attempted suicides and suicides. [121]

b. Survey Data

Surveys allow DOD to measure the perceptions of Service members regarding a wide range of topics. DSPO has recently added questions related to suicide prevention topics to two surveys administered yearly to Service members. These surveys are the Defense Equal Opportunity Management Institute (DEOMI) Organizational Climate Survey (DEOCS) and the Status of Forces Survey of Active Duty Members (SOFS-A).

The DEOCS assesses Service member perceptions of inclusiveness and organizational climate. It is administered annually to all Service members and results are reported at the unit level.[122] The results are then disseminated to base commanders, the Services, and other decision makers to influence policymaking at the unit-level and higher. DSPO and DEOMI developed a

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[120] The DoDSER and SDR are described in detail in Chapter 5.

[121] An odds ratio is the odds of an event occurring in a group divided by the odds of the event occurring in a distinct other group. For example, the odds of a Service member attempting suicide would be the number of Service members who attempted suicide divided by the number of Service members who did not. An odds ratio for measuring the effectiveness of a program may be the odds for the group of Service members exposed to the program divided by the odds for the group that was not exposed.

[122] Bryan Ripple, *DEOMI Organizational Climate Survey Enhancements Improve Commander's Opportunities to Strengthen Readiness through Awareness*, Defense Equal Opportunity Management Institute, https://www.deomi.org/publicaffairs/documents/DEOMI_organizational_climate_survey_version_4.pdf.

suicide sub-scale using DEOCS. The sub-scale is comprised of four questions which assess suicidality. An additional question assesses the prevalence of ideation, attempts, and suicides. However, this last question asks the respondent about the individual's experience with suicide events in his or her unit; it does not account for the respondent's own suicide event history. The sub-scale and additional question will appear for the first time on the DEOCS in October 2016, and DSPO will receive the first data release in spring 2017. Each Service is given access to its own data retrieval system, which houses statistics on survey results.

DSPO will receive responses only to the questions it integrated into DEOCS. However, it will receive these data for all Service members at the unit level, which will facilitate linking suicide prevention programs administered in each unit to unit-level trends in suicidal ideation. The questions DSPO has integrated into the DEOCS are listed in Appendix E.

The SOFS-A is operated by the Defense Manpower Data Center (DMDC) and covers a number of topics that may be relevant to program evaluation including satisfaction, stress, adaptability, financial health, and family life.[123] Additionally, the survey contains a number of suicide prevention-specific questions added by DSPO, beginning with the 2015 survey. These questions are also listed in Appendix E. They address topics such as ease of access to suicide prevention and mental health programs, the efficacy of those programs, and prevalence of help-seeking behaviors or suicidal ideation. The survey is fielded yearly, and results are used to inform policy and program decisions at various DOD agencies, including DSPO. As with DEOCS, DSPO has access only to the questions it has added to SOFS-A. Because the SOFS-A survey is administered to approximately five percent of Service members each year, it is inadequate for unit-level program evaluation. However, because the SOFS-A is conducted by stratified random sampling and weighted to adjust for selection probability and nonresponse, it is appropriate for drawing conclusions about the underlying population using standard statistical techniques.

The DEOCS and SOFS-A surveys are especially valuable sources of data for DSPO. Tables E-1 and E-2 in Appendix E identify the specific DSPO-supplied questions that pertain to each proximal outcome: five questions to the DEOCS beginning in 2016 and eight base questions as well as eight conditional questions to the 2015 SOFS-A. These surveys provide individual responses from Service members regarding their knowledge, attitudes, and behaviors, including resilience. In addition, the SOFS-A directly asks Service members about the effectiveness of their suicide prevention training.

Likert items form the majority of DSPO-supplied inputs to the DEOCS and SOFS-A.[124] Four of the five DEOCS items, which compose a "suicide sub-scale," are six-level Likert items.

[123] Mary Snavely-Dixon, *Approval of the 2015 Status of Forces Survey of Active Duty Members*, Defense Manpower Data Center.

[124] A Likert item is a statement to which the respondent assigns a quantitative value on a sliding scale. For example, the possible responses may be "strongly disagree," "disagree," "neither agree nor disagree," "agree," and

Of the eight base DSPO-supplied questions on the SOFS-A, six are five-level Likert items. An appropriate metric for a Likert item is the share of respondents that reported a certain value or higher. For example, DSPO can use SOFS-A Question 83 to report the share of Service members that agree or strongly agree that they have the necessary knowledge to determine whether a person is in need of help.

The SOFS-A provides information about access to resources and care. Question 84 of the SOFS-A asks if lack of confidence in available resources or not knowing who to turn to would prevent individuals who need mental healthcare from seeking help. For respondents that report having ever had suicidal thoughts, questions 94 through 96 ask who the respondent talked to or would talk to about those thoughts. If the respondent did not considering talking to anyone, question 97 asks why, presenting fourteen non-mutually exclusive options for the respondent to check, such as "I did not know where to get help" and "It was difficult to arrange the time to talk to someone."

For binary questions, DSPO can report the share of respondents that answered in the affirmative. This pertains to the share of respondents that check "Yes" on a question such as "have you ever in your life had thoughts of actually killing yourself?" as well as the share that check a box such as "I did not know where to get help." This also pertains to the share of respondents that reported having not received suicide prevention training in the past 12 months on SOFS-A Question 82.

Questions 86 through 88 of the SOFS-A provide valuable data on research-informed communication efforts within DOD, which could be used to establish metrics for new proximal outcomes. Question 86 of the 2015 SOFS-A asks for the respondent's level of awareness of six support services. For each support service, the respondent reports whether he or she has heard of, knows about, or used the service. For each support service, the share of respondents that know about the service (which includes those who have used it) is a metric as to the quality of DOD communication efforts.

Question 87 is a Likert item referring to the respondent's awareness of military suicide prevention campaigns. DSPO can show evidence of improved communication efforts through a rising share of Service members that agree or strongly agree that they are aware of such campaigns. Question 88 solicits the respondent's advice on the effectiveness of suicide prevention communications for eight types of media. The potential responses are coded from one to five, ranging from "need a lot less" to "need a lot more." The mean of these responses for a given type of media is a metric for the appropriateness of DOD communications. A mean near three suggests that the "messaging level is about right."

Through the questions it has supplied to the DEOCS and SOFS-A, DSPO has made a potent contribution to DOD surveillance of issues related to suicide prevention. This is especially true

"strongly agree." These responses would correspond to the values 1, 2, 3, 4, and 5, respectively. A Likert scale is the sum of a respondent's values for several Likert items.

for the DEOCS, which all commanders are required to administer annually.[125] Comprehensive DEOCS results at the unit level allow researchers to explore the effects of programs, commander interventions, changes in demographic characteristics, suicide events, or any other happenings that vary in exposure at the unit level or higher. Each additional year of results will amplify the usefulness of survey data by allowing before-and-after comparisons.

c. Service Reports on their Prevention Activities

DSPO has identified general information to be requested from the Services on a regular basis. Some of this information will come from the other data sources described in this section. The Services will be expected to assemble and manipulate these data and report the requested metrics to DSPO. Other metrics will come from information sources internal to each Service and will depend on the Service's own criteria and requirements. These include the following metrics DSPO has identified:

- The proportion of suicide prevention positions that are staffed
- The proportion of the force that has received its required annual suicide prevention training
- The number of service-hours provided for suicide prevention counseling
- The proportion of chaplain billets that are staffed
- The proportion of chaplains that have received required specialized training

Further analysis will be warranted when DSPO obtains the first round of Service reports.

d. Statistics on Service Self-Assessments

Ideally, the number of SSA programs (as described in section D of Chapter 3) will grow as the process matures.[126] This number serves as a metric for the success of DOD program evaluation efforts. In addition, DSPO is developing a Program Evaluation Activity Index to measure the extent to which the Services' suicide prevention programs are evidence-informed. By citing the research that supports the assessed program, the SSA provides a platform for the Services to determine the index.

Through the SSA process, in collaboration with DSPO, Services should be able to 1) align the assessed program with the DSSP; 2) determine cost, budgeting, and funding for the assessed program; and 3) report appropriate effectiveness measures.[127] For each of these three elements of

[125] *National Defense Authorization Act for Fiscal Year 2013*, Pub. L. No. 112–239; 126 Stat. 1753 (2013); 10 U.S.C. 1561 note.

[126] The initial SSAs are described above in Chapter 4, section D on program evaluation.

[127] DOD, *Department of Defense Strategy for Suicide Prevention* (Washington, D.C.: DOD, December 2015).

program evaluation, the number of self-assessments that achieve DSPO's goals is a measure of progress toward DSPO's oversight task.

e. The DSPRAT

The DSPRAT is a relational database of over 5,000 published articles and DOD-funded studies related to suicide prevention. One of the primary purposes of the DSPRAT is to be "a tool for DSPO internal use to track research cost, analyze research gaps, and support the translation of research into practice."[128] Thus, the DSPRAT is a source for metrics related to the proximal outcome of expanding the translation and impact of research. DSPO is developing a Research Translation Index as a translation metric. For research impact, DSPO can measure the number and funding-weighted share of DOD-funded research studies that are published in peer-reviewed journals.

The DSPRAT will inform DSPO's production of the DRAP, which will provide specific recommendations for research proposals and research translation. In turn, new additions to the DSPRAT can be compared to the DRAP recommendations to measure improvements in research quality. Following the release of a DRAP, DSPO can determine the number and funding-weighted share of new DOD-funded research studies that meet each relevant recommendation.

f. Analysis of News Reports

By analyzing news reports and identifying areas for improvement, it is possible to improve responsible reporting of suicides and suicide attempts. Data on news reporting come in the unique form of written articles on military suicide from both DOD and public media sources. The number of articles published about DOD suicide events and DOD suicide prevention is the most straightforward measure in this context. Evaluating content in reporting requires greater detail, and is a special challenge because of the unstructured nature of news reports. That is, it is much more difficult to analyze paragraphs of text than numerical data fields.

In tackling this challenge, DSPO has developed an article scoring methodology based on media professional guidelines on suicide reporting established by the World Health Organization and the International Association for Suicide Prevention.[129] Out of 14 items to avoid in suicide reporting, the scoring method determines what fraction the given article avoided. DSPO has developed a user guide and computer application to facilitate article scoring. Because some of the items to avoid are subjective, for example "provides morbid graphics," the scoring is done by manually determining which items the article has or has not avoided.

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[128] DSPO, *Research Summit: Identifying Gaps in Practice*, Research Summit Outline, November 10, 2015 (unpublished).

[129] WHO Department of Mental Health and Substance Abuse. *Preventing Suicide: A Resource for Media Professionals*, http://www.who.int/mental_health/prevention/suicide/resource_media.pdf.

The article scoring methodology is a significant step toward measuring the quality of reporting on DOD suicide. It is simple and intuitive but due to its simplicity has some flaws. The most immediate flaw is subjectivity in scoring. Despite the developed guidance, it is possible that different people will assign different scores to the same article. Another flaw inherent to the methodology's simplicity is that each item is weighted equally. DSPO could consider weighting each item corresponding to the degree to which it should be avoided.

g. The Military Healthcare System Data Repository

DSSP Goals 8 and 9 refer explicitly to the need for the medical healthcare system to be more attuned to the needs of individuals seeking assistance. The Military Health System Data Repository (MDR) is valuable for measuring access to care and inpatient hospitalizations as well as alternative methods of treatment. The MDR is a series of datasets owned and operated by DHA. In order to access these data, researchers need to obtain a data-sharing agreement with DHA. DSPO currently has other data-sharing arrangements with DHA, most notably DoDSER flat-file access through T2, as described in Chapter 5.

The MDR consists of individual-level datasets covering a variety of medical events. The data include information on TRICARE claims and encounters, including records of acute inpatient hospitalizations at military hospitals. MDR data allow for the determination of counts of Service members receiving various types of treatment at the unit, facility, Service, or DOD level. Particularly, MDR data can reveal ways programs can reduce barriers to medical care and reduce reliance on inpatient hospitalization as a means of addressing suicidal ideation/action.

B. Recommendations

1. Creating Metrics to Achieve Comprehensive Coverage of the DSSP Goals

IDA recommends that DSPO identify additional proximal outcomes in order to 1) more comprehensively assess progress toward DSSP goals; and 2) take advantage of extant and emerging data sources. For each of the DSSP goals that did not directly relate to one of the ten proximal outcomes, a recommended entry is provided in Table 5. In addition, the last entry of Table 5 acknowledges the potential for questions from the SOFS-A to provide information about DOD suicide prevention communication efforts. This list of recommended additional outcomes is not comprehensive or final. As organizational roles, goals, and access to information change over time, so should the proximal outcomes.

Table 5. Recommended Additional Proximal Outcomes

DSSP Goal(s)	Proximal Outcome	Data Source(s)
1	Improve oversight of suicide prevention programs	SSAs
10	Improve postvention support	Internal; DoDSER
11	Improve usefulness of data	DEOCS and SOFS-A metadata; DSPRAT
2	Improve communication-focused efforts	SOFS-A Q. 86-88; SSAs

a. Improving Oversight of Suicide Prevention Programs

IDA recommends that DSPO establish an outcome related to DSSP Goal 1, which is to "integrate and coordinate suicide prevention activities across the Department of Defense." While progress toward this goal is difficult to quantify, DSPO can look to its own program oversight activities to provide relevant metrics. DSPO has identified the SSA process as a primary method of improving program oversight. Metrics for such improvement include the number of programs assessed and the number of assessments that comply with DSSP guidance.

b. Improving Postvention Support

None of the current ten proximal outcomes directly relate to the provision of support and services following a suicide event, which is covered by DSSP Goal 10. This is reasonable, as DSPO is currently not directly involved in providing or collecting information on postvention. However, opportunities to achieve DSSP Goal 10 in the future also represent opportunities for new measurable outcomes. In Chapter 7 of this report, IDA recommends that DSPO consider the establishment of a DOD-level postvention response team. This team would directly serve DSSP Goal 10. Any funds or manpower that DSPO makes available for the postvention response team would indicate progress toward that goal. Alternatively, DSPO could require the Services to report on the status of their individual postvention teams, including the frequency of requests for their assistance.

DSPO is currently developing a Postvention Performance Index to measure statistical evidence indicating the presence of suicide clusters. The DoDSER could provide data for computing this index. Alternatively, a retrospective analysis could take advantage of the longer time series provided by the SDR. Under the assumption of no suicide clusters, i.e., multiple suicidal behaviors or suicides within an accelerated time frame, suicides occur independently of the time and location of the last suicide event. Statistical methods can detect when this independence assumption is violated and, therefore, find evidence for suicide clusters.[130] To

[130] Robert D Gibbons, David C. Clark, and Jan Fawcett. "A Statistical Method for Evaluating Suicide Clusters and Implementing Cluster Surveillance," *American Journal of Epidemiology*, 132 supplement 1 (1990): 183-191.

calculate a Postvention Performance Index, DSPO or an external researcher could apply these methods at the military installation level.

c. Improving Usefulness of Data

Data quality is an issue with the DoDSER. On a two-year lag, the Navy conducts a week-long deep dive on all suicides that occurred in a given year. This deep dive process has uncovered missing inputs in individual DoDSERs and inconsistencies in the DoDSER annual report.[131] IDA recommends that DSPO encourage all Services to adopt this deep dive process. In general, DSPO should request that the Services report on the completeness of their DoDSER reporting. For each input field on the DoDSER form, the Services should report the share missing an entry and the share entered as unknown.

For survey data, IDA recommends that DSPO measure usefulness both across years and within individual survey years. The number of consecutive years that an identical set of questions has been asked on a survey measures usefulness across years, although this is only one dimension of usefulness. Response rates at the individual and unit level are important metrics for data usefulness in a single year.

More directly, DSPO can measure the usefulness of DOD data related to suicide prevention by observing the number of and funds invested in research projects that use DOD data. These measures are holistic because they depend on multiple dimensions of "usefulness," including researcher awareness of DOD data related to suicide prevention, the value of the data for research, and the ease with which researchers are able to access the data. Each of these individual dimensions is difficult to measure on its own, but the research itself conveys the usefulness of the data through how intensely the data were actually used. By design, the DSPRAT allows DSPO to observe data use.

d. Improving Communication-Focused Efforts

DSPO is pursuing SSAs for multiple communication-focused programs, such as the Army's Ask, Care, and Escort (ACE) program and the Navy's Operational Stress Control program. The number of and monetary investment in these programs are natural metrics. Specific to the "research-informed" condition of DSSP Goal 2, DSPO can also apply the Program Evaluation Activity Index, once it is developed, to these particular programs.

2. Continuing the Development of Measures of Effectiveness for Each of the Proximal Outcomes

The IDA review identified a number of opportunities for developing and strengthening metrics. IDA's recommendations are as follows:

[131] DOD stakeholder interview, December 1, 2015.

a. Access to Statistics from the Military Health System Data Repository

DSPO should request statistics derived from MDR data, which is owned and operated by DHA. The MDR represents a wealth of opportunities for evaluating progress toward clinically oriented DSSP goals. This would include counts of and funds disbursed for inpatient and outpatient care delivered to TRICARE beneficiaries through the direct care and purchased care systems. It may also include the share of Service members receiving different types of treatment, the share of those Service members that sought help on their own or were referred for help, and the share of those Service members who were but are no longer receiving mental health treatment.

Services can also use the MDR to calculate percentiles for travel time, appointment wait time, and office wait times for mental health treatment across facilities, regions, treatment methods, and time periods. An appropriate set of DOD-wide metrics for access to care would include Military Health System (MHS)-wide travel and wait times for outpatient mental healthcare. The Code of Federal Regulations specifies the following standards for access to care in the MHS:[132]

- Travel time from home no longer than 30 minutes to primary care and 60 minutes to specialty care, unless there is an absence of providers in the area
- Wait times no longer than four weeks, one week, and 24 hours for one-time appointments, routine visits, and urgent care, respectively
- 24/7 emergency services
- Office waiting time no longer than 30 minutes, except when emergency care is being provided

The potential of MDR data is not limited to these suggestions and should be leveraged as appropriate to inform the establishment of additional outcomes and metrics.

b. Time Consistency

Comparing metrics over time is an essential part of suicide evaluation efforts. IDA recommends that DSPO maintain as much consistency as possible in its measures of effectiveness from year to year. For each SSA, DSPO should request the same data elements as those reported in previous years. For surveys, DSPO should strive to ask the same questions in consecutive years. Changing or removing survey questions harms the usefulness of survey response data for research and analysis. Keeping the question text, question order, and response options the same from year to year will maximize the usefulness of survey responses for analysis.

[132] 32 C.F.R., § 199.17, *Tricare Program*, 5.

c. Service Self-Assessments

SSAs provide an opportunity to combine unit-level DEOCS data with program information, which would allow for comparisons of metrics across units that vary in their exposure to one or more programs. IDA recommends that DSPO obtain the finest level of detail possible on what groups were exposed to a given program to maximize the research value of the data.

IDA also recommends that DSPO consider modelling its Program Evaluation Activity Index after the "continuum of evidence" method used by Military Community and Family Policy (MCFP). MCFP has partnered with the U.S. Department of Agriculture (USDA) and Penn State University to establish the Clearinghouse for Military Family Readiness, which is a public database of over 1,000 evaluated programs. The MCFP evaluation process is a combination of internal monitoring by program administrators and contractor support for external evaluations.[133] In the context of suicide prevention, SSAs would bridge the gap between internal monitoring and external evaluations. For each assessed program, DSPO or a DSPO-sponsored contractor could use the SSA to determine where the program falls on the continuum of evidence.

d. Automation of News Article Scoring

The method of scoring news articles developed by DSPO and discussed earlier in this chapter is a leap forward in monitoring responsibility in suicide reporting. However, the human-driven nature of the scoring method makes it costly and potentially inconsistent. IDA recommends that DSPO consider hiring a contractor to develop an automated article scoring system based on the 14 responsible reporting guidelines or some other set of criteria. This automated system could use deterministic rules derived directly from the criteria or it could implement a machine learning algorithm using training and test sets of human-scored articles. The system could automatically find relevant articles online, score them, and produce reports on the articles scored over a chosen time period. The scoring could also be applied retrospectively to archived articles. The articles and scores would be reviewable by humans to ensure reliability.

e. Text Mining the DoDSER

Each individual DoDSER includes a narrative description of the suicide event and the prior circumstances. In its current unstructured form, this text is unusable for research, despite containing extensive information not captured in other sections of the DoDSER. IDA recommends that DSPO consider hiring a contractor to develop a text mining algorithm to extract information from the DoDSER narratives. An algorithm has the potential to reveal currently unidentified risk factors for suicide attempts and deaths. It could also be a way to test the quality of DoDSER reporting.

[133] DOD stakeholder interview, April 5, 2016.

f. Service Reports

IDA recommends that DSPO use the metrics it has identified to guide its request for information from the Services. DSPO should request any information the Services can provide that match MOEs. DSPO should maintain communication with the Services to determine the feasibility of requests and guide reporting accordingly. As this communication develops, DSPO should also ensure that the metrics provided are consistent across the Services and over time.

5. Data Management and Reporting

A. Introduction

1. Overview

Since its creation in 2011, DSPO has faced several data-related challenges. Foremost among those challenges is the ability to access data in a timely fashion. Due to the nature of its mission, DSPO requires unfettered, swift access to numerous repositories that hold data on active duty, reserve duty, and, now, dependent suicides. DSPO's main sources of suicide data for the Active Component and Reserve Component, which includes both Reserve and National Guard forces[134] personnel, are the DoDSER and the SDR. Both have presented challenges for DSPO. In the case of the former, DSPO has not had easy access to these data due to administrative control; in the case of the latter, lags in the availability of external data make it difficult to provide the most up-to-date information. Some of the data access issues have been mitigated through recent data access agreements discussed later in the chapter. However, the repositories that DSPO pulls its information from are incomplete, as some subgroups, such as military dependents, are either not currently represented or are not captured by sufficiently longitudinal data. Indeed, in the case of military dependents, DSPO had to develop a whole new process for obtaining these data.

This chapter describes DSPO's two primary data sources, its data management responsibilities, and the challenges DSPO faces in executing them. The chapter concludes with recommendations regarding DSPO's access to and maintenance of suicide prevention data.

2. About the DOD Suicide Event Report

The main reporting mechanism for DOD suicides and suicide attempts is the DoDSER. There are, in effect, two components to the DoDSER: a database containing a report for each suicide event and the annual report, which extracts statistical information from the database. The database consists of objective and subjective elements, with the intention of characterizing suicide behavior by gathering risk and protective factor information. Data fields include details about the suicide event circumstances as well as associated factors such as behavioral health diagnoses, psychological stressors, demographics (age, sex race, marital status, etc.), and deployment history.[135] The annual reports then use these data to compile detailed statistics and information about suicides and suicide attempts for that calendar year.

The Military Services have used the DoDSER as a reporting system to record individual suicide events since 2008. Cases that require a DoDSER have expanded over time; today, they

[134] Unless otherwise indicated, references throughout to the Reserve Component include both Reserve and National Guard forces.

[135] As described in T2, *DoDSER 2014 Annual Report*.

include both suicide attempts and reserves regardless of duty status at the time of the event, as described below. Prior to the cross-service implementation of the DoDSER in 2008, each of the Services collected suicide event data using separate, non-standardized systems and Service-specific forms.[136] Now, because all the Services use a common data collection form, items about the event and individual's history are standardized. This protocol helps to reduce some reporting inconsistencies across the Services, although the completeness and accuracy of the data inserted can still vary, depending on the skills and experience of the person designated to complete the DoDSER, especially for those questions that are subjective in nature.[137] DMDC provides supplemental data on Service member demographics and deployment histories.

It should be noted that the DoDSER Annual Report does not calculate a suicide rate for those categories for which there are less than 20 suicides. Per the 2013 DoDSER Annual Report, "all rates associated with fewer than 20 suicides [are] suppressed because of the statistical instability of rates derived from such a small numerator."[138] However, in the past, rates per 100,000 were calculated when there were at least five data points.[139] This change in the minimum number necessary to calculate a rate generally affects the Reserve Component more frequently, as they often have fewer than 20 suicides per reporting cycle.[140] Additionally, there are some inconsistencies in the data categories in DoDSERs from year to year. For example, in some years, "poisoning" is its own distinct category in the section on method; while in others, poisoning is split into "gas, vehicle exhaust"; "gas, utility, or other"; and "chemicals."

The DoDSER is maintained by DCoE T2; DCoE resides within the Defense Health Agency's Healthcare Operations Directorate. T2 has also prepared the annual DoDSER report since 2008, using data collected by the Services and input into the DoDSER database. T2 has coordinated with AFMES, Service Suicide Prevention Program Managers (SPPMs), Service DoDSER Program Managers, DMDC, DSPO, and SAPRO to develop the annual report, which is released and disseminated in coordination with DSPO.[141]

3. About the Suicide Data Repository

Launched in 2011 and operational in 2014, the SDR represents a collaborative effort between DOD and the VA. It is a longitudinal dataset, with some of the data going back 40 years. The SDR aggregates data from multiple DOD and VA repositories, as well as non-military

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[136] DOD Task Force, *The Challenge and the Promise*, 13-14.

[137] DOD stakeholder interview, February 3, 2016. As noted in the acknowledgements to the DoDSER Annual Report, the Army has a DoDSER Program Manager to supervise DoDSER data collection, but this does not appear to be the case for the other Services. And, there is no one single person or small group of people who input the data within each of the Services.

[138] T2, *DoDSER 2013 Annual Report.*

[139] DOD stakeholder interview, December 9, 2015.

[140] Ibid.

[141] T2, *DoDSER 2014 Annual Report.*

government repositories, to achieve this breadth.[142] DSPO and the VA are currently working to document military personnel suicides dating back to 1979.[143] The most recent expansion, to include the years 2012-2014, added 52.6 million records to the repository. The SDR's focus is explicitly longitudinal: DOD and the VA structured the SDR with the goal of viewing suicide-related outcomes over time. SDR is intended for use in the research community and it is the most comprehensive and accurate de-duplicated data currently available.[144] Table 6 lists the data sources included in the SDR; each is explained more fully in the following paragraphs.

Table 6. SDR Data Sources

CDC's National Death Index (NDI) Plus (contains roughly 2.5 million records from 1979-2011)
Active Duty Master File (from DMDC)
Active Duty Transaction File
Reserve Components Common Personnel Data System (RCCPDS) Master File and RCCPDS Transaction File (from DMDC)
Veterans Health Administration Master User File (from the VA)
Defense Casualty Analysis System (DCAS)
Social Security Administration Death Index
Military Veteran Mortality Database (MVMD)

The CDC National Death Index (NDI) is a product of the National Center for Health Statistics (NCHS).[145] It is a centralized database of state-level death records available from 1979-2014. It is sourced from state vital statistics offices. DSPO already has an established procedure with the CDC NCHS for querying the NDI through DMDC and such data are incorporated into the SDR. The NDI Plus provides more detailed death information not available in the NDI. The NDI Plus also contains "cause of death" codes that researchers can use to separate suicides from non-suicides. NDI Plus is only available to investigators in the medical and health research fields.

[142] Department of Defense and Department of Veteran Affairs, *Suicide Data Repository Board of Governors Charter*, October 2015.

[143] This is to cover Active, Reserve Component, and Veteran suicides.

[144] Data surveillance section of *DSPO 2015 Annual Report* (draft, not yet published).

[145] Noreen Arnold, *Ascertaining Veterans' Vital Status: VA Data Sources for Mortality Ascertainment and Cause of Death*, May 2015.

DMDC Master Files are comprehensive databases containing detailed information about military personnel. The files comprise an inventory of all Service members at a point in time.[146] The database is centralized and standardized and it contains Personally Identifiable Information (PII) and demographic data on Service members. Data fields include Social Security Number, race, education, Armed Forces Qualification Test percentile, number of dependents, Unit Identification Code, etc. The files track individuals as they proceed through their military service. The Active Duty Master File and the Reserve Components Common Personnel Data System (RCCPDS) Master File contain these data for active and reserve personnel, respectively. The Transaction files also contain these data.

The Defense Casualty Analysis System (DCAS) is also run by DMDC. DCAS collects and maintains casualty information on warfighters.[147] The data cover both service members and civilians working in conflict zones. The Services provide this information to DMDC, which manages the database. Detailed casualty information collection began during the Korean War, although the database also houses summary-level data on older conflicts. The DCAS can be used to identify suicides that occurred in combat zones.

The Social Security Death Index is a database of deaths reported to the Social Security Administration (SSA) beginning in 1962.[148] It was created from the SSA Death Master File and contains over 90 million records. The SSA Master File contains data from a variety of sources, including funeral homes, financial institutions, states, and other Federal agencies. The Index can be used to fill in gaps in the NDI for individuals who hold Social Security cards. It is more complete for the population of residents over age 65. It is updated weekly.

The Veterans Health Administration Master User File is a comprehensive database of VHA-using individuals.[149] It is a subset of the VHA Vital Statistics File, which contains information on VHA activity and veterans' benefits compensation. The Master File comprises information on veterans known to the VA and non-veterans, and records VHA activity from FY1992 and later. As of 2015, the data contained one record per social security number (SSN)/date of birth/gender combination and consisted of 26,331,067 records.[150] The Military Veteran Mortality Database (MVMD) is updated monthly and contains approximately 240 data elements.[151]

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[146] A.E. Street, et al., "Understanding the Elevated Suicide Risk of Female Soldiers during Deployments," *Psychological Medicine*, 45 (2015).

[147] https://www.dmdc.osd.mil/dcas/pages/summary_data.xhtml.

[148] https://www.deathindexes.com/ssdi.html.

[149] Ibid.

[150] Ibid.

[151] DSPO, *Frequently Asked Questions (FAQ)* and http://www.hsrd.research.va.gov.

Access to SDR must be sponsored by a governing DOD or VA office for the purpose of surveillance, research, or program evaluation.[152] Access requests fall in three categories: *Exempted* - DOD or VA employee requesting de-identified data; *Full* - DOD or VA employee requesting identifiable data; and *Expedited* - Access requiring full review that must be satisfied within 30 days. The SDR Board of Governors reviews and acts on requests, generally at its quarterly meetings.[153]

B. DSPO's Data Management Responsibilities

In its data management role, DSPO staff has identified two important functions: using data to respond to requests for information and using data to help inform future DOD suicide prevention activities and research.[154] Inherent to the ability to respond to data requests is (1) access to the necessary data; (2) having relevant (namely, timely) data; and (3) having the necessary expertise to analyze the data. DSPO has made notable progress in the first and third aspects, the second is one that it cannot control.

1. Evolution of DSPO's Data Management Responsibilities

DSPO requires access to a breadth of data repositories because it generates reports on different military-affiliated subgroups, the scope of which has grown notably over the years. It has long sought greater access to DoDSER and, as described above, undertook the initiative with the VA to create the SDR to have more comprehensive data available.

As part of the DoDSER process, reporting, prior to DSPO's creation, focused on suicide and suicide attempts of Active Duty Service members and Reserve Component Service members who were on active status.[155] Beginning in 2012, the DoDSER began to capture suicide events for all Reserve Component Service members, regardless of duty status at the time of death.[156] This expansion posed certain challenges. For example, capturing off-base suicides was difficult and, because these suicides occurred outside the military recording system, the Services historically underreported suicide numbers for these populations.[157]

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[152] The Principal Investigator must be from DOD or VA, although third parties can be part of the research team. Department of Defense and Department of Veteran Affairs, *Suicide Data Repository Board of Governors Charter*, October 2015.

[153] Ibid.

[154] DSPO interview, March 28, 2016.

[155] The annual DoDSER reports have, in fact, been produced since 2008 by T2. In that year, all Services reported on suicides within the Active and Reserve Components. In 2009, the annual report also included suicide attempts in the Army and, in 2010, this expanded to all the Services.

[156] T2, *DoDSER 2012 Annual Report.*

[157] Andrew Lehren, "Why National Guard and Reservist Suicide Numbers May Be Misleading," *The New York Times*, May 16, 2013, http://atwar.blogs.nytimes.com/2013/05/16/why-national-guard-and-reservist-suicide-numbers-may-be-misleading/?_r=0.

Another change occurred in 2013, when DSPO began producing quarterly suicide reports to supplement the annual DoDSERs. In the quarterly reports, DSPO summarized suicide counts and annual rates for each Service component. DSPO used suicide mortality data collected by the AFMES and population data collected by the DMDC to calculate these estimates.

A 2014 memorandum from a team of DOD stakeholders, including DSPO, AFMES, DMDC, and T2, standardized component suicide rate calculations and reporting for both the Services and the DOD.[158] DSPO's forthcoming DODI will allow DSPO to provide further guidance on suicide event data collection and analysis. Additionally, DSPO has begun to explore linkages between other personnel issues (such as sexual assault, financial problems, and alcohol use) and suicide.

Most recently, the FY2015 NDAA required that the DOD improve standardization of data collection and reporting on suicides and suicide attempts for all members of the Armed Forces as well as suicides of military dependents.[159] Many of the Services have acknowledged that, while they believe tracking dependent suicide rates is important, they have not collected these data due to a variety of constraints.[160] Now, such reporting is required. Thus, on January 7, 2016, OSD issued DTM 16-001, "Policy for Reporting Suicides and Attempts of Service Members and Suicides of Service Members' Dependents," which requires that the Services track and report military family suicide data.[161] This process is described below. Reporting to DSPO began in July 2016.[162]

While DSPO does not have responsibility for tracking veteran suicides, it should be noted that DSPO has been actively working with OSD's In Transition office and the VA to improve the transition of personnel from DOD to VA, especially for those with mental health issues.[163] Some studies have highlighted important aspects of the transition phase, which DSPO recognizes may benefit from additional study. For example, one study noted that separation from Service causes

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158 See http://www.dspo.mil/Prevention/Data-Surveillance/Standardized-Data-and-Reporting.

159 Public Law 113-291, section 567.

160 Jacqueline Garrick, *Suicide and Military Families: A Report on the Feasibility of Tracking Deaths by Suicide among Military Family Members*, DSPO, January 2013. A large challenge is that there has been no centralized repository for such information; linking together various Census and death index databases does not suffice to capture this population.

161 DOD Directive Type Memorandum 16-001, *Policy for Reporting Suicides and Attempts of Service Members and Suicides of Service Members' Dependents* (Washington, D.C.: DOD, January 7, 2016).

162 *Initial Analysis: Process for Capturing and Assessing Dependent Suicide Data*, June 2015.

163 For example, Service members receiving behavioral healthcare have a warm hand-off with VA or another provider; for 180 days, there are premium-free healthcare benefits after regular TRICARE benefits end; and temporary healthcare is provided for a fee for 18-36 months under another program. The challenge lies in identifying and providing assistance to those who are in transition but have not manifested symptoms before or during the transition. Source: *The Grey Area*, DSPO briefing to SPGOSC, April 2016.

a significant increase in the "hazard [risk] of suicide."[164] Suicide risk is greater among non-VHA-using veterans, and it declines as individuals age. Multiple researchers have found that a history of deployments does not translate to higher suicide risk. The same researchers discovered that this risk is higher among veterans who are male, white, former enlisted, unmarried, and whose prior service was in the Army or Marines.[165]

C. Findings and Observations

1. DSPO and DoDSER

Discussions between DSPO and T2 concerning access to DoDSER are long-standing. T2 has managed DoDSER since the latter's inception, i.e., since before DSPO was established. However, when DSPO was stood up with the mandate to unify DOD efforts and to be responsible for reporting on DOD-wide suicide issues, including data trends, a reasoned argument was made that, to fulfill effectively this mandate, DSPO needed to have direct and rapid access to the data contained in DoDSER. During the course of its research, IDA identified a series of options for organizational control of DoDSER:

- Maintain the status quo, whereby T2 retains full control and responds to queries from DSPO
- Develop an MOU between DSPO and T2 to provide DSPO mirror access
- Move DoDSER in its entirety to DMDC
- Move the IT component to DMDC, but DSPO would manage ("own") the data
- Move DoDSER in its entirety to DSPO
- Maintain the status quo, but develop a liaison function between T2 and DSPO to facilitate data access

An argument can be made for a fairly clear differentiation of roles between T2 and DSPO. T2 has the role of an independent data collector and manages the supporting infrastructure for that data collection; DSPO has the policy role of determining how to use the data. The issue for DSPO has been that this operating model still did not allow it the access it needed to the data itself. T2 has questioned whether DSPO has the appropriate certifications to have access to the

[164] Mark Reger, et al., "Risk of Suicide Among US Military Service Members Following Operation Enduring Freedom or Operation Iraqi Freedom Deployment and Separation From the US Military," *JAMA Psychiatry*, 76 (6) (2015).

[165] Ibid. As the VA reported, from 2001-2007, while veterans in general were at greater risk for suicide than the general U.S. population, veterans who had deployed had a 41 percent higher suicide risk compared to the general population, whereas those who had not deployed had a 61 percent higher suicide risk. See http://www.publichealth.va.gov/epidemiology/studies/index.asp.

data.[166] There have also been questions about whether granting DSPO direct access to DoDSER would generate additional complications, including the need to update two sets of DoDSER data.[167] Under a scenario in which DoDSER were moved in its entirety to DSPO, issues could arise about the office's data warehousing capability, infrastructure to store and analyze the data, and the staffing implications involved. Under options in which DMDC were to become involved, which has a certain logic because DMDC already manages so many other datasets, there were uncertainties about whether DMDC would be any more responsive than T2 in providing the necessary data.

The resolution of this issue finally occurred on June 3, 2016, when DHA signed an MOU with DSPO to allow consistent access.[168] Per the agreement, case-level data in the form of a flat file is to be sent to DSPO on the 15th of each month. If DSPO wishes to supplement the DoDSER data with additional data, it must update its database through the *Federal Register* process. Overall, this agreement marks a drastic improvement in relations between DHA and DSPO and should enable DSPO to access the necessary data to respond to inquiries in a timely manner.

Currently, DSPO issues quarterly reports. The report breaks down the number of suicides by Component and by Service. Historically, the annual DoDSER report has been prepared by T2, with DSPO serving in supervisory and coordinating roles. As of mid-2016, in accordance with the June MOU, DSPO assumes the responsibility for writing the annual DoDSER report as well. It should also be noted that T2 uses the data to produce its own research papers, although some have questioned whether the topics are of particular interest to the DOD and would like T2 to take a more active role in sharing its research results with the DOD community so that potential implications for DOD can be better understood.[169] In turn, DSPO will also now be able to use the DoDSER data to help identify potential topics for research.

2. Potential Improvements to SDR Content and Use

SDR data quality issues arise due to the repository's structure. Because the data come from many sources, there are often inconsistencies between data categorization. SDR may eventually incorporate elements of the DoDSER, which may help ameliorate categorization issues.[170] Additionally, there is often a two-year lag in the CDC data used in the SDR, which prohibits analysis of the most recent trends. In particular, NDI "manner of death" determinations can take

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[166] For example, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and DOD 6025-18-R prescribe the permitted uses of DoDSER Protected Health Information (PHI), so DSPO needed to become a HIPPA-covered entity, which it has done. T2, *Briefing for Keita Franklin, LCSW, PhD, Director, Defense Suicide Prevention Office*, June 11, 2015.

[167] DOD stakeholder interview, February 3, 2016.

[168] *Memorandum of Understanding Between The Defense Suicide Prevention Office And Defense Health Agency For Guidance On Use Of Department Of Defense Suicide Event Report Data*, DHA-2016-S-025.

[169] For example, DSPO interview, September 21, 2015.

[170] Robert Bossarte, *An Introduction to the Joint DoD/VA Data Repository*, Veterans Health Administration, 2009.

up to nine months for suicide cases.[171] This lag is a relic of outmoded vital registration practices and systems at all levels of government.[172] Vital statistics data, such as mortality and fertility counts and rates, have historically been aggregated through manual data entry of physical birth and death certificates. Updating these records required the coordination of a number of data providers, including funeral directors, medical examiners, and physicians, and state registration officers.[173] A lack of funding and policy makers' tolerance of annual reporting delays has exacerbated the strain on Federal and state collaboration. The combination of these factors has ensured that vital statistics collection systems remain ill-equipped to process the massive amount of data that accumulates in each state. To address these concerns, the CDC plans by 2018 to have "at least 80 percent of all vital records within ten days of the event," birth or death, from the states with which it is working closely.[174] If this occurs, this would be an important change in SDR's capabilities to examine more recent trends.

Using the SDR, DSPO has the ability to look at trends within clusters such as within a given base, geographic locality, or occupational specialty. DSPO also uses that data to produce demographic analyses, which can be important in responding to the various inquiries it receives. DSPO intends to document suicide attempts over time in a longitudinal study using the SDR and DoDSER. DSPO's research plan for this project involves following a cohort of those who have attempted suicide and identifying interventions that worked, similar to an analysis performed by Army STARRS.[175] Additionally, DSPO plans to support research on the involvement of gun culture in suicides and when to train Service members on improving their problem solving skills.

IDA has identified potential additional sources of information that might be incorporated into SDR. One such source is the Deployment Health Assessment, which is administered to Service members before each deployment. These assessments contain demographic and mental health data and are available to medical service providers. A similar study, the National Post Deployment Adjustment Survey, was developed to identify Service members at high risk of performing violent actions.[176] These surveys may reveal the importance of extant mental health history to suicide events as compared to deployment history.

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[171] DSPO interview, September 21, 2015.

[172] "Something Old into Something New – Revitalizing Vital Statistics through Innovation and Improved Efficiency: Notes by the National Center for Health Statistics of the United States of America," *Economic Commission for Europe Conference of European Statisticians*, 63rd plenary session, Geneva, June 15-17, 2015.

[173] Ibid.

[174] Ibid.

[175] DSPO interview, September 28, 2015.

[176] EL Edens, et al., "Association of Substance Use and VA Service-Connected Disability Benefits with Risk of Homelessness among Veterans," *The American Journal on Addictions / American Academy of Psychiatrists in Alcoholism and Addictions*, September-October 2011, 20(5).

3. Reporting on Military Personnel Suicides and Suicide Attempts

The primary data for the Active Duty population are taken from annual DoDSERs and augmented by data from AFMES and DMDC. However, the Services also have access to a wealth of information informing suicide events including criminal reports, suicide notes, social media, and autopsy data.[177] The Services have begun to conduct deeper analyses using DoDSER and these other sources of information. The Navy performs this sort of analysis on an annual basis and takes a week to review all the cases that occurred two years prior. The Air Force produces fatality reviews in addition to yearly reviews, and the Marine Corps produces monthly reports on critical incidents, beginning with suicides, with the aim of identifying emergent issues and taking corrective actions as quickly as possible. DSPO has been considering performing similar deep dives into the data to span across DOD. [178]

Reflecting the high-level attention paid to the issue of suicides and suicide attempts, the Service SPPMs provide weekly or monthly suicide reports up their respective chains of command. The Joint Staff also receives weekly reports. However, DSPO does not regularly receive copies of these routine reports. As a result, when responding to requests, DSPO may not have access to the most up-to-date data and must, therefore, request Service validation of the accuracy of the numbers it provides.

4. Reporting on Suicides of Military Dependents

Data on military dependent suicides are currently limited mainly because the collection of these data is a new requirement for DOD. To address the FY2015 NDAA mandate, DSPO developed the DTM issued in January 2016 and – working in close collaboration with the Service SPPMs – has identified the potential for using the Defense Enrollment Eligibility Reporting System (DEERS) to record dependent suicides. DEERS contains records of all living and deceased DOD dependents. When there is a dependent death, all Services require that death certificates be presented to the Service within a specified time window.[179] Beginning in July 2016, death certificates will be scanned once submitted to DEERS and DEERS will include "suicide" in its death categorizations.[180] This change will allow researchers to identify more accurately military dependent suicide trends in the future.

DEERS has outlined the following methodology for integrating dependent deaths by category into its query system:

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[177] Unpublished information paper on Wellness Assessment and Risk Nexus (WARN), October 26, 2015.

[178] DOD stakeholder interviews, December 1, 2015, and December 3, 2015, and DSPO interview, September 28, 2015.

[179] Air Force Instruction 36-3026 IP (June 17, 2009) requires presentation of the death certificate by military sponsors as proof of dependent death within 30 days of receipt of the death certificate. The instruction does not require a data element to capture manner or cause death, nor is there a requirement to scan the death certificate.

[180] Public Law 113-291, Section 567, *Carl Levin and Howard P. "Buck" McKeon National Defense Authorization Act for Fiscal Year 2015*, December 19, 2014. DSPO interviews, March 28, 2016, and April 14, 2016.

1. Modify DEERS' business processes and software to require and support scanning of all death certificates.
2. Modify the software to include a drop down box identifying Manner of Death (six total).
3. Query DEERS for all records of dependents containing the death termination-of-eligibility code to retrieve the desired population.
4. Query DEERS for dependent death records with manner of death notated as suicide.[181]

DMDC has recommended that one of the Services do a trial sample of the DEERS death certificate data to determine an approximate number of dependent suicides, as well as assess how burdensome the data cleaning process will be.

Additionally, DMDC receives monthly SSNs of deceased Service members and their dependents, which can be used to capture all deaths not reported via death certificate submission, although the cause of death would still need to be traced. Before submission to DSPO, DMDC can remove SSNs to preserve the decedent's anonymity. This DMDC input may be particularly valuable, not only as an additional data point, but, in the case of dependents of reservists who are not healthcare beneficiaries and are, therefore, not in DEERS, this may be the only way of obtaining suicide information about this cohort.[182]

Within the Army, the Criminal Investigative Division (CID) has the ability to report only on on-base dependent suicides, excluding a large segment of the dependent population that lives off base. However, CID is occasionally able to leverage its connections to the community to give DOD access to local suicide files.[183] Cultivating those relationships across all DOD investigative units might help fill the gaps in this knowledge.

IDA has found that an additional possible source of data for military dependent suicides is dependent TRICARE records. Two possible TRICARE databases for these records are the MDR and the Military Health System Management Analysis and Reporting Tool (MHS M2). The MDR is a centralized data repository that aggregates DHA healthcare data. M2 allows users to query the MDR in a secure, online environment. Using these tools, it is possible to search for suicides and self-inflicted injuries by Interface Control Document (ICD)-9 code.

5. DSPO's Data Analytical Capabilities

DSPO's data analytical capabilities have increased considerably in 2016. There is now a director of data and surveillance, in addition to one data analyst. The former comes to the

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[181] DSPO, *Initial Process for Capturing and Assessing Dependent Suicide Data*, June 23, 2015. In a DSPO interview on March 28, 2016, staff reported that DMDC had indicated it might take two years to implement this change in DEERS.

[182] DOD stakeholder interview, December 9, 2015.

[183] DSPO interview, September 28, 2015.

position with a strong grasp of the issues that need to be addressed and the proper analytical approach for doing so. This capability is all the more important now that DSPO has access to the DoDSER flat file and will be responsible for producing the annual report. The latter is a significant undertaking and will likely require additional support, either staff or contractor, to conduct all the needed analysis and prepare the document.

Another improvement in DSPO's data analysis focus was its decision to halt an internally generated initiative, which was not supported by either the DOD stakeholder community or the current DSPO leadership. This was DSPO's internal development of the Wellness Assessment Dashboard, which aimed to provide DSPO with the ability "to visually assess and analyze the underlying causes and correlations of behavioral stressors."[184] This initiative was seen as duplicative of other DOD efforts, especially the Army STARRS program, and the current DSPO leadership agreed that the dashboard did not represent a good investment of time or money. As such, this work was terminated at the end of the contract in December 2015.

D. Recommendations

Overall, IDA recommends that DSPO continue in its role of enforcing a standardized policy and providing guidance related to data across the DOD, to include how to count and report on suicides and suicide attempts. The DODI, once issued, provides the necessary mechanisms to enforce this policy and guidance. IDA further supports the current DSPO leadership's focus on consolidating data and improving accessibility. Responding to data inquiries and helping inform future research are additional important data-related tasks for DSPO, both of which are facilitated by changes described in this chapter. Further enhancements may be possible, based on recommendations outlined below.

1. DSPO and DoDSER

IDA supports the recent MOU signed between DSPO and DHA to provide an updated flat file of DoDSER on a monthly basis. We believe that the MOU is adequately comprehensive and cogently resolves DSPO's historical data access constraints. Assuming each party upholds the agreement, DSPO should be able to respond more quickly to data inquiries and analyze data in a more meaningful way for the entire DOD community. IDA recommends that should difficulties arise in the execution of the MOU, every effort be made to work out these difficulties. Direct DSPO access to the data, without the burden of having to re-create and maintain the infrastructure underlying the database, is the most efficient use of DOD resources.

The MOU also appropriately establishes DSPO as the lead creator of the DoDSER annual report. This responsibility is fully in line with DSPO's role as "the authoritative source for suicide data in the DOD."[185] At the same time, this new responsibility places additional work

[184] Unpublished information paper on WARN, October 26, 2015.

[185] *2015 DSPO Strategy*.

demands on a small data staff. One possible option to help meet this workload, as well as contribute further to DSPO's analytical base, would be to investigate the opportunity of appointing a T2 representative at DSPO on a rotational basis. This rotation could be a temporary, short-term one, tied to the creation of the annual report. Such an assignment could also ameliorate relations between the two organizations and help develop a better mutual understanding of their respective roles.

2. SDR: Additional Datasets

There are a number of datasets that would be beneficial to add to the SDR. Data on TRICARE hospitalizations related to suicide attempts and from the Deployment Health Assessment would provide additional vantage points which could enhance the robustness of SDR. Another dataset that should be reviewed, if DSPO has not done so already, is the Force Risk Reduction (FR2) oversight management tool, which draws from 13 different databases and is hosted in OUSD(P&R)'s Personnel Risk Reduction office.[186] DSPO should consider adding these datasets to the SDR. In addition, a dedicated effort should be made to standardize categorization methods across the different datasets.

Finally, DSPO and the VA currently pay to access one component of the SDR, the CDC's NDI Plus. However, if DMDC could combine purchase of the NDI Plus with other data purchases from the CDC, this would free up DSPO resources for other purposes.

3. Reporting on Military Personnel Suicides and Suicide Attempts

In addition to establishing greater DoDSER access, DSPO should also request copies of the weekly or monthly updates developed by the Service SPPMs for their respective chains of command. This requirement could be included in the DODI under development. Engaging in this form of data sharing would reduce DSPO's need to make case-by-case requests and ultimately lower the burden on the Services as data providers.[187]

Each Service is pursuing some type of deep dive (also called psychological autopsies) into recent suicide events. IDA recommends that DSPO provide a mechanism for sharing the results of these deep dives, which might take the form of a dedicated SPARRC meeting. IDA further supports DSPO's consideration of requesting observer status at some of the Services' deep dives.

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[186] According to its website, the FR2 oversight management tool "is a DOD enterprise-level, data warehousing and monitoring tool that integrates related information in a central location for a more comprehensive and integrated representation of Total Force wellness. The information in FR2 is used to evaluate trends and assist organizations in identifying areas to reduce risks inherent in daily operations, and minimize unexpected and unintentional negative consequences that harm personnel and erode readiness/operational capacity." https://joint.safety.army.mil/Pages/home.html.

[187] As recommended in DOD stakeholder interview, March 3, 2016.

4. Reporting on Dependent Suicides

An area of data collection that could prove helpful in tracking both military and dependent suicides is tracking hospitalization and results from hospitalization. IDA recommends that DSPO investigate the possibility of merging TRICARE data related to suicide attempts into the SDR. In a TRICARE database such as the MHS Data Repository or the M2, researchers can search for suicide cases by ICD-9 code. This addition would enable researchers to compare suicide attempt rates, as well as suicide rates.

5. The Potential of "Big Data"

DSPO has recognized the need to develop the skills to run complex analyses on data and store data efficiently. The evolution of "big data" could offer ways to understand possible correlations better between deployment, operational (unit) experience, or other factors and suicide risk. Some researchers have already began to utilize machine learning models to analyze patient data; for example, a study sponsored by Army STARRS used machine learning tools to develop a predictive model of suicide risk among hospitalized soldiers.[188] The VA has also utilized predictive analyses to serve better the veteran population.[189] It is currently using predictive models to target individuals who have the greatest need for care, specifically those in the top 0.1 percent of risk.[190] The VA reports that those who fall into the high risk category receive an enhanced level of care, including appointment follow-ups, safety planning, and individualized suicidality-adjusted care plans. Analyses such as these demonstrate that big data tools are an emerging method among researchers for predicting suicide risk in the military community.

However, while machine learning methods can often produce useful insights into the data-generating process of a phenomenon, these methods are often only salient when executed on large amounts of data. Access to sufficiently large data is a necessity for researchers who wish to use these methods. Privacy requirements and administrative constraints often restrict access to PII, the type of data needed to achieve this breadth. Expanding access to these data, which are housed in repositories like the SDR, can inform the military about additional preventative measures and attributing factors that may affect rates of suicidal ideation. The kind of precise prediction that often arises from machine learning can help the Services learn which programs are effective and, thus, tailor their budgets accordingly. This is just the kind of study that DSPO has identified as an area in which it would like to invest efforts.[191]

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[188] RC Kessler, et al., "Predicting Suicides after Psychiatric Hospitalization in US Army Soldiers," *JAMA Psychiatry*, vol. 72, no. 1 (2015).

[189] John F. McCarthy, et al., "Predictive Modeling and Concentration of the Risk of Suicide: Implications for Preventive Interventions in the US Department of Veterans Affairs," *Journal of Public Health*, 105 (9) (2015).

[190] *VA Conducts Nation's Largest Analysis of Veteran Suicide*, July 7, 2016, http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2801.

[191] DSPO interview, September 28, 2015.

One of the methods that the DOD can use to expand access to PII datasets without breaching privacy requirements is to promote access to de-identified data extracts. Encouraging the external research community to use these methods, and expanding access to de-identified data repositories, may help expand the knowledge base in the military suicide prevention community.

IDA recommends that DSPO continue to bolster big data research in the suicide research community, which might include providing contractor support to conduct pilot studies or financial support through its research proposal process.

6. DSPO's Analytical Capabilities

IDA recommends that DSPO continue on its established path of enhancing its data analytical capabilities. Options for doing so include contractor support, creation of a temporary T2 liaison position, or, perhaps, an additional government position. The experience of producing the DoDSER annual report for the first time in 2016 will help to determine how much and which type of additional analytical expertise may be necessary.

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6. Mechanisms to Support Research Needs

The 2010 Task Force report, which led to the creation of DSPO, stated that "focused research in suicide prevention for Service Members is essential to identifying best practices, decreasing variation in prevention practices, and in achieving desired outcomes," recommending that DOD "support and fund ongoing DOD suicide prevention research to enhance our knowledge and inform future suicide prevention efforts, and to incorporate evidenced-based solutions."[192] Additionally, this report tasked DOD with "creat[ing] 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."[193] Once DSPO was stood up, it took on these tasks as part of its mission.

It is, of course, important to put DSPO's activities into the context of the broader community's efforts. Indeed, the suicide prevention community includes a host of organizations involved to varying degrees in conducting and supporting research, as well as numerous efforts to characterize the research conducted. The responsibilities and activities of these organizations are not always clearly delineated, nor are the efforts to characterize research always unified or transparent. It is essential to understand the nature and scope of research organizations and their activities to identify gaps in practice and opportunities to leverage capabilities. Details about these other efforts are captured in Appendixes F through I.[194]

This chapter outlines some of the mechanisms that DSPO has developed to help survey, catalog, and coordinate suicide prevention research activities and offers IDA's findings and recommendations for improvement.

A. DSPO's Mechanisms to Support Research

1. Hosting a Summit

In November 2015, DSPO convened a meeting titled "Research Summit: Identifying Gaps in Practice."[195] The research summit had the mission of "support[ing] a collaboration of research

[192] DOD Task Force, *The Challenge and the Promise*, 49.

[193] Ibid., 106.

[194] Appendix F describes many of these organizations, while Appendix G identifies cross-cutting efforts such as working groups, steering committees, and advisory boards that include a focus on such research. Appendix H lists the work of other organizations to survey and coordinate suicide prevention research. Finally, Appendix I provides information about the five main taxonomies IDA has identified for the characterization of this research.

[195] DSPO, *Research Summit: Identifying Gaps in Practice*, Research Summit Outline.

and clinical stakeholders to help DSPO identify the gaps in our understanding and practices for suicide prevention across the DoD."[196] Objectives of the research summit included introducing DSPO research tools designed to help support DOD suicide prevention research and effectively translate that research into practice.

At the summit, DSPO presented its DSPRAT, DRAP, and Translation and Implementation of Evaluation and Research Studies (TIERS) process; each of these is described in the following sections. In addition, several suicide prevention researchers from academia presented their research.[197] Participants representing DOD and non-DOD research organizations provided their input on research topics that are not being sufficiently addressed. Following the summit, DSPO created an AAR describing the research priorities identified and the steps it would take to address them.[198] Topics identified as needing more research included: informal sources of help (non-clinician gatekeepers), firearm safety, elements of successful suicide prevention programs, and more comprehensive trainings and/or programs.[199] Per the summit AAR, the research questions and themes developed during the summit would be further refined and incorporated into the DRAP.[200] Additionally, DSPO identified the topic for another summit: piloting the TIERS process.[201]

An important gap in practice identified at the summit is means safety in DOD, although it should be noted that this is by no means a new priority; this topic was identified in the DOD Task Force as one of its nine principal goals.[202] Following the summit, DSPO stood up the Defense Means Safety Task Force to address this topic.[203] The group is led by the Director of DSPO and includes members from academia, the CDC, J1, MOMRP, SAMHSA, NIMH, SPRC, and the VA.[204] The task force has experienced considerable success in translation since its inception. In its first six months of existence, data and research were examined to scope the problem, the context of the problem was assessed, recommendations were developed, and a plan for implementation was established. Currently, DSPO and the Defense Means Safety Task Force are working to implement pilot studies resulting from the recommendations put forth by the task force.

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196 Ibid.

197 Ibid.

198 DSPO, *Outcomes of Research Summit; Identifying Gaps in Practice*, as provided by Dr. Adam Walsh.

199 DSPO, *After Action Report (AAR), Research Summit: Identifying Gaps in Practice*, 1.

200 Ibid., 1-2.

201 Ibid., 2.

202 DOD Task Force report, *The Challenge and the Promise*.

203 "*Outcomes of Research Summit: Identifying Gaps in Practice*.

204 Ibid.

2. Defense Suicide Prevention Research Analysis Tool

As described at DSPO's 2015 research summit, the DSPO-developed DSPRAT is a "relational database that incorporates both published research directly and indirectly related to suicide prevention and DoD-funded suicide prevention research."[205] The DSPRAT is a tool for the DOD suicide prevention community to search for specific studies, obtain full text articles, support literature reviews, and promote the use of evidence-based interventions.[206] The DSPRAT is also a tool for DSPO's internal use to track research costs, analyze research gaps, and support the translation of research into practice.[207] As of November 2015, it had uploaded approximately 4,700 published studies on suicide prevention and resiliency from 2011 to the present.[208]

3. Defense Research Action Plan for Suicide Prevention

As explained at the research summit, the DRAP is planned to be an annual report produced by DSPO that outlines the "strategic, scientific, and practice gaps in suicide prevention across the DoD."[209] The 2016 DRAP will be the first produced. The DRAP will include:

- "A State of Science review that covers the range of military, veterans, civilians, and international research to inform our greater understanding of suicide.
- Specific recommendations for research proposals, both within DSPO and with other funding agencies.
- Specific recommendations for translating high quality research into suicide prevention policy, program, and/or practices in the DoD."[210]

4. Translation and Implementation of Evaluation and Research Studies

TIERS is a tool developed in response the 2010 DOD Task Force Report recommendation to create a comprehensive research strategy for military suicide prevention.[211] DSPO, the Military Suicide Research Consortium (MSRC), and RAND Corporation worked together to create a TIERS framework as a companion product to the research strategy. TIERS is intended to be used to "convert knowledge accrued from evaluation and research studies into clinical and non-clinical practice that benefits leaders and support personnel."[212]

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[205] DSPO, *Research Summit: Identifying Gaps in Practice*, Research Summit Outline.

[206] Ibid.

[207] Ibid.

[208] Ibid.

[209] Ibid.

[210] Ibid.

[211] DOD Task Force, *The Challenge and the Promise*, 106.

[212] DSPO, *Annual Report for FY 2012* (Washington, D.C.: DOD, March 2013), 23.

DSPO has since decided to move away from the use of TIERS;[213] however, as described at the 2015 research summit, TIERS is a standardized methodology for:

- Identifying promising practices in research
- Rating the quality of evidence behind those practices
- Determining context and relevancy for military practice
- Identifying the implementation platforms best suited to the practice (e.g., pilot study, training program, policy recommendation, communication)
- Disseminating and supporting those practices (e.g., workshops, web-based community forums, operation guides)
- Evaluating continually the practice to ensure effectiveness and relevance[214]

5. The Suicide Data Repository

An important contribution to the research community, developed jointly by DSPO and the VA, is the SDR. Its content and purpose are described in section A3 of Chapter 5. Notably, SDR offers the most comprehensive dataset available to researchers in suicide prevention. Its Board of Governors reviews requests to use the SDR, generally on a quarterly basis. Each project must have a DOD or VA official as the Principal Investigator, although other members of the research team can come from elsewhere including academia.

6. Providing Financial Support to Research

Also in 2015, DSPO issued a call for research proposals to be funded using some of the funds provided by the Congressional add to its budget. This process was described in section G of Chapter 3. The following pilot studies were selected and, as of the writing of this report, are in the process of being funded:

- Air Force:
  - Baseline of problem solving skills
  - Zero Suicide framework implementation
  - Integrated marketing campaign
- Air National Guard:
  - Zero Suicide initiative implementation
- Marine Corps:

[213] DSPO's more recent efforts to translate research into practice are described in section B3 of this chapter.

[214] DSPO, *Research Summit: Identifying Gaps in Practice*, Research Summit Outline.

  - Internal evaluation of the Marine Intercept Program
  - Expansion of community counseling programs
  - Effectiveness of MIP
- Navy:
  - Columbia Suicide Severity Scale for gatekeepers and trainers
  - Suicide-related behaviors
  - 21st Century integrated social media campaign
- Uniformed Services University of the Health Sciences (USUHS):
  - Efficacy of cognitive behavioral strategies—a randomized controlled trial (RCT) of the Chaplains CARE program[215]

This call for proposals process was well received by the Services, although concerns were voiced regarding the ability of DSPO to provide the money to the Services quickly enough since the funds were O&M and had to be obligated before the end of the fiscal year.

Beyond the Service pilot studies, DSPO is involved in conducting and/or facilitating additional research. For example, one study evaluates the efficacy of training non-clinical individuals in the Marine Corps on the Columbia Suicide Severity Scale.[216] DSPO is also facilitating three DHRA-funded studies on gun safety/gun locks, universal problem solving training, evaluation of gatekeeper training, and the practice of ACE/ACT/RACE and its effects on suicide rates.[217] Research study proposals on the evaluation of a gun violence restraining order policy in California and an exploration of the specific needs for the lesbian, gay, bisexual, and transgender (LGBT) community regarding suicide prevention have also been accepted by DSPO.[218] And, in partnership with AAS and the University of Utah National Center for Veterans Studies, DSPO is developing and implementing webinar trainings for mental healthcare providers and Service members and families.[219]

[215] DSPO, Suicide Prevention General Officer Steering Committee (SPGOSC) meeting slides, April 11, 2016, 8.

[216] DSPO interview, January 8, 2016.

[217] Note: ACE: Ask, Care, Escort; ACT: Ask, Care, Treat; RACE: Recognize Distress, Ask, Care, and Escort. DSPO interview, January 8, 2016.

[218] *Outcomes of Research Summit: Identifying Gaps in Practice*.

[219] U.S. Military Matters, http://usmilitarymatters.org/.

B. Findings and Observations

1. Enhancing DSPO's Tools for Research

DSPO has made important progress in the development of tools such as DSPRAT and DRAP, which contribute to DSPO's research responsibilities. Through initiatives such as the Research Summit, the office has sought to increase the community's awareness of these tools. For example, better knowledge of and access to DSPRAT can help address the DOD's community's desire for DSPO to play a clearinghouse role in disseminating information about relevant research.

In the course of its interviews, IDA found that many DOD stakeholders were not familiar with the SDR, either its content or the process by which research studies using SDR are submitted for consideration to the SDR Board of Governors. Both VA and DSPO leadership recognize the need to develop a strategic plan for SDR to enhance its utility; furthermore, SDR offers important opportunities for collaborating with VA in addressing transition issues in addition to affording researchers centralized access to data from diverse sources.[220] One option might be to issue a request for proposals (RFP) in areas of particular interest to the DOD and VA, such as how military and veteran populations compare to similar populations such as police and fire fighters.[221] More generally, neither the SDR Fact Sheet nor the SDR Board of Governors Charter explicitly stipulates the need for researchers to report back on their findings.

2. Facilitating and Funding Research

Currently, DSPO facilitates numerous research projects, provides subject matter expertise on studies, and funds research through a newly established proposal process. DSPO's stakeholders see these roles as appropriate and adding value to the suicide prevention research community.

Overall, stakeholders were pleased with DSPO's use of its Congressional add funding in FY16 to support research proposals from the Services, as described above. However, a few stakeholders advocated for DSPO to be more strategic in the proposal process. One individual thought that DSPO should have requested proposals to fit predetermined prioritized areas, while another called for the involvement of the Services and research stakeholders in a DOD-wide capabilities gap assessment, following which DSPO would solicit research proposals to fill the gaps identified.[222] They thought that taking these steps would better direct research proposals submitted and allow for better communication between submitters, avoiding duplication of effort.[223] However, other stakeholders valued that they were free to submit research proposals

[220] Non-DOD stakeholder interview, January 27, 2016.

[221] Ibid. and DOD stakeholder interview, February 22, 2016.

[222] DOD stakeholder interviews, December 10, 2015, and March 3, 2016.

[223] DOD stakeholder interview, March 3, 2016.

designed to fill gaps they noticed and thought that DSPO receiving the perspective of those "out in the field" was crucial. Wherever DSPO falls on these two differing opinions, it is clear that open communication and collaboration with stakeholders is critical to an effective and successful proposal solicitation, review, and award process.

3. Focusing Research Proposals and Projects on Translation to Practice

DSPO and its stakeholders recognize the importance of research geared toward translation; the ability of research conducted to be translated into practice. Currently, DSPO is involved in several practices to ensure research identified, disseminated, funded, or otherwise facilitated is focused on translation. DSPO has met with a team from MSRC focused on the dissemination and implementation of research (a project called CORE D). DSPO plans to conduct weekly meetings with this MSRC team to coordinate and execute the translation of suicide prevention research into Service-level suicide prevention programs. Additionally, DSPO recently became a member of the Army STARRS translation working group. This group meets once a month to determine if findings from Army STARRS can be applied and implemented across the Services.

4. The Absence of a Unified System for Surveying, Cataloguing, and Coordinating Research

Currently, there exists no document outlining the range of professionals in the suicide prevention research arena and their responsibilities. Similarly, while numerous working groups, advisory bodies, and steering committees in the suicide prevention arena exist, there is no single group with representation from all of the organizations. Additionally, there seems to be some potentially duplicative efforts to survey and catalogue research. Notably, the DSPO DSPRAT and the NIMH PFC have the potential to be duplicative in the areas of DOD-related suicide prevention research. With greater awareness among current DSPO staff about this possible overlap, the two organizations are now working together to merge information from the DSPRAT into the NIMH PFC to ensure that the NIMH PFC captures all DOD-related suicide prevention research.

5. Taxonomies for Characterizing Research

Five taxonomies for the characterization of suicide prevention research were identified by the IDA research team. Described more fully in Appendix I, the five taxonomies are the:

- NAASP RPTF six guiding questions and 12 aspirational goals;
- DSSP four strategic directions and 13 goals;
- NAASP suicide prevention research categories described in a RAND report;[224]

[224] Rajeev Ramchand, et al., *Developing a Research Strategy for Suicide Prevention in the Department of Defense* (Santa Monica, CA: RAND, 2014).

- MOMRP suicide prevention research categories described in the above RAND report;[225] and
- Veterans Integrated Service Network (VISN) 2: Center of Excellence for Suicide Prevention Five Research Goals and Priorities.

The fact that there is no single taxonomy that all research organizations in the suicide prevention arena follow can impede improved unification efforts. While numerous organizations have adopted the NAASP RPTF six guiding questions to prioritize their research, the use of these questions is not consistent across the field. Some organizations, including DSPO, have used stakeholders and subject matter experts' elicitation to identify priority areas for and characterization of research.

C. Recommendations

1. Enhancing DSPO's Tools for Research: SDR as an Example

The SDR offers a useful vehicle for research in general and for DOD-VA collaboration on important transition issues, but its utility has yet to be exploited to the fullest extent. To do so, IDA supports the initiative by DSPO and VA SDR leaders to develop a strategic plan. Part of this plan could include raising awareness about SDR, requiring closer connections to topics of interest to these two organizations, and investigating possible additional data repositories.

To heighten awareness about SDR among suicide prevention researchers and others in the suicide prevention community, DSPO should work with the VA to publicize its existence and capabilities through a variety of means, including poster displays, as part of presentations at conferences, and on their websites. The SDR's Board of Governors can potentially help guide awareness efforts and disseminate research conducted using the SDR.

Because the SDR Board of Governors Charter does not require researchers to report their findings when they use SDR data, the results and value of this research is often unknown. To rectify this shortcoming, IDA recommends that all studies that use the SDR in their research should be required to report their findings and potential implications, specifically as they relate to the military and veteran populations. DSPO might also consider issuing guidance for research priorities using the SDR. As one example, future research could compare suicide events in the military community to those in similar communities, such as among firefighters and police. At the same time, IDA does not recommend that all proposals for using SDR would be required to meet this guidance. Researchers may also identify topics that have not previously been considered but could yield important results, helping to shape future DOD and VA suicide programs.

[225] Ibid.

2. Facilitating and Funding Research

IDA recommends that DSPO continue to facilitate and fund research through partnerships with the Services, stakeholders, and a formal proposal review process using Congressional adds to DSPO's budget. In this way, DSPO collaborates with stakeholders, coordinates research efforts, and funds rigorous studies well aligned with research priorities and goals.

IDA recommends that DSPO discuss the two opinions of stakeholders regarding the proposal solicitation and award process presented in Chapter 3 to understand better stakeholder desires and needs. Regardless of DSPO's decision, it can use the proposal solicitation and review process to collaborate with and maintain open lines of communication between the Services and other stakeholders.

3. Focusing Research Proposals and Projects on Translation to Practice

DSPO recognizes the need for research to be focused on translation to practice and has acted on this by participating in two key working groups: the MSRC CORE D project and the Army STARRS translation working group. IDA recommends that DSPO continue to participate in these groups and others that may already exist or will be stood up in the future.

Additionally, IDA recommends that DSPO take one of two steps to ensure that the research it identifies, disseminates, funds, or otherwise facilitates is focused on translation into practice. First, DSPO could hire a contractor with expertise in the area of translation to assist DSPO and its stakeholders in translating existing research into practice and ensuring that forthcoming research proposals and projects are geared toward translation. Second, DSPO could highlight the importance of translation in its research proposal solicitation and award process, specifically requiring that all research studies proposed must include a plan for translation, similar to the requirement for proposals to include a program evaluation component.

4. Actions Needed to Establish a Unified System for Surveying, Cataloguing, and Coordinating Research

a. A Document to Describe Research Professionals and Roles

The IDA research team recommends the creation of a document which outlines all professionals in the suicide prevention research field and discusses their roles and responsibilities; this would be an important step toward greater clarity and transparency. IDA recommends that DSPO develop such a document in collaboration with stakeholders to ensure its comprehensiveness. Appendixes F, G, and H, which outline organizations in the suicide prevention arena; cross-cutting efforts in suicide prevention research; and actions taken to survey, catalogue, or coordinate research, may provide a starting point for this document. DSPO should also consider maintaining an updatable version of this document on its website.

b. Suicide Prevention Research Community of Interest[226]

While numerous working groups, advisory bodies, and steering committees in the suicide prevention arena exist, there is no forum for collaboration among the memberships from all of these organizations. A suicide prevention research COI would contribute to greater clarity and transparency in the suicide prevention research community. The COI would promote information sharing, avoid duplication of effort in research, and inspire collaboration and networking between research organizations. IDA recommends that DSPO discuss with other stakeholders the idea of forming this COI, perhaps after developing and disseminating the aforementioned document describing research professionals and their roles which would set the stage to determine the utility of such a group.

c. DSPRAT and PFC Collaboration

To encourage transparency and aid in the development of a comprehensive portfolio analysis tool in the suicide prevention field, DSPO should continue its efforts to provide all DSPRAT inputs to NIMH for inclusion in NIMH's PFC. However, DSPO should still continue to develop the DSPRAT independently as it differs from the PFC and offers value-added benefits to the DOD community. In the future, new efforts to survey and catalogue research should be discussed with stakeholders to ensure awareness of the effort and avoid duplication.

5. RAND Recommendations

RAND's 2014 report on developing a DOD research strategy for suicide prevention offers several recommendations: areas in which DOD should prioritize research funding, processes that DOD should adopt or enhance to allocate more efficiently research funding, and processes that DOD should adopt or enhance to ensure that evidence-supported suicide prevention strategies are integrated into current operations.[227] This report was developed for DSPO as part of the effort to address the Task Force Report requirement for a comprehensive suicide prevention research strategy. IDA suggests that DSPO review these recommendations, outlined in Table 7, and identify which are currently being followed and which may necessitate further work.

[226] A Community of Interest is a group of people who share a common interest or passion.

[227] Ramchand, et al., *Developing a Research Strategy for Suicide Prevention in the Department of Defense*, xvi-xvii.

Table 7. RAND Report Recommendations[228]

Category	Recommendations
Overarching Recommendation	1. Leadership is needed to provide strategic guidance for implementing a unified research strategy.
Areas in which DoD should prioritize research funding	2. Eliciting the opinions of relevant stakeholders can inform the development of DoD's research priorities. 3. Research investment is needed to prioritize strategies with low benefit-cost values; policy changes are needed to make already high benefit-cost strategies more culturally acceptable. 4. Funding agencies in DoD should make a proactive effort to fund effectiveness research, in which interventions that prior research (funded by DoD or another entity) has deemed efficacious are evaluated for their effectiveness in the military context.
Processes that DoD should adopt or enhance to more efficiently allocate research funding	5. DoD should have a central repository to identify and track the research it is funding on suicide prevention. 6. The designated leadership agency in DoD (per recommendation 1) should continually reevaluate its research priorities in light of new research findings, new policies, and the adoption of new suicide prevention strategies.
Processes that DoD should adopt or enhance to ensure that evidence-supported suicide prevention strategies are integrated into current operations	7. DoD should encourage both formal and informal collaboration across the DoD entities responsible for funding and implementing suicide prevention programs and strategies. 8. Agencies that fund suicide prevention research and those responsible for implementing suicide prevention programs should keep abreast of new research, bearing of mind the quality of different studies. Efficiencies may be gained by creating a centralized clearinghouse for this purpose, perhaps capitalizing on existing sources. 9. Agencies and organizations within DoD should be encouraged to adopt evidence-based technologies. Such encouragement may include funding, materials, and technical assistance. 10. Both leadership buy-in and peer engagement are key in promoting new technologies.

[228] Ibid., xvii.

6. Taxonomies for Characterizing Research

There is no single taxonomy to characterize suicide prevention research that all organizations in the suicide prevention arena follow. In order to enhance clarity and transparency across the research community, IDA recommends that DSPO publish a document for DOD outlining all the potential taxonomies for the characterization of suicide prevention research. This will raise awareness of different or lesser known taxonomies for consideration and/or adoption by research organizations.

It is not clear if it would be beneficial for research organizations to use the same taxonomy to characterize research. While this would ensure consistency in the setting of the research agenda and promote understanding of research across the community, it could also lead to redundancies and contribute to a narrow research focus. If research organizations are aware of all potential taxonomies but use different ones, the same understanding is achieved but a broader research agenda is possible.

At this time, IDA does not recommend that only one taxonomy for characterizing suicide prevention research be used across the research community, nor does it recommend one taxonomy over another. Rather, it has identified five potential taxonomies for the characterization of research and recommends that DSPO publish these taxonomies (and any others identified by DSPO or other stakeholders) in a document and on its website, discuss the taxonomies with stakeholders across the community, and promote the sharing of information regarding research goals and priorities based on these taxonomies across the research community.

Part Three

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7. Organizational Overview

This chapter, representing part three of this report, examines the staffing and structure of DSPO, noting the important changes that have occurred in both these areas since early 2015. It also considers DSPO's placement within the OUSD(P&R) organization. An understanding of these organizational issues is vital to addressing whether the office's authorities and institutional relationships are well-aligned with its mission.

A. DSPO's Organizational Structure, Staff, and Skill Sets

As depicted in Figure 3, DSPO's staff is aligned with the office's primary functional areas: policy, data, program evaluation, research support, and outreach. The fifth element of the organization, current operations, covers functions associated with running the office, including resource management. Of note, the DSPO website now posts the names and a short biography of the current personnel assigned to lead each topic.[229] This change can help DOD and non-DOD stakeholders know the appropriate contact for a given issue; thereby, streamlining suicide prevention community interactions. It ultimately enhances transparency, clarifies roles and responsibilities, and promotes accessibility and responsiveness.

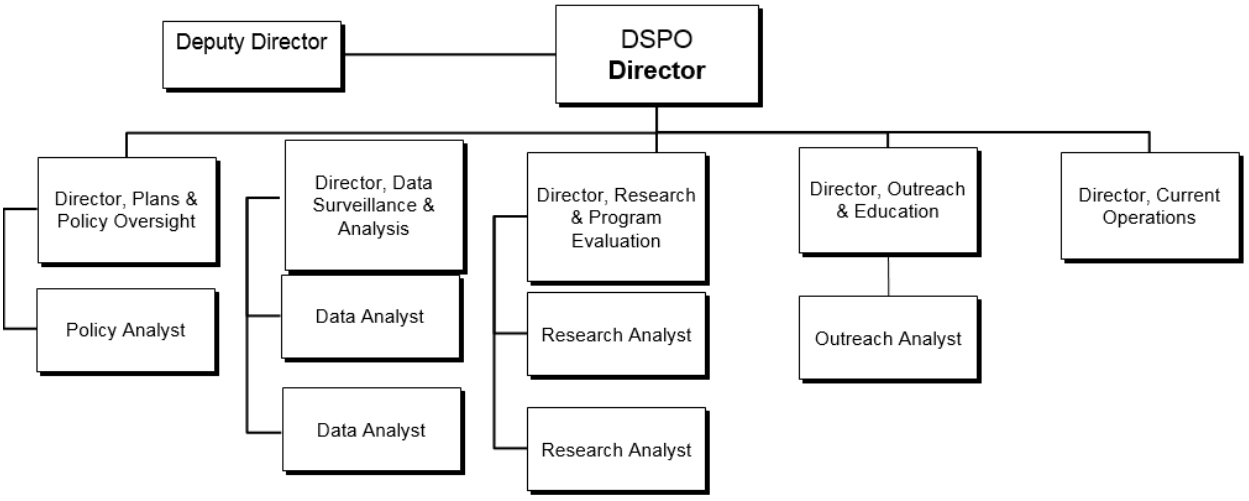

Figure 3. DSPO Organizational Chart

When DSPO was initially stood up, the composition of the staff was arbitrary in nature, with little regard for the necessary skill sets and seemingly not driven by a considered office strategy. Members of the staff were drawn from other OSD offices who were available to move to the new office. In many cases, those who were available did not have expertise in suicide

[229] http://www.dspo.mil/About-DSPO/Leadership/. Note: Currently, only some personnel listed have biographies. The addition of biographies for all personnel listed would be beneficial.

prevention, social science backgrounds, or other necessary skills. In a similar vein, the size of DSPO's staff was established at 10 authorized government personnel but this number was not determined on the basis of a strategic plan of what the office needed to accomplish. DSPO's experience is not unique in OSD. Typically the stand-up of a new OSD office can be characterized as a "pick-up" game to secure available people and billets to get the office running. Given OSD staff ceilings, new offices often need to use existing billets and volunteers from other offices whose portfolios and expertise do not always match what is required. Further, in DSPO's case, the office was placed into a Defense Field Activity administratively controlled by DHRA. DSPO's placement in DHRA means that they are funded out of the DHRA budget and DHRA has final say on DSPO's budget, how that money is spent, how procurement contracts are processed, as well as what can potentially be cut from DSPO's budget in order to meet other DHRA needs.

A result of the ad hoc manner in which new OSD offices are created is that they often are challenged in gaining the traction needed to be effective. This was certainly true for DSPO, which initially had a difficult time building the necessary credibility, trust, and rapport with key Service stakeholders. It took time for DSPO to develop constructive working relationships with the Services, especially given the emotional nature of the subject, the fact that the Services had established programs long before DSPO was created, and the high levels of attention on this topic by the Service Chiefs, Congress, and others. The infusion of openness, transparency, and collaboration during the second phase of DSPO's operations has greatly helped to improve those relationships.

The current DSPO leadership has worked diligently to attract new personnel who bring needed subject matter expertise, as well as to retain those who understand how DOD functions and how to operate effectively within it. DSPO leadership has also succeeded in increasing its authorized ceiling to 13 government personnel plus contractor support, no small feat when OSD offices generally are facing 20 percent cuts in staff billets.[230] Finally, in 2015-16, DSPO was able to bring in several military personnel on a rotational basis (which did not count against DSPO's ceiling).

1. Findings and Observations

By their very nature, OSD offices require interactions and collaboration with the Military Departments as well as with other parts of OSD and, often, other government agencies. As such, the effectiveness of the organization depends on its leadership's commitment to setting the correct tone to ensure sound working relationships. IDA finds that the current DSPO leadership has placed top priority on developing a more collaborative relationship with stakeholders inside and outside DOD. Throughout IDA's interviews, stakeholders consistently identified this

[230] The authorized level may in fact be 15 (rather than 13) due to personnel who are no longer in DSPO, but their billets may still remain.

approach as an important change in DSPO's interactions with them. Equally important, DSPO's success in hiring several new experts with behavioral health and research backgrounds has appreciably raised the staff's credibility among the suicide prevention community.

IDA's study did not involve a position-by-position staff assessment but, rather, examined staffing and structure from the perspective of the office's ability to fulfill its mission. Recent hires in the past year to lead the data, research and program evaluation, and outreach sections of the office all bring notable experience to their positions. Having personnel with the appropriate skill sets puts DSPO in a much better position to execute its roles and responsibilities.

In considering overall staff size for the future, DSPO should take into consideration several factors:

- Are there sufficient personnel to accomplish what DSPO has outlined as its missions and responsibilities?
- If there are gaps, which of them require permanent additional staff, which might be addressed using contractor support whose use can be altered as needs change, and which might be filled using rotational assignments?
- How might an increase in DSPO staff affect the Services? Would more DSPO staff generate more demands for information and work from the latter or, on the contrary, would more DSPO staff effectively relieve some of the burden on the Services' much smaller suicide prevention staffs?
- Is the requirement for additional staff strong enough to counteract the overall trend within OSD to reduce staffs by some 20 percent?

Despite notable improvements in DSPO's structure and staffing, IDA identifies several organizational modifications that could further improve DSPO's functioning. For example, there has not been a consistent military presence on the DSPO staff, but DSPO's work would benefit from the perspective that those in uniform could offer. In interviews with DSPO staff, IDA learned that DSPO had lost two military billets previously filled by a Marine behavioral health expert and a Navy chaplain, but that it is exploring opportunities for one or two of the existing unfilled military billets within P&R to be moved over to DSPO.[231]

Another skill set (area of expertise) that would help DSPO is a better understanding of the Reserve Component (i.e., both Reserves and the National Guard). There are a number of areas in which the Active Duty differs from the Reserves; having someone on the staff who understands these differences and could focus on how to address them within the suicide prevention context would be useful. Among the most notable differences:

[231] DSPO interview, March 25, 2016.

- Many members of the Reserve Component do not live near a military base, are geographically dispersed, are often located in more remote locations, and may train far from where they live.[232]
- There is often no contact among members of a unit between monthly drills.
- Medical insurance, including access to mental healthcare, is not provided automatically to Reserve Component members as it is to Active Duty personnel. Indeed, some members of the Reserve Component have no health insurance and, therefore, are less likely or able to seek help. Reserve members are generally eligible for access to free mental healthcare only when they are activated for more than 30 days. Inactive Reserve personnel may be able to obtain referrals to non-DOD community resources or purchase coverage through TRICARE Reserve Select.[233]
- There are, of course, even differences within the Reserve Component which would need to be taken into account. For example, the Air National Guard has a designated point of contact (POC) for suicide prevention within each wing covering an average of 1,100 personnel. This arrangement offers more opportunities for in-person interactions as compared to the Army National Guard whose designated POC covers 3,000 – 4,000 personnel and may deploy, thereby leaving the non-deploying troops without a POC.[234]

Should a Reserve Component position be established in DSPO, it should have responsibility for interacting with the rest of the DSPO staff across its functional areas – policy, research, data, and outreach – as they all have issues specific to the Reserves. The essential remit for this person would be to look across all the Services and National Guard, serve as an advocate for the Reserve perspective and Reserve-related issues, and identify gaps and/or differences specifically related to the Reserve Component and work to identify evidence-based programs to fill those gaps. One source of information on issues affecting the National Guard is the Service Members, Veterans, and their Families Technical Assistance Center, which SAMHSA created about five years ago. A process for such collaboration would need to be established.[235]

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[232] See, for example, *Armed Forces Press Service*, "Guard Enlisted Leader Stresses Help Available," http://archive.defense.gov/news/newsarticle.aspx?id=117985.

[233] U.S. Government Accountability Office (GAO), *Defense Health Care: DOD is Meeting Most Mental Health Care Access Standards, But It Needs a Standard for Follow-up Appointments* (Washington, D.C.: GAO, April 2016).

[234] Of note, in January 2014, only 9 of the 89 air wings had the required suicide prevention program manager; but, before the end of the year, that number had been raised to 88. DOD stakeholder interview, December 2, 2015.

[235] This program provides policy academies that representatives from the states and territories, who are approved by the governor, attend. There can be up to ten team members, and must include the state mental health and substance use official, the National Guard's Adjutant General, and the state's Veterans' Affairs point of contact. The purpose of the team is to create and implement a strategic plan to improve mental health services. SAMHSA

Among the challenges, or gaps, which stakeholders identified is the fact that current law does not allow the Directors of Psychological Health (DPH) to provide psychological health services unless the member is under Title 10.[236] An additional function in this portfolio could be the creation of a Reserve Component COI, which could help not only in identifying gaps but also in sharing best practices on topics such as data surveillance, strategic messaging, and ways to adapt suicide prevention training to meet better the Reserve Components' needs. Numbering among the latter is the Wingman Toolkit, which the Air Force developed for the Reserves and has since been embraced by its Active Duty component as well.

A third focus area, particularly in light of its high profile, is DSPO's relations with Congress. While DSPO has a process in place for handling Congressional and other inquiries, having that responsibility clearly designated in its organizational chart and on its website, with a point of contact listed, would be helpful. Currently, the entry point is through the Director of Current Operations, who then reaches out to the appropriate staff, depending on the substance of the inquiry. IDA does not find that it is necessary to change the POC, but rather only to make better known who executes this function.

There are other areas of expertise that would more naturally lend themselves to reliance on contractor support or other personnel performing temporary additional duties. As an example of the former, in the areas of both outreach and research, DSPO could benefit from being able to access those well-versed in the use of social media and how to maximize the appeal and impact of DSPO's efforts.

As an example of a temporary additional duty (likely drawn from DSPO and other appropriately skilled government personnel), DSPO could assess the development of a DOD-level postvention capability similar to what P&R's Family Advocacy Program has done in the creation of FACATs.[237] Such an activity is fully in line with DSPO's mission. The DSSP highlights postvention as one of its goals, and DSPO's roles and responsibilities specific to postvention are articulated in the DODD 6490.10.[238]

None of these suggestions alone would translate into an appreciable increase in the size of DSPO's staff, although, taken together, they could result in the requirement for another two-to-three staff. Indeed, within the current structure, the responsibilities for research and program evaluation appear to be significantly greater than what only two personnel can comfortably accomplish. In particular, DSPO's recent initiatives to undertake a more substantial and

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has worked with 47 states, two territories, and Washington, D.C. Non-DOD stakeholder interview, February 5, 2016.

[236] DOD stakeholder interview, December 9, 2015. The National Guard Psychological Health Program provides mental health support through the Directors of Psychological Health in each state and territory.

[237] FACAT team members are multidisciplinary and specially trained and experienced to respond to incidents involving multiple victims of child sexual abuse. Policy guidance for them is spelled out in DODI 6400.01, *Family Advocacy Program (FAP)*, February 13, 2015, 11.

[238] DSSP Goal 10 addresses postvention. DODD 6490.14 describes DSPO postvention roles and responsibilities.

sustained program evaluation role, as described in Chapter 4, represent an important and well-founded shift in the office's responsibilities in this area and would benefit from additional staff support. Another consideration, as described in Chapter 5, is the additional requirements imposed now that DSPO will be producing the annual DoDSER report. Thus, sound arguments can be made for a modest increase in DSPO's staff; the underlying challenge that must be taken into consideration is whether this is possible in the context of OSD staff downsizing plans.

2. Recommendations

Since the inception of this study, DSPO has already made a number of improvements to its staff composition and structure. It has also increased transparency by taking actions such as posting information on its website about its organizational structure and lead points of contact for specific areas of activity.

To further enhance DSPO's effectiveness, IDA recommends that DSPO continue to investigate the assignment of existing unfilled military billets within OUSD(P&R) to DSPO. Especially those with relevant skill sets, such as chaplains or public affairs officers, could present the opportunity to make particularly useful contributions to the office. IDA further recommends that DSPO investigate ways to add a staff member with Reserve Component expertise. Options could include a permanent position, use of a military billet, or rotations from the field.

Current levels of responsibility, as described in Chapters 4 and 6 on program evaluation and research, make a strong case for adding another staff member or, at least, contractor support to the research and program evaluation line of effort. DSPO is making notable progress in developing a program evaluation methodology, which had been distinctly lacking in previous years. This is an important and time-consuming effort that should have a full-time person dedicated to its execution. Depending on DSPO's progress in preparing the annual DoDSER in CY2016, consideration could be given to assigning another staff member to the data surveillance portfolio as well.

IDA recommends that DSPO consider re-naming Current Operations as Current Operations and Legislative Liaison. Given that this is also the one Director position that lacks an additional staff member to support these functions and given the importance of responsiveness to external inquiries and the current leadership's commitment to enhancing the relationship with Congress, additional support, either through another staff member or contractor support, is warranted.

Finally, IDA recommends that DSPO consider the potential value of establishing a postvention response team, drawing on FAP's FACAT model. Such a postvention team could consist of a roster of certified experts, drawn from DOD, other government agencies, and the non-government world, who would be available for surge deployment on travel orders to an installation in need. Such as effort would require identification of potential team members, updating this roster as necessary, and setting aside some travel funds should the need arise. This team could assist leadership with strategic communications, advise on memorial service policy,

and provide surge counseling capacity to the community. DSPO could explore this capability on a pilot basis.

B. DSPO's Placement within Personnel & Readiness

In the short time since its creation, DSPO has always been aligned administratively under DHRA. But, it has been subjected to several different reporting structures, each of which has generated a certain level of disruption since such changes often contribute to a lack of continuity in leadership philosophy and approach. During the research and writing of this report, DSPO continued to report administratively to DHRA while reporting operationally to the OEDFR during its brief tenure. While originally tasked with responsibility for the topic of resiliency, neither the size nor expertise of DSPO's staff was sufficient to address adequately this mandate. Moreover, resiliency encompasses a much broader portfolio than suicide prevention alone. OEDFR assumed responsibility for resiliency, logically placing it into the larger context of the Total Force construct.[239] In late 2016, OEDFR was eliminated and DSPO began reporting to the ASD for Readiness within P&R.

1. Findings and Observations

The success of any office depends on sufficient leadership support and continuity to put policies and practices into place. To continue with the notable progress DSPO has been making in its areas of responsibility, it would benefit from a stable reporting structure. The 2016 realignment creates the need, again, for time to solidify relationships within the new reporting structure, which did not have the opportunity to mature under OEDFR. Regardless of its reporting structure, DSPO's positive evolution is assisted by the fact that DSPO now has a strategy in place and corresponding organizational structure to execute that strategy.[240]

The creation of OEDFR brought under one umbrella a number of offices focused on different aspects of the Total Force, including responsibility for the resiliency mandate.[241] This structure had the potential to provide opportunities for collaboration and leveraging best practices among offices charged with personnel wellness initiatives, some of which had begun to be manifested. One initiative has been the expansion of the Prevention Collaboration Forum among several of the OSD offices. To date, it has focused on the topics of culture, training, awareness, and leadership influence and it is working to share best practices and identify

[239] The mission of the OEDFR, according to the P&R website in mid-2016 "is to strengthen and promote the resiliency of activities in the areas of diversity management and equal opportunity, personnel risk reduction, suicide prevention, sexual assault prevention and response, and collaborative efforts with the Department of Veterans' Affairs." *Force Resiliency Mission*, http://prhome.defense.gov/ForceResiliency.Mission.aspx; this link is no longer active.

[240] As described and cited in Chapter 2, *2015 DSPO Strategy*.

[241] These offices included: Office of Diversity Management and Equal Opportunity, Personnel Risk Reduction, Sexual Assault Prevention and Response Office, Operation Live Well, and DOD-VA Collaboration.

opportunities for collaboration across these offices. For example, the forum has explored ways to combine some training requirements and surveys administered to personnel. It has also identified the value of collaborating on risk reduction by addressing a range of risk factors including financial, alcohol, and relationship issues.[242] As of the writing of this report, participation in the forum has been limited to OSD representatives, but there is the expectation that it will be expanded to include the Services as well.[243] Senior leadership commitment within P&R will be necessary to ensure momentum and the ability of the forum to address more complex collaborative opportunities.

IDA finds that there are opportunities for enhanced collaboration and communication across the offices that had fallen under OEDFR. For example, the Operation Live Well (OLW) office, which in February 2016 moved from DHA to OEDFR, is undertaking a BHMC pilot study in partnership with the National Guard Bureau. The pilot study is leveraging OLW's Joining Community Forces infrastructure to examine ways in which Family Program access points such as the National Guard's 500 Family Assistance Centers (FACs) might be better utilized to improve force readiness, well-being, and resiliency, including in areas related to mental health.[244] DSPO had been unaware of this initiative as of late-July 2016, but could have important contributions to make in several areas. First, a partnership between OLW and DSPO would increase Service Members' and families' awareness about community resources and eligibility to use them. Second, there could be opportunities to share information on metrics for program evaluation. The BHMC pilot study plans to assess changes in family health and well-being due to interventions using the CDC's Health-Related Quality of Life metrics. DSPO might have additional metrics that could be applied and, in turn, DSPO could benefit from seeing how effective the CDC's metrics might be for evaluating suicide prevention program outcomes. In a discussion with OLW, staff indicated the potential for DSPO to use the pilot study to test relevant suicide prevention-related interventions or training programs.[245] One specific example for potential DSPO collaboration with the OLW pilot would be to ensure that the State coordinators, who will serve as FAC reach back on available resources, are aware of suicide prevention training materials being prepared through DSPO-AAS collaboration and that these coordinators, in turn, ensure the FAC personnel in their respective states know how to access these materials. Finally, there could be opportunities for DSPO staff to participate as part of the evaluation team for the pilot study.

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[242] DOD stakeholder interview, February 11, 2016.

[243] Ibid.

[244] According to NGB guidance, "all active reserve and retired uniformed Service members; their family members; civilian employees; and surviving family members of military personnel are eligible for assistance" through the National Guard's Family Program. See Chief National Guard Bureau Instruction (CNGB) 1800.02, *National Guard Family Program*, July 31, 2013, 2. For additional information, see Building Healthy Military Communities (BHMC) Outreach, https://www.jointservicessupport.org/Outreach/Index8.aspx.

[245] DOD stakeholder interview, April 13, 2016.

The need to address stigma offers another example of an opportunity for more collaboration, which should be initiated within the P&R leadership. Stigma reduction efforts have been part of the defense suicide prevention program's overarching goals as highlighted in the DOD Task Force Report's recommendations and addressed in the DSSP. It has also been identified as key in the broader context of improving Service Member readiness and resilience. As the Government Accountability Office (GAO) recommended in its April 2016 report, OUSD(P&R) should "leverage recommendations made by the RAND Corporation in its 2014 report on mental health stigma in the military to update and clarify policies as needed to remove stigmatizing provisions."[246] Developing a clear and consistent definition of stigma as well as coordinating stigma reduction-related efforts across DOD is a tasking too broad for DSPO to lead. As stigma pertains to a broad range of mental health issues, it is one that would logically fall under the purview of whatever office will now have responsibility for resiliency, with DSPO having an important participatory role.

2. Recommendations

To help ensure that DSPO continues on its current path, IDA recommends that there be sufficient time to allow the staffs to align under the new P&R organizational structure and seek opportunities to collaborate on common challenges, such as the above-mentioned case of stigma. While DSPO does not have the responsibility or authority to establish those collaborative relationships, its staff can and should be prepared to participate if and when the P&R leadership creates the necessary mechanisms.

In the meantime, DSPO should explore collaboration opportunities with OUSD(P&R) counterpart organizations, such as the OLW BHMC pilot. This effort might include leveraging existing programs to improve military community awareness of suicide prevention resources and coordinating on planned surveys to collect data relevant to assess the impact of suicide prevention programs/interventions.

C. The Sufficiency of DSPO Authorities

DSPO was created by Congressional mandate as a result of the DOD Task Force's recommendation to establish an OSD office with the responsibility for better integrating DOD's suicide prevention work. To date, DSPO's roles and responsibilities, as well as those of other stakeholders, are codified only in DODD 6490.14, "Defense Suicide Prevention Program." DSPO continues to work on finalizing the corresponding DODI 6490.##, "Defense Suicide Prevention Policy and Program Procedures."

[246] GAO, *Human Capital: Additional Actions Needed to Enhance DOD's Efforts to Address Mental Health Care Stigma*, 39.

1. Findings and Observations

The DODD and especially the DODI, when issued, are the most important documents for ensuring that DSPO has effective mechanisms in place for necessary governance and oversight. IDA finds that, because the DODI has not been finalized as of the writing of this report, there are uncertainties and sometimes challenges arising from other stakeholders unaware of what DSPO does. These differences of opinion have, in many cases, been surmounted because of the strong collaborative approach that DSPO has adopted since 2015. Only when the DODI takes effect will the differences be more clearly resolved. Having reviewed and commented on a draft of the DODI, IDA finds that this document should sufficiently address roles and responsibilities, reporting requirements, and other criteria for the effective execution of DOD's suicide prevention program. Once in effect, it will be important for DSPO actively to track information it requires from others in the DOD community as well as its own reporting requirements.

2. Recommendations

In addition to pursuing as rapid an approval process as possible for the DODI, IDA recommends that designated members of DSPO staff be assigned responsibility for tracking individual reporting requirements to ensure DODI-stipulated deadlines are met and required information is provided.

Part Four

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8. Conclusions

This report provides IDA's assessment of DSPO's organizational effectiveness and program efficacy based upon an analysis of strategic plans, roles and responsibilities (value-added functions), organizational structure, data analysis capabilities and challenges, program evaluation approaches, and research mechanisms. Reflecting on the organizational review findings and observations presented in the body of this report, the IDA research team concludes that, overall, DSPO is on the right trajectory to drive progress across the DOD toward strategically aligned efforts that support an environment where suicide prevention is integrated into DOD's policies and programs. The research has identified some areas of DSPO's operations and organization for continued emphasis, as well as other areas with opportunities for improvement. The associated recommendations related to DSPO's organizational effectiveness and program efficacy are summarized in Tables 8 through 12 at the end of this chapter. They are organized by chapter and address roles and responsibilities, evaluation, data, research, and organization.

The findings presented in the body of this report suggest several common themes as instrumental influences upon or key contributing factors to DSPO's organizational effectiveness and program efficacy. First, DSPO's shift to a more holistic public health approach to suicide prevention has improved its alignment with other key stakeholders, within and outside of DOD. Second, DSPO's development of an office strategy, built on the foundation of this public health approach and complementary to the broader DOD suicide prevention strategy, has provided a rationalized organizational structure to carry out its mission in a more coherent manner. This has also increased DPSO's ability to serve the roles of DOD suicide prevention policy advocate, integrator, and collaborator. Third, the new office strategy has provided DSPO the justification for hiring individuals with required subject matter expertise which, in turn, has increased the office's skill sets, put it in a better position to execute its roles and responsibilities, increased staff credibility with stakeholders, and enhanced its ability to serve as an informed collaborative partner with stakeholders. Fourth, more clarity is needed on DOD-wide roles and responsibilities and DSPO should continue to press for completion of the DODI to fill that policy guidance gap. Finally, and, perhaps, most importantly, DSPO's new leadership as of 2015 has set the tone for a strong culture of collaboration as reflected in a distinct shift in the office's approach. The emphasis upon collaboration inside and outside of the DOD has resonated with stakeholders as an important improvement.

Collaboration is essential for DSPO to carry out its roles and responsibilities within its existing authorities, internal to its organization, and in conjunction with key DOD and non-DOD stakeholders whose support is necessary for successful implementation of its mandate. DSPO has revitalized the DOD suicide prevention governance structures of the SPGOSC and SPARRC, transforming them into more collaborative mechanisms in a manner which is contributing to

improved community situational awareness and the sharing of best practices. One area for improvement would be ensuring that all appropriate participants are formally included so that discussions are fully informed and represent the broad array of stakeholders needed to ensure issues impacting the total force, both Active and Reserve Components, are taken into account. Furthermore, SPGOSC meetings should be structured to ensure decisions are informed by appropriate subject matter expert insights from both the evidence-based research perspective as well as that of practical implementation experience.

With the hiring of outreach staff, DSPO has been able to pursue other collaboration avenues to foster outreach and education such as the improved website, webinars on key issues of interest to the suicide prevention community, and the issuance of a Training Competency Framework developed in collaboration with the Services. DSPO should continue these outreach and education efforts and maintain a repository of relevant suicide prevention resources on its website in order to serve the clearinghouse role that DOD stakeholders have cited as one of its greatest opportunities to add value to the community.

DSPO has made significant progress recently in the realm of data management, overcoming some of the data challenges experienced in its initial years of existence. Unfettered access to reliable data is essential to fulfilling its functions of responding to requests for information and informing DOD suicide prevention activities and research. The hiring of a subject matter expert to lead the data and surveillance team and the establishment of an MOU with DHA that allows DSPO direct access to DoDSER data in the form of a flat file have been key to this progress. However, the SDR database that is co-run by DSPO and the VA is a promising vehicle that has yet to be fully leveraged. Work remains to be done to improve the SDR data repository content, governance, and utilization. DSPO and the VA should continue crafting a strategic plan to improve its content and structure, raise awareness about it, and, most importantly, require research utilizing it be aligned more closely with DOD/VA research priority areas. Furthermore, the results of any research utilizing these data should be reported back to DSPO and the VA to maintain awareness among the military and veteran suicide prevention communities. Beyond DoDSER and the SDR, DSPO should explore avenues for sharing the results of Service deep dives in addition to exploring the feasibility of requesting observer status at some of these Service deep dives. Finally, DSPO and the Services must address a new requirement for reporting on military dependents, a challenging task given gaps in the data for this population. DSPO has made positive steps in addressing the requirement with the issuance of the DTM developed in collaboration with Service SPPMs and the identification of DEERS as a possible mechanism for recording dependent suicides. DMDC has suggested the Services do trial sampling of the new DEERS suicide data to test its feasibility. DSPO should collaborate with the Services on this and work with them and DMDC to explore avenues to gain access to data for those dependents not captured in DEERS.

On the topic of research, per its office strategy, DSPO seeks to establish itself as a leader in setting the DOD research agenda for suicide prevention, which it sees as a key function in

support of its mandate. There are other professionals in the DOD research community who have been fulfilling a similar role. It is important that DSPO continue to work collaboratively with them and the members of the suicide prevention governance bodies to craft an agenda that identifies priority areas to address research gaps in support of the goals laid out in the *Defense Strategy for Suicide Prevention*. One important gap that DSPO has already identified is research in suicide prevention (in contrast to research on intervention and treatment). DSPO's positive steps in this direction include its Research Summit series, as well as communication and coordination with MOMRP and other DOD stakeholders to develop and update collaboratively the DOD suicide prevention research agenda. Besides the research agenda-setting role, DSPO should continue to fund research studies, participate in scientific conferences and working groups to maintain awareness of research, and facilitate awareness of and access to research via DSPRAT and the DSPO website.

DSPO can serve a greater role as a research clearinghouse by sharing information on the roles and responsibilities of the various entities involved in suicide prevention research. It may consider working with those stakeholders inside and outside DOD to form a research community of interest to promote information sharing, avoid duplication of effort, and foster collaboration among research organizations. Information sharing could address not only research being supported but also taxonomies for the research. DSPO should support research through gap identification, priority setting, funding, and information sharing and assist in facilitating the translation of that research to practice. DSPO can do even more to foster translation of research beyond its participation in working groups with the MSRC's CORE D and Army STARRS. DSPO can emphasize this in its research proposal award process, requiring that all proposed studies include a plan for translation of research into practice. It can also consider hiring an expert in research translation to assist DSPO and stakeholders in translating current research into practice as well as ensure that future research proposals and projects are geared toward translation. Finally, DSPO can utilize the SPARRC body to engage Service program managers on this goal.

Program evaluation remains one of DSPO's most challenging and important mandates. Assessing programs aimed at prevention is inherently difficult, especially for an issue with such a complex array of human factors influencing it. That said, DSPO has made concerted efforts during 2016 to address this area. One aspect requiring clarification is determining who should be performing the evaluations of suicide prevention programs: DSPO or the Services. Service stakeholders expressed concern that multiple entities have conducted evaluations with considerable overlap. IDA contends that DSPO's main effort in assessing programs should take the form of an evaluation framework, philosophy, and needed capabilities. DSPO should request that the Services report annually on their programs using this established framework, as DSPO has now begun to do, in order to perform its oversight function. Furthermore, DSPO could explore sharing this proposed program evaluation framework with OSD's Prevention

Collaboration Forum to inform development of a generic template for more broadly evaluating DOD prevention programs.

DOD suicide prevention program evaluation efforts should continue to be developed with an awareness of existing external tools and best practices. DSPO should coordinate with relevant DOD and non-DOD stakeholders to explore the applicability of such tools and practices to the DOD context. DSPO can also more methodically leverage installation field visits to complement Service reporting and better understand ground truth. DSPO's field visits, thus far, have been ad hoc and sometimes perceived by the Services as overstepping role boundaries. To mitigate this, DSPO could develop a more structured approach in coordination with the Services to visit specifically identified bases to learn about their suicide prevention successes, their challenges, and the practical considerations encountered. Such visits could also provide an avenue to share expertise and best practices and increase field awareness of resources available through DSPO.

The hiring of new staff with behavioral health and research expertise has raised DSPO's credibility appreciably within the suicide prevention community. DSPO's recent hires to lead data, research and assessments, and outreach areas have brought in notable experience, putting DSPO in a better position to execute its roles and responsibilities. Despite improvements in organization and staffing, several additional modifications could improve DSPO's functioning; namely, a more consistent military presence representing both Active and Reserve Components. DSPO benefitted greatly from past military billets filled by AC SMEs and has sought the transfer of unfilled P&R billets to bring on additional military expertise. DSPO would especially benefit from Reserve Component representation on staff given the unique nature of circumstances distinct from the AC experience. Having a Reserve Component position at DSPO could inform the office's various functional areas, including policy, research, data, and outreach on issues unique to the Reserve/National Guard, help to identify gaps, work to identify evidence-based programs to fill those gaps, and facilitate the sharing of best practices on ways to adapt suicide prevention programs and training to better serve Reserve Component needs. Other areas of staff augmentation that DSPO could consider include adding experts to the program evaluation and data surveillance portfolios, as well as legislative liaison staff support for DSPO responses to Congressional inquiries. A new organizational function that DSPO should consider piloting to fulfill both its postvention and outreach mandates is the establishment of deployable postvention teams, drawing on a roster of certified experts from DOD and other government/non-government entities who could provide surge support to installations in need in the aftermath of multiple suicide incidents. These teams could assist installation leadership with strategic communications and policy advice, and could also provide surge counseling capacity. The OUSD MC&FP's FACAT model could serve as a possible template to draw on for the postvention team concept.

DSPO's placement and reporting structures within P&R have shifted over the years since its inception. Leadership support and continuity are important for an OSD office to fulfill its duties and ensure steady implementation of policies and practices. Accordingly, DSPO would benefit from a stable reporting structure within P&R. The creation of the OEDFR structure

within P&R, to which DSPO briefly operationally reported during the course of IDA's research, provided a more coherent umbrella for DSPO and counterpart offices which share responsibility in support of DOD's Total Force resiliency mandate. This structure should have helped to facilitate collaboration and sharing of best practices among the offices charged with personnel wellness initiatives through avenues such as the Prevention Wellness Collaboration forum. DSPO should take advantage of that forum and explore collaboration opportunities with other P&R counterparts. It will be important for the new P&R reporting structure, put in place in late 2016, to encourage such collaboration. One opportunity to explore is Operation Live Well's Building Healthy Military Communities pilot. This pilot could be used to leverage existing programs to improve military community awareness of suicide prevention resources and coordinate planned surveys to collect data relevant to assessing the impact of suicide prevention programs and interventions.

DSPO has evolved markedly since it was formed in 2011. Despite many challenges along its path, it has made considerable progress developing into an office poised to carry out its mandate to provide an overarching policy framework and a more standardized approach to suicide prevention in the DOD. The current DSPO leadership is on the right trajectory to foster strategic alignment on suicide prevention programming across the DOD enterprise. The recommendations in this report provide DSPO with options to improve further its operations and organization to drive continued progress.

Table 8. Recommendations: DSPO's Value-Added Functions

Category	Subcategory	Recommendation
a. Policy and Strategy		1. Pursue DODI issuance
		2. Designate DSPO staff to monitor DODI implementation requirements
		3. Review/update DSPO office strategy periodically, post on website
b. Collaboration, Communication, and Advocacy		4. Raise awareness/improve communication of *2015 DSPO Strategy* and other guidance documents
		5. Advocate for improved access to mental healthcare for Reserve Component who are not on 30-plus day activated status
		6. Ensure taskings to the Services and other DOD stakeholders are clearly articulated, use appropriate mechanisms, and allow sufficient time for response
	Mechanisms for collaboration (Improve SPARRC/SPGOSC function/utility)	7. Establish a full year's meeting schedule at beginning of CY or FY
		8. Ensure meeting materials are delivered to members NLT one week prior to meetings
		9. Report back on status of actions identified at meetings within 10-15 business days
		10. Review memberships codified in charters and confirm appropriate stakeholders are included; consider adding RC and USCG representatives
		11. Consider more external presentations at SPARRC and SPGOSC meetings to foster information sharing and raise awareness
		12. Reduce time spent reviewing Service-specific suicide numbers during SPARRC
	Disseminating Best Practices	13. Continue efforts to improve DSPO website to enhance dissemination of best practices and serve as repository for guidance, research initiatives, and training materials
		14. Consider creation of controlled, password-protected area on website for members of the DOD suicide prevention community
c. Outreach and Education		15. Continue to pursue outreach with internal (DOD) and external stakeholders, including participating in relevant fora to enhance situational awareness and clearinghouse function
		16. Continue to improve content and structure of website to foster collaboration and partnering

Category	Subcategory	Recommendation
	Improve outreach and training	17a. Ensure use of uniform terminology in DOD suicide prevention materials
		17b. Work with DOD stakeholders to develop consistent universal baseline suicide prevention curriculum that could be tailored as necessary to the Service culture
		17c. Seek to translate “best practices” into “shared practices” across the Services
		18. Consider creation of deployable postvention SME teams to provide surge support to installations overwhelmed by multiple suicide incidents
	Expand collaboration external to DOD	19a. Include external stakeholders in SPARRC more frequently to promote greater information sharing on best practices; poll SPGOSC members on interest to do so during their meetings as well
		19b. Include USCG more routinely in DSPO outreach initiatives
		19c. Explore additional partnerships in professional meetings, such as resuming DOD-VA suicide prevention conference, perhaps biennially, or DOD track at AAS annual conference
		19d. Continue work with NIMH to maximize database integration between DSPO’s DSPRAT and NIMH’s PFC research survey tool, consider MOU with NIMH to enable automated inclusion of DOD grant information in PFC and provide permission for DSPO to access that system
		20. Continue collaboration with VA on suicide prevention, including addressing challenges encountered by transitioning Service members
d. Program Evaluation	Evaluating DOD Suicide Prevention Programs	21a. Focus program assessment efforts on maintaining an evaluation framework, philosophy, and needed capabilities
		21b. Continue to develop annual SSAs as DSPO’s primary method of program oversight
		22. Standardize SSAs according to the DSSP “major assessments of Program Evaluation”
		23. Explore sharing program evaluation framework with the Prevention Collaboration Forum to inform generic template for counterpart offices evaluating prevention programs
		24. Explore hosting off-site meeting on best practices and evaluation tools involving relevant DOD and external stakeholders
		25. Work with the Services to develop structured field visit approach to complement annual Service program evaluation reports

Category	Subcategory	Recommendation
e. Data Management and Reporting	Suicide data	26. Continue role in providing policy and guidance on standardization of suicide prevention data
		27. Seek copies of weekly/monthly Service suicide number reports to reduce frequency of data validation taskings to the Services
	Improve SDR usage and access	28a. Raise awareness of SDR through various mechanisms including DSPO and VA websites and relevant scientific workshops and conferences
		28b. Require researchers utilizing SDR data to brief DSPO/VA on findings related to military suicide prevention
f. Research Support	Participating in Research Arena	29. Continue to participate in various venues to maintain awareness of suicide prevention research and avoid duplication of effort
	Setting Research Agenda	30. Continue to collaborate with stakeholders inside/outside DOD to set suicide prevention research agenda
		31. Continue open and consistent communication with MOMRP and other DOD stakeholders regarding research priorities, gaps, and funded projects to set collaboratively DOD suicide prevention research agenda
		32. Continue to help fund research studies, especially in identified gap areas such as prevention
		33a. Retain focus on documenting relevant research inside/outside DOD
		33b. Maintain currency of suicide prevention research agenda, identify gaps
		33c. Provide funding support to help address research gaps
		34. Continue to improve research-related content on DSPO website, include information on Research Summits, DSPRAT database, results from SDR and DSPO-funded studies
		35. Centralize DOD-specific research information on DSPO website, as well as links to external stakeholder sites such as NIMH PFC, outside best practices registries, and evaluations of evidence databases
g. Resource Management		36. Pursue plans to clarify the language used by Congress to provide additional funding to DSPO
		37. Forgo pursuit of RDT&E funds for Congressional adds
		38a. Continue to use new process for vetting and financially supporting DOD suicide prevention proposals for pilots or research using Congressional adds

Category	Subcategory	Recommendation
		38b. Consider modifying white paper proposal submission requirements to include program evaluation as well as references to both technical and financial points of contact 38c. Formally request input from SPGOSC and/or SPAARC members on timing of white paper solicitation and how topic priorities should be determined (by DSPO annually or by submitters) 39. Archive information on funded projects; consider using DSPRAT and/or the research section of DSPO website for storing/cataloguing

Table 9. Recommendations: Metrics for Evaluation

Category	Subcategory	Recommendation
a. Create Metrics		40a. Identify additional proximal outcomes to: 1) assess more comprehensively progress toward DSSP goals; and 2) take advantage of extant and emerging data sources
		40b. Consider the following examples of additional proximal outcomes: improve oversight of suicide prevention programs; improve postvention support; improve usefulness of data; improve communication efforts (See Table 5 for suggested data sources for each)
b. Measures of Effectiveness	Access to Statistics from the MDR	41. Request MDR statistics, including patient counts and access to care metrics
	Time Consistency	42. Maintain as much consistency as possible in measures of effectiveness from year to year by asking the same survey questions in consecutive years
	Service Self-Assessments	43. Obtain finest level of detail possible for SSAs as to what groups were exposed to a given program
		44. Consider modelling DSPO Program Evaluation Activity Index after the “continuum of evidence” method used by the Clearinghouse for Military Family Readiness
	Automation of News Article Scoring	45. Consider hiring a contractor to develop an automated article scoring system based on criteria such as the 14 responsible reporting guidelines
	Text Mining the DoDSER	46. Consider hiring a contractor to develop a text mining algorithm to extract information from DoDSER narratives in order to reveal unidentified risk factors and test the quality of DoDSER reporting
	Service Reports	47a. Use MOEs and communication with the Services to guide requests for metrics
		47b. Develop a consistent set of reported metrics across the Services and over time

Table 10. Recommendations: Data Management and Reporting

Category	Subcategory	Recommendation
a. DSPO and DoDSER		48. Make every effort to work through any difficulties that arise in execution of DHA-DSPO MOU on DoDSER data access 49. Explore feasibility of appointing T2 representative to DSPO on rotational basis to handle increased workload linked to production of annual DoDSER report
b. SDR: Additional Datasets		50a. Consider adding datasets to the SDR such as TRICARE hospitalizations related to suicide attempts, data from Force Risk Reduction oversight management tool 50b. Pursue dedicated effort to standardize categorization methods across different datasets 51. Advocate that DMDC combine purchase of NDI+ with other data purchases from CDD to free up DSPO resources for other purposes
c. Reporting on Military Personnel		52. Request copies of the Service's weekly and monthly suicide number updates and consider including as requirement in DODI 53. Provide the Services a mechanism for sharing results of deep dives, such as dedicated SPARRC meeting 54. Request observer status at some of the Service deep dives
d. Reporting on Military Dependents		55. Investigate possibility of merging TRICARE data related to suicide attempts into SDR and allowing searching for cases by ICD-9 number
e. Potential of "Big Data"		56. Continue to bolster big data research in the suicide research community, which might include providing contractor support to conduct pilot studies or financial support through its research proposal process
f. DSPO's Data Analytical Capabilities		57. Continue to enhance data analytical capabilities through avenues such as contractor support, temporary T2 liaison position, or additional government billets

Table 11. Recommendations: Mechanisms to Support Research Needs

Category	Subcategory	Recommendation
a. Enhancing DSPO's Tools for Research: SDR as Example		58. SDR leaders should develop a strategic plan that raises awareness about SDR and requires research using its data to have closer connection to topics of interest to DOD and the VA 59. Work with VA to publicize SDR and its capabilities 60. SDR Board of Governors should guide awareness efforts and disseminate results of research using its data 61. Require researchers utilizing SDR to report findings and potential implications related to military and/or veteran populations 62. Consider issuing research priorities guidance for those seeking to use SDR data, while still allowing for consideration of additional topics that could yield important results
b. Facilitating and Funding Research		63. Continue to facilitate and fund research through partnerships with the Services and stakeholders, formalize pilot proposal review process using Congressional additions to budget 64. Engage stakeholders on views of pilot proposal solicitation and award process to understand better their needs
c. Focusing Research Proposals and Projects on Translation into Practice		65. Continue to participate in research translation-focused groups such as MSRC Core D project, Army STARRS translation working group, and others that exist or may be formed 66a. Take steps to ensure research DSPO identifies, disseminates, funds, or facilitates is focused on translation into practice 66b. Hire contractor with expertise to assist DSPO and stakeholders in translation of current research into practice, as well as ensure new research proposals are geared toward translation 66c. Highlight importance of translation in the research proposal solicitation and award process, requiring all proposed studies to include a plan for translation similar to program evaluation requirement
d. Actions to Establish Unified System for Surveying, Cataloguing, and Coordinating Research	Research Entities and Roles Document	67a. Develop a document outlining all organizational entities in suicide prevention research field and their roles and responsibilities 67b. Develop document in collaboration with stakeholders to ensure

Category	Subcategory	Recommendation
		comprehensiveness and accuracy
		67c. Use Appendixes F, G, and H of the IDA Report as a starting point
		67d. Consider maintaining living, updatable version on website
	Suicide Prevention COI	68. Engage suicide prevention stakeholders to explore the value of a new research COI to promote information sharing, avoid duplication of efforts, and inspire collaboration and networking between organizations
	Surveying and Cataloguing Research	69. Continue efforts to provide DSPRAT inputs to NIMH's PFC, while continuing to develop DSPRAT independently to meet DOD needs
	RAND Recommendations	70. Review recommendations of 2014 RAND report on DOD research strategy to identify which are being followed and which need further work
e. Taxonomies for Characterizing Research		71. Publish a document for DOD outlining all potential taxonomies for characterization of suicide prevention research, drawing on those identified in this report
		72. Discuss utility of various taxonomies with community stakeholders and promote sharing of information on research goals/priorities developed from these taxonomies

Table 12. Recommendations: Organizational Structure

Category	Subcategory	Recommendation
a. Organizational Structure, Staff Skill Sets		73. Continue to investigate assignment of existing unfilled military billets within OUSD (P&R) to DSPO 74. Investigate ways to add a staff member with Reserve Component expertise via permanent position, use of military billet, or rotations from the field 75. Consider need for additional staff, government or contractor, to support research and program evaluation line of effort and the data surveillance portfolio 76. Consider renaming Director-level position of Current Operations to Current Operations and Legislative Liaison; consider adding staff to support position given the importance of responsiveness to Congressional inquiries 77. Consider value of establishing postvention team that draws on MC&FP FACAT model, consists of roster of certified experts from DOD and other government/non-government entities, and is available for surge deployment to advise/assist installations with strategic communications, memorial policy, counseling; explore on pilot basis
b. Placement within P&R		78. Be prepared to participate in P&R-led collaborative initiatives on common force resilience challenges 79. Explore collaboration opportunities with P&R counterpart organizations and initiatives such as OLW and its BHMC pilot
c. Sufficiency of DSPO Authorities		80. Assign designated DSPO staff to track reporting required by the DODI to ensure deadlines are met and required information is provided

Appendix A.
History of the Services' Suicide Prevention Programs

This appendix provides an abbreviated summary on the history of the Military Service's Suicide Prevention programs prior to the stand up of DSPO, drawing primarily upon information contained in the 2010 DOD Task Force Report.

The U.S. Army's program began in 1984. In 1999, the Army Chief of Staff stood up a panel of experts to review existing suicide prevention efforts. This review was completed in 2000 by the Army G-1, the Office of the Surgeon General, and the Office of the Chief of Chaplains with a call for renewed emphasis on leadership involvement and command policy/action, resulting in a program focused on leadership and a community approach. Its 2001 Suicide Prevention Campaign Plan focused on prevention and intervention, commander ownership, and integrated resources at the installation level. The Army contracted for advanced training packages to improve intervention skills and prevention awareness in 2002 and 2005. The increase of suicides in theater combat operations in Afghanistan and Iraq, from 2002-2009, led the Army to reassess mental fitness of the force and review the suicide prevention programs. They found that the suicide prevention training was being conducted at intervals during the deployment cycle predominately by unit ministry teams and only occasionally involved behavioral health personnel. They also found reduced Soldier confidence in the adequacy of the training.

Despite increased suicide prevention efforts, the Army's suicide rates increased, exceeding that of the U.S. civilian population for the first time in 2005.[247] The Army initiated "Battlemind" training, now called Resilience Training, in 2006, mandating its service-wide application in 2007. This training was also made available to all members of the military. In 2008, the Army entered into a Memorandum of Agreement (MOA) with NIMH for the five-year Army Study to Assess Risk and Resilience in Service members (STARRS), with the initial goal of identifying modifiable risk and protective factors. Army STARRS was the largest study of suicide and mental health of the military attempted to date. The Comprehensive Soldier Fitness Directorate was established in 2008, with the goal of improving resilience for Soldiers and their families in certain areas through training, intervention, and treatment programs as well as total fitness assessments that helped to tailor programs as needed. The program began at accession into the Army and included periodic reassessments. In 2009, the Army stood up a Suicide Prevention Task Force during a month-long stand down for suicide prevention training, with the goal of assessing suicide prevention programs for effectiveness and informing Army regulations, policies, and programs.[248]

[247] DOD Task Force, *The Challenge and the Promise*, 15-17

[248] Ibid., 18.

The U.S. Navy (USN) has had ad hoc, localized suicide prevention training and leadership communications for many years. It formalized those efforts only in 1996, when the other Services initiated programs following record high suicide rates experienced across the military in 1995, and the suicide of Chief of Naval Operations ADM Boorda in May 1996. In 1998, the Department of the Navy (DON) did a comprehensive assessment of suicide prevention efforts. The Navy viewed this as a readiness issue and put suicide prevention in Navy Personnel Command, with the cornerstones of prevention identified as "Leadership, Policy, and Education." Suicide prevention then became a component of the Behavioral Health Program of Record under OPNAV N135, Personal Readiness and Community Support.[249] The DOD review and DON assessment also led the Navy to initiate suicide data surveillance efforts in 1999 with the Department of the Navy Suicide Incident Report (DONSIR), which was used to collect data on all suicides in the USN and Marine Corps. This effort helped to provide leadership with detailed information on suicide trends within the Navy and improve prevention through identification of military specific risk factors. The DONSIR collected data from 1999 to 2007, and informed development of the DoDSER, which replaced it in 2008.[250] Navy published its first prevention policy in 2005, OPNAVINST 1720.4, which outlined a 10 point action plan. It was revised in 2009 to focus on four key elements of local command suicide prevention: training, intervention, response, and reporting. This revision extended USN DoDSER surveillance to cover drilling Selected Reserve personnel and suicide attempts; it also extended training to civilians as well as provided additional training requirements for first responders.[251] Other training efforts have consisted of inclusion in annual general military training for all Sailors in the form of videos and computer-based training, live interactive facilitated peer-to-peer training with role playing, interactive front line supervisor training, and, as of 2008, workshop training for suicide prevention coordinators at the command level.[252] In 2009, the Navy started "Operational Stress Control" which was an integrated health promotion, family readiness, and prevention program aimed at building resilience, early problem identification/mitigation, and the creation of healthy climates. In 2010, the Chief of Naval Operations formed a cross-functional team to analyze Navy suicide prevention efforts and stood up a special projects team to review all 2008 and 2009 suicide cases to identify trends and lessons learned.[253] Also in 2010, the Navy held a two-and-one-half day training conference for upper echelon and installation-level suicide prevention coordinators, with a train-the-trainer approach, to prepare them to train/mentor the suicide prevention coordinators in their subordinate and/or tenant commands.[254]

[249] Ibid., 19.

[250] Ibid., 21.

[251] Ibid., 19-20.

[252] Ibid., 20.

[253] Ibid., 19.

[254] Ibid., 20.

The U.S. Air Force (USAF) had been tracking suicide rates since the 1980s. In response to increasing rates in the mid-1990s, it established an Integrated Project Team in 1996 to address the Air Force rates. This led to the creation of the Air Force Suicide Prevention Program. This new program shifted suicide prevention from a medical issue to a commander's issue, relevant to all areas of the Airman's life. The Air Force had data within its public health tracking system that revealed primary suicide risk factors and showed that two-thirds of suicides had no prior related contact with the healthcare system. The USAF program developed a comprehensive approach to suicide prevention with 11 key elements that were then codified in Air Force publications; AFPAM 44-160 on the Air Force Suicide Prevention Program outlines those program elements.[255] Drawing from the public health tracking system, the suicide prevention program developed a separate secure, web-based Suicide Event Surveillance System (SESS) which expanded tracking beyond active duty members and increased patient confidentiality. The Air Force Health Force Protection office used data from this system to produce monthly and annual reports, as well as address queries from leadership. It expanded the ability to track suicides of Airmen assigned to the Guard and Reserve who were not on active status and, in 2008, began tracking suicides of USAF civilians. USAF fully transitioned from the SESS to the DoDSER by 2009 as its data collection system for all suicide deaths and attempts. Air Force suicides decreased following implementation of its program; the impact and implications were documented in scholarly research literature.[256] The success of the USAF program led to other military and civilian suicide prevention programs adopting some of its elements.[257]

The U.S. Marine Corps (USMC) first identified suicide prevention as a key element in its 1992 guidance, per the Marine Corps Health Promotion order that required small unit prevention and awareness training. Previously, USMC had considered this a leadership and medical activity. The 1993 Marine Corps Quality of Life Assessment and the 1994 standardized lesson plan on "Suicide Awareness and Prevention" supported the requirements set out in the 1992 order. A 1997 USMC policy update of the health promotion order mandated annual training for all Marines. The 1998 DON comprehensive assessment of suicide prevention efforts resulted in new initiatives and increased coordination between headquarters USMC and Navy personnel, health, and criminal investigations elements. At that time, the USMC also reorganized headquarters to increase collaboration among those working on suicide prevention, drug and alcohol abuse, and

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[255] Ibid., 24.

[256] To date, the USAF suicide prevention program, as studied by Knox, et al., is found to have the strongest evidential basis compared to other Military Service programs. Further according to Harmon, et al.: "The largest and most promising study that yields the greatest evidence of effectiveness is the multilayered program developed by the U.S. Air Force." See Lisa M. Harmon, et al., "A Review of the Effectiveness of Military Suicide Prevention Programs in Reducing Rates of Military Suicides," *Journal of Human Behavior in the Social Environment,* 26:1 (2016), 15-24, downloaded from http://www.tandfonline.com/doi/pdf/10.1080/10911359.2015.1058139. And K.L Knox, et al., "Risk of Suicide and Related Adverse Outcomes after Exposure to a Suicide Prevention Programme in the US Air Force: Cohort Study," *British Medical Journa*l, 327 (2003), 1376–1381, doi:10.1136/bmj.327.7428.1376.

[257] DOD Task Force, *The Challenge and the Promise*, 25.

domestic violence. The USMC suicide prevention program encapsulates a continuum of care. USMC began capturing suicide data in the 1970s. USMC's suicide data was collected by the Department of the Navy's DONSIR surveillance program from 1999 to 2007, and by the DoDSER since 2008. USMC added DoDSER entries for suicide attempts in 2009. These had been previously tracked by the Personnel Casualty Reporting system only; however, adding them to the DoDSER allowed for a dual track process that improved the validity/reliability of data collection.

The U.S. Coast Guard, while outside DOD authority, is considered a member of the Armed Forces. The USCG suicide prevention program was revised in December 2009 to incorporate seven elements. These elements are: Command Climate, Crisis Response, Limit on Command Access to Mental Healthcare Information, Notification and Hands-off in Criminal Investigations, Postvention, Reporting, and Training. This program is formalized in Commandant Instruction (COMDTINST) 1734.1A, Suicide Prevention Program. Commands are also responsible for establishing protocols for at-risk persons. USCG's program has drawn upon the USAF's example for medical requirements for managing suicidal behavior; however, quality assurance has been challenged by the lack of behavioral healthcare availability within the Coast Guard. USCG requires formal reporting of suicides and attempts, utilizing a form that mirrors the DoDSER to be filled out by the Suicide Prevention program manager. While data from USCG are not included in the DoDSER database, USCG seeks future inclusion.[258] USCG mandates annual suicide prevention training for all members and civilian employees, predominately delivered online prior to 2010. In 2008, USCG participated in the triennial DOD Survey of Health Related Behaviors among Active Duty Military Personnel and determined it would monitor the findings from future surveys as a way to measure the effectiveness of USCG suicide prevention programs. In 2010, USCG began to examine the application of an Operational Stress Control (OSC) program similar to that of the Navy, with options for more "intrusive leadership" to take appropriate action when stress signs are recognized in order to keep personnel mission ready and support suicide prevention efforts.[259]

[258] Non-DOD stakeholder interview, March 17, 2016.

[259] DOD Task Force, *The Challenge and the Promise*, 30-33.

Appendix B.
Active, Reserve Duty, and National Guard Suicide Trends

A. Active Duty, Reserve, and National Guard Suicide Trends

In 2008, the military suicide rate surpassed that of the general civilian population for the first time since 1977.[260] While comparisons between civilian and military populations can be made to identify general trends, to draw specific comparisons, it is important to use matched populations, typically matched by age, sex, and race. Notably, since 2008, the active duty military suicide rate has consistently surpassed that of a matched civilian population.[261] However, it should be noted that per the 2014 DoDSER, "there were no statistically significant differences between the CY 2014 military suicide rate and the CY 2013 U.S. population suicide rate after adjusting for differences in age and sex."[262] Its data further showed that Active Duty suicide rates decreased in 2013, but rose again in 2014. In 2014, the Active Duty military suicide rate was 19.9 per 100,000 people.[263] Figure B-1 illustrates the suicide rates of Active Duty Service members since 2008.

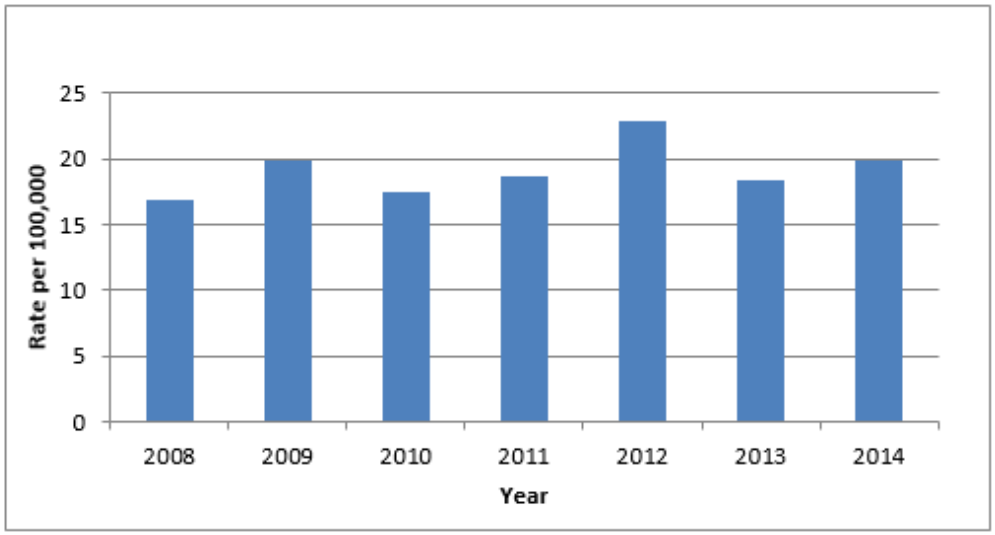

Figure B-1. Active Duty Suicide Rates by Year[264]

[260] Bower, *Science News*, https://www.sciencenews.org/article/suicide-rates-rise-researchers-separate-thoughts-actions.

[261] Ibid.

[262] T2, *DoDSER 2014 Annual Report.*

[263] Ibid.

[264] Ibid. and T2, *DoDSER 2010 Annual Report.*

Figure B-2 displays the suicide rates for civilians and Active Duty, Reserve, and National Guard Military Service members since 2012. The military rates displayed in this figure have been adjusted to match demographic criteria. This demonstrates that the adjusted military suicide rates are higher than civilian rates, even in comparable populations. Unless otherwise specified, all graphs following B-2 display unadjusted Service-specific rates.

The Component of the military with the highest unadjusted suicide rate in 2014 is the Reserve, with a rate of 21.9.[265] The Active Duty suicide rate was the second highest in 2014, with an unadjusted rate of 19.9.[266] The unadjusted suicide rate for the National Guard Component in 2014 was 19.4, a sharp decrease from its 2013 rate of 28.9.[267] Figure B-3 displays the total force (Active, Reserve, and Guard) suicide numbers since 2008.

Again, it must be noted that before 2012, Reserve and National Guard suicides were only counted if they occurred while a Service member was on base or on Active Duty status. Now, Reserve and National Guard suicide deaths are included in counts regardless of duty status. Figure B-3 is provided for reference as, before 2011, the counting method skewed the Reserve and Guard suicide numbers too low for a rate to be calculated. The absence of a line between the 2010 and 2011 numbers highlights the change in reporting guidelines.

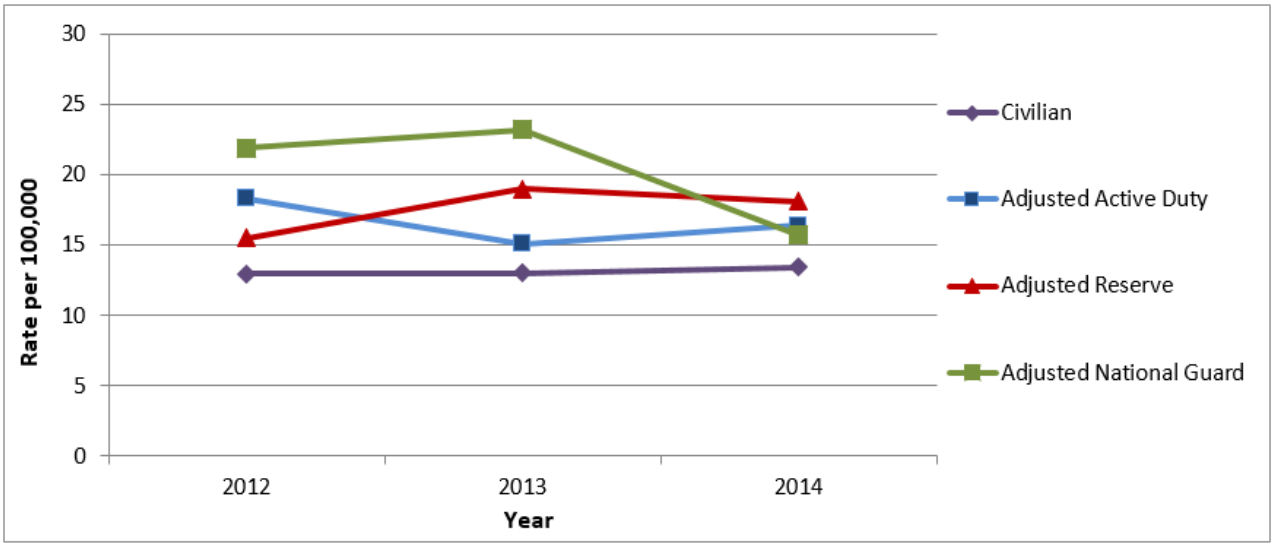

Figure B-2. Civilian and Adjusted Active, Reserve, and Guard Suicide Rates by Year[268]

[265] Ibid.

[266] Ibid.

[267] Ibid.

[268] Ibid.

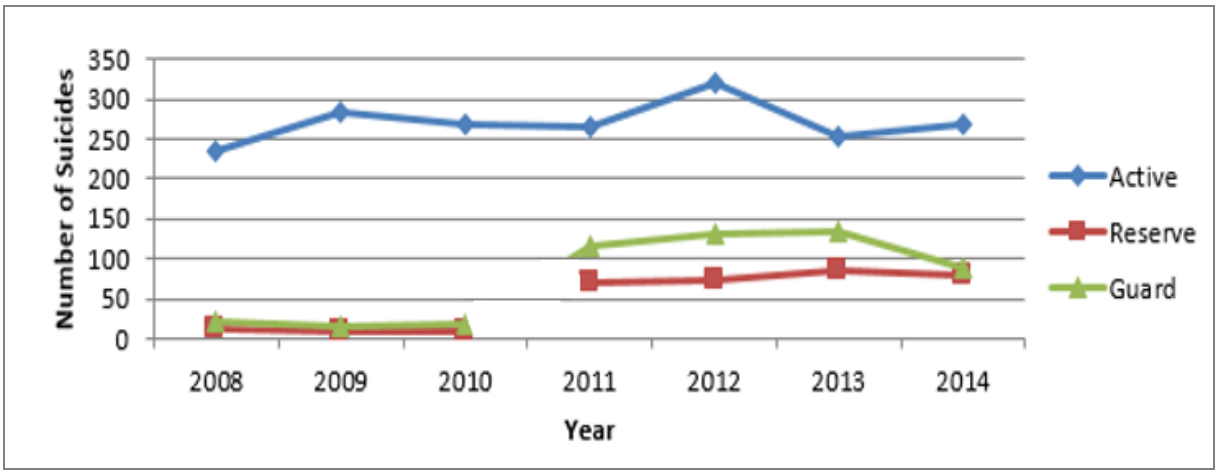

Figure B-3. Active, Reserve, and Guard Suicide Numbers by Year[269]

B. Suicides by Age and Component

Much younger age groups die by suicide in the Active Duty military versus the general civilian population.[270] Among civilians, from the years 2004-2014, the age group 45-54 consistently had the highest suicide rate per 100,000.[271] In this age group, the suicide rate reached a high of 20.2 in 2014. The 25-34 and 55-64 age groups follow as the groups with the second highest suicide rate. Among the military population, since 2011, the group with the highest Active Duty suicide rate has fluctuated between the 20-24 and 25-29 age groups.[272] In 2014, however, the highest suicide rate in the Active Duty military was that of the 30-34 age group, at 23.3.[273] Figure B-4 shows Active Duty military suicide rates by age group. The number of Active Duty suicides in the 17-19, 40-44, and 45-74 age groups was too low for a rate to be counted. Figure B-5 provides raw numbers of Active Duty suicides to supplement this gap in data and is an overall look at general trends.

It should be noted that data from before 2011 are not included because, prior to 2011, annual DoDSER reports combined all military Components when reporting demographic characteristics such as age and sex, making an analysis of demographics by Component impossible.

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[269] Ibid.

[270] AAS, *U.S.A. Suicide: 2014 Official Final Data*; T2, *DoDSER 2014 Annual Report*; and T2, *DoDSER 2010 Annual Report*.

[271] AAS, *U.S.A. Suicide: 2014 Official Final Data*.

[272] T2, *DoDSER 2014 Annual Report*; and T2, *DoDSER 2010 Annual Report*.

[273] Ibid.

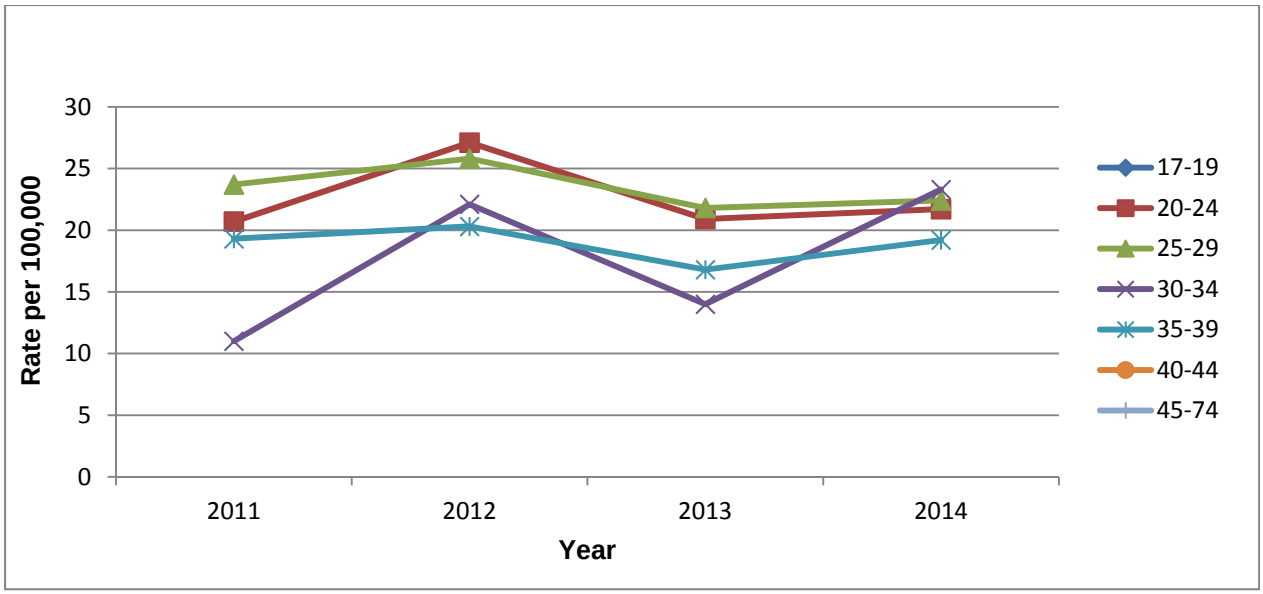

Figure B-4. Active Duty Military Suicide Rates by Age[274,275]

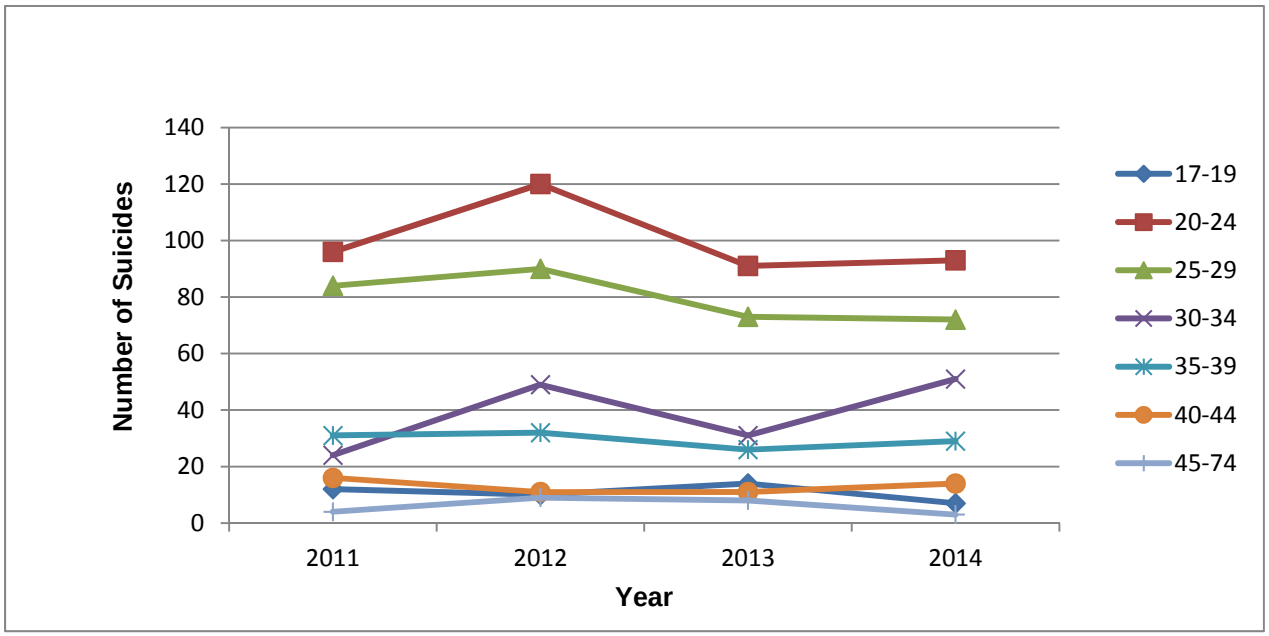

Figure B-5. Active Duty Suicide Numbers by Age[276]

[274] Ibid.

[275] The number of active duty suicides in the 17-19, 40-44, and 45-74 age groups was too low for a rate to be counted.

[276] T2, *DoDSER 2014 Annual Report*; and T2, *DoDSER 2010 Annual Report*.

In the Reserve Component, the 20-24 age group dies by suicide more than any other group, followed by the 25-29 age group.[277] While a decreasing trend had been observed in the 20-24 age group through 2013, the number of suicides in this group sharply increased from 2013 to 2014.[278] Figure B-6 shows the number of suicides in the Reserve Component since 2011.[279]

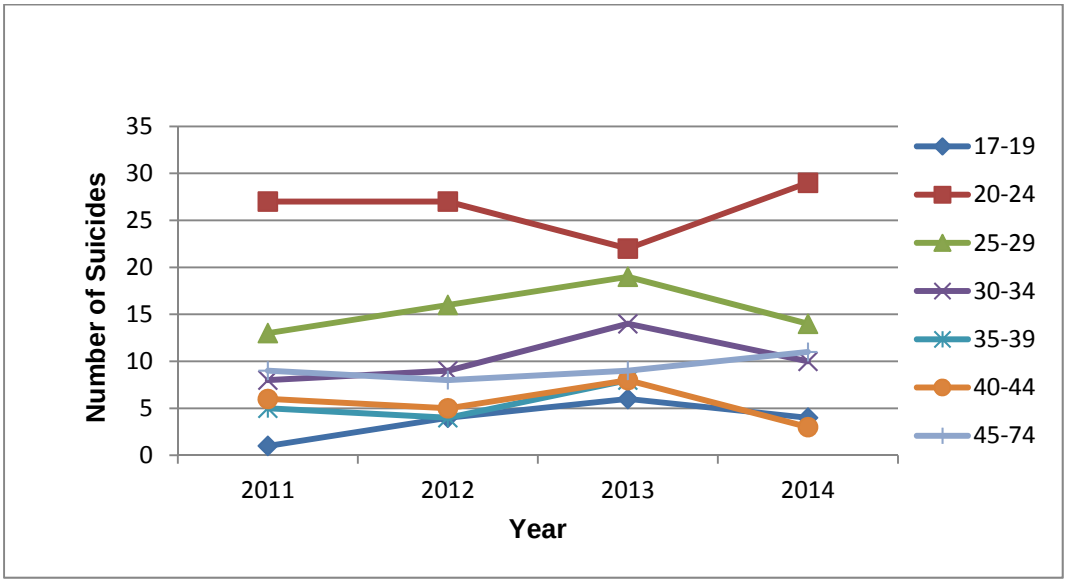

Figure B-6. Reserve Suicide Numbers by Age[280]

Similarly, the 20-24 age group has historically had the highest numbers of suicides in the National Guard, followed by the 25-29 age group.[281] From 2013 to 2014, the numbers of suicides in both of these age groups decreased significantly.[282] Figure B-7 shows the number of suicides in the National Guard Component since 2011.[283]

[277] Ibid.

[278] Ibid.

[279] Since the number of Reserve suicides was too low for a rate to be calculated in DoDSER, raw numbers are provided for reference.

[280] T2, *DoDSER 2014 Annual Report*; and T2, *DoDSER 2010 Annual Report*.

[281] Ibid.

[282] Ibid.

[283] Since the number of National Guard suicides was too low for a rate to be calculated in DoDSER, raw numbers are provided for reference.

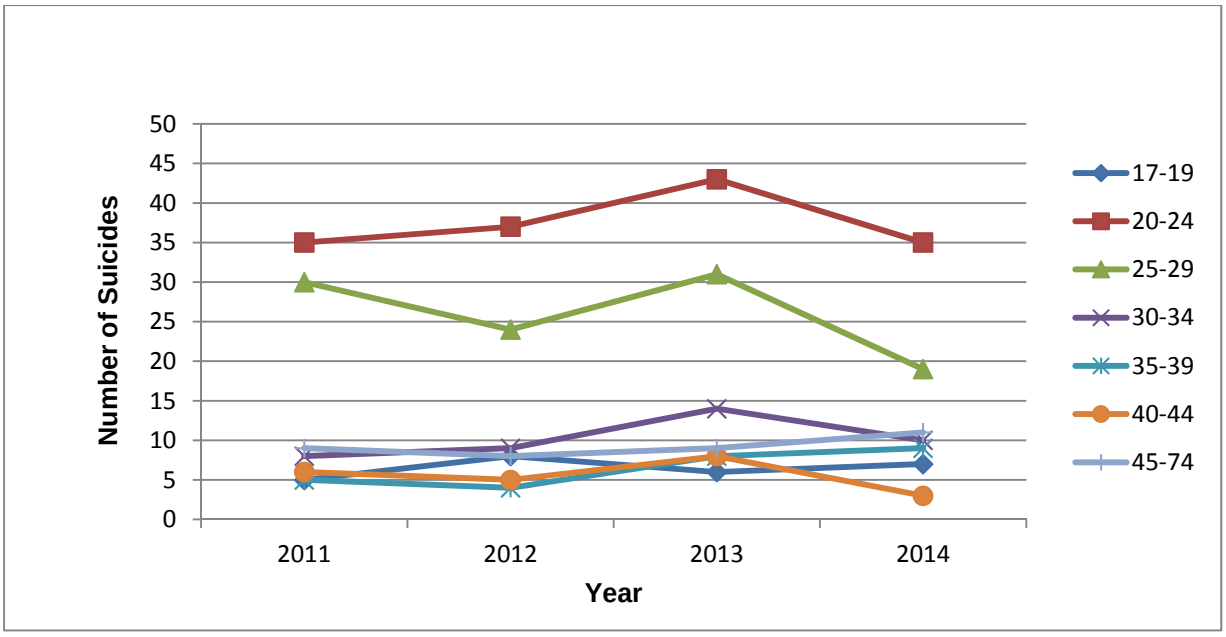

Figure B-7. National Guard Suicide Numbers by Age[284]

C. Active Duty Suicides by Sex

As in the civilian world, males in the Active Duty military die by suicide at a much higher rate than females.[285] While 2013 marked a decrease in male suicide deaths, the rate increased in 2014.[286] Figure B-8 illustrates the suicide rates of military males and females since 2008. Since the number of female military suicides was too low for a rate to be calculated in annual DoDSERs, Figure B-9 shows raw numbers of suicides for reference.

[284] T2, *DoDSER 2014 Annual Report*; and T2, *DoDSER 2010 Annual Report.*

[285] AAS, *U.S.A. Suicide: 2014 Official Final Data*; T2, *DoDSER 2014 Annual Report*; and T2, *DoDSER 2010 Annual Report.*

[286] T2, *DoDSER 2014 Annual Report*; and T2, *DoDSER 2010 Annual Report.*

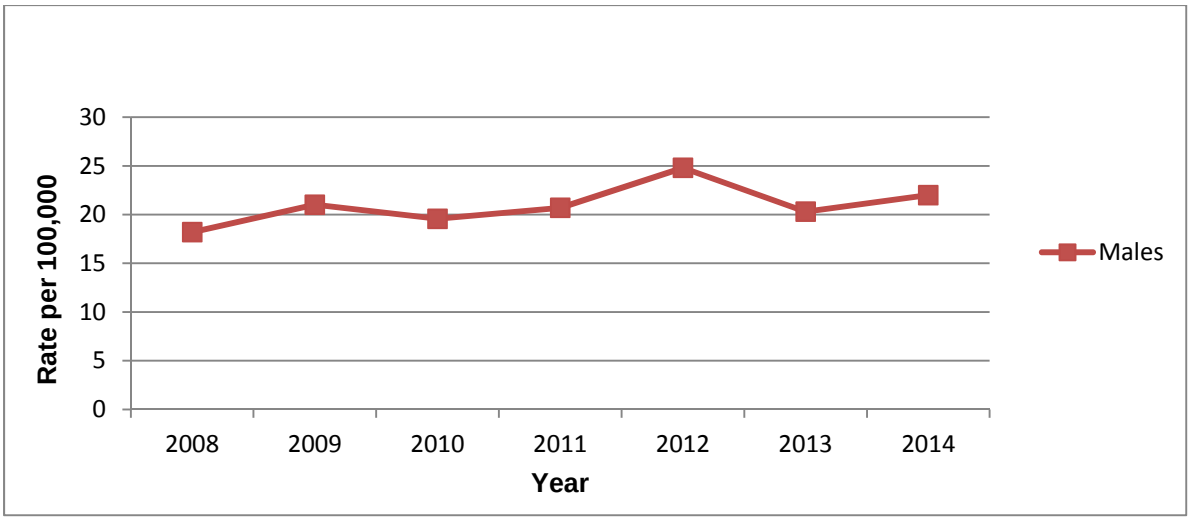

Figure B-8. Active Duty Military Suicide Rates by Sex[287,288]

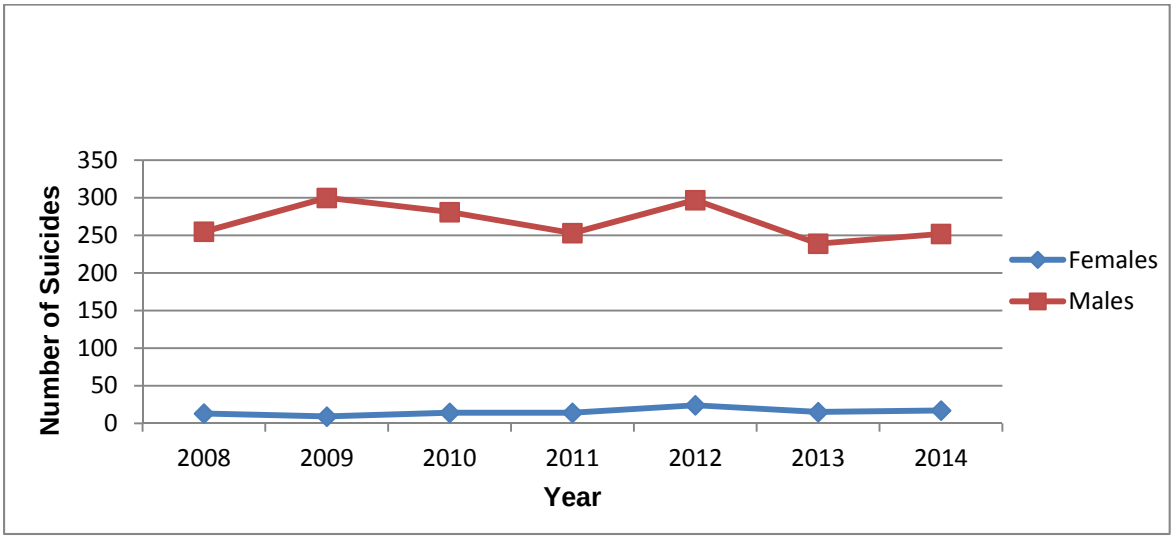

Figure B-9. Active Duty Suicide Numbers by Sex[289]

D. Active Duty Military Suicide Rates by Branch

All branches of the military experienced a drop in suicide rates from 2012 to 2013, and all branches except the Marine Corps experienced an increase in 2014.[290] The branch with the highest Active Duty suicide rate in 2014, at 23.8 per 100,000 people, was the Army.[291] The

[287] Ibid.

[288] The number of female active duty suicides was too low for a rate to be counted.

[289] T2, *DoDSER 2014 Annual Report*; and T2, *DoDSER 2010 Annual Report.*

[290] Ibid.

[291] Ibid.

branch with the lowest rate, at 16.3, was the Navy.[292] Figure B-10 shows the rate of suicide for the Active Component for each branch of the military.

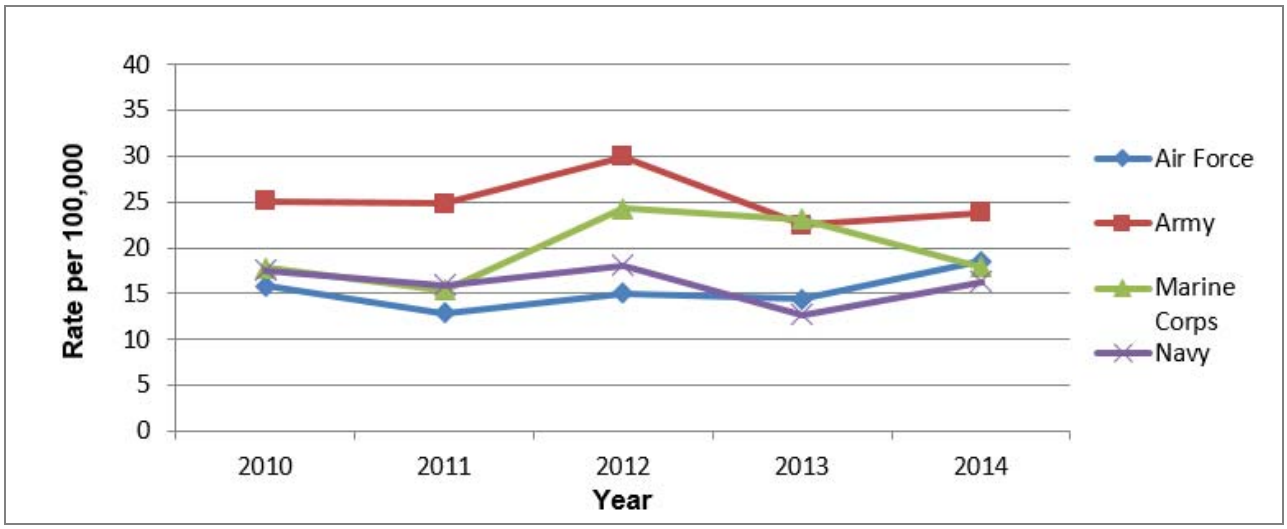

Figure B-10. Military Suicide Rates by Branch (Active Component Only)[293]

E. Army Suicides by Component

Army Reserve and National Guard suicide rates have steadily increased since 2011, when data began to be reported, but dipped significantly in 2014.[294] The Army Active Duty suicide rate increased slightly in 2014.[295] Figure B-11 shows the suicide rates of the Army by Component. Figure B-12, which shows raw numbers of suicides for prior years, is provided for reference.

[292] Ibid.

[293] Ibid.

[294] Ibid.

[295] Ibid.

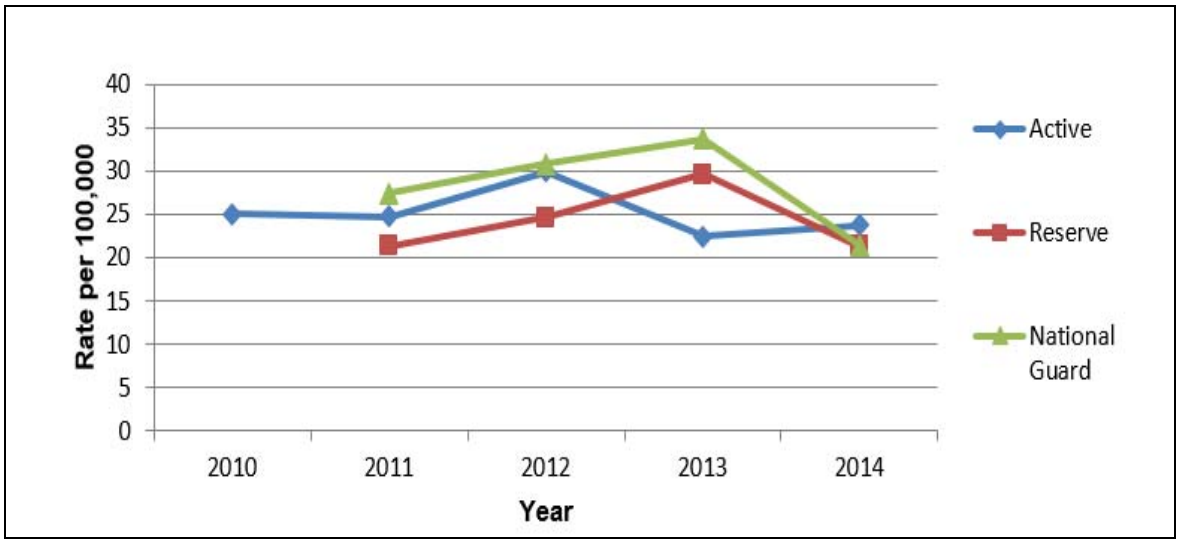

Figure B-11. Army Suicide Rates by Component[296]

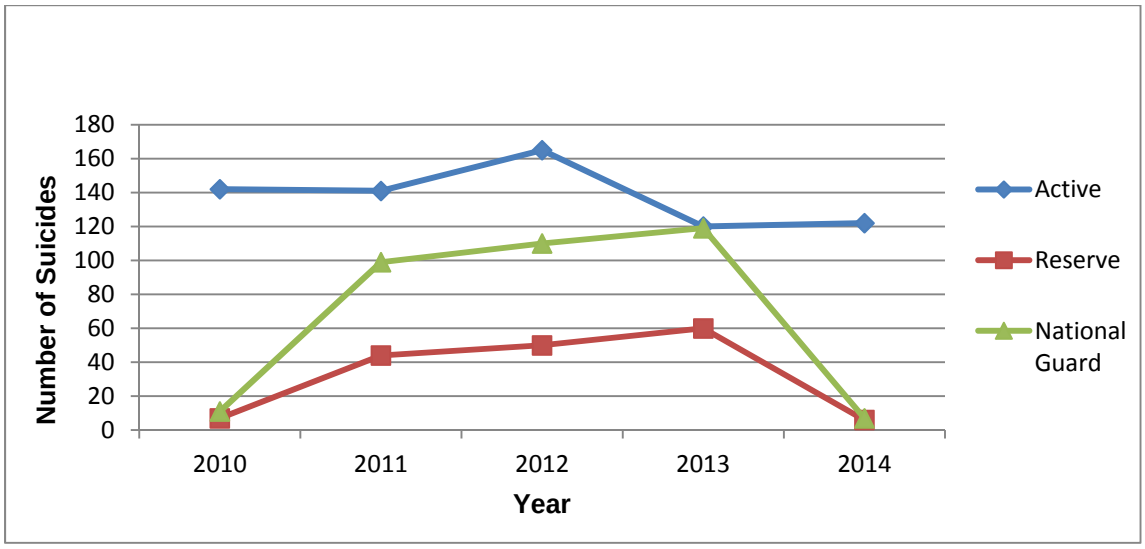

Figure B-12. Army Suicide Numbers by Component[297]

F. Navy Suicides by Component

In 2014, the Active Duty Component of the Navy had the lowest suicide rate of any of the military branches.[298] The Navy Active Duty suicide rate decreased significantly from 2012 to 2013, from a rate of 17.8 to 13.4 per 100,000 people, but climbed to 16.3 in 2014.[299] Figure B-13

[296] Ibid.

[297] Ibid.

[298] Ibid.

[299] Ibid.

shows the suicide rates of the Navy by Component.[300] As the number of Reserve Component suicides was too low for a rate to be calculated in DoDSERs, Figure B-14, which shows raw numbers of suicides, is provided for reference.

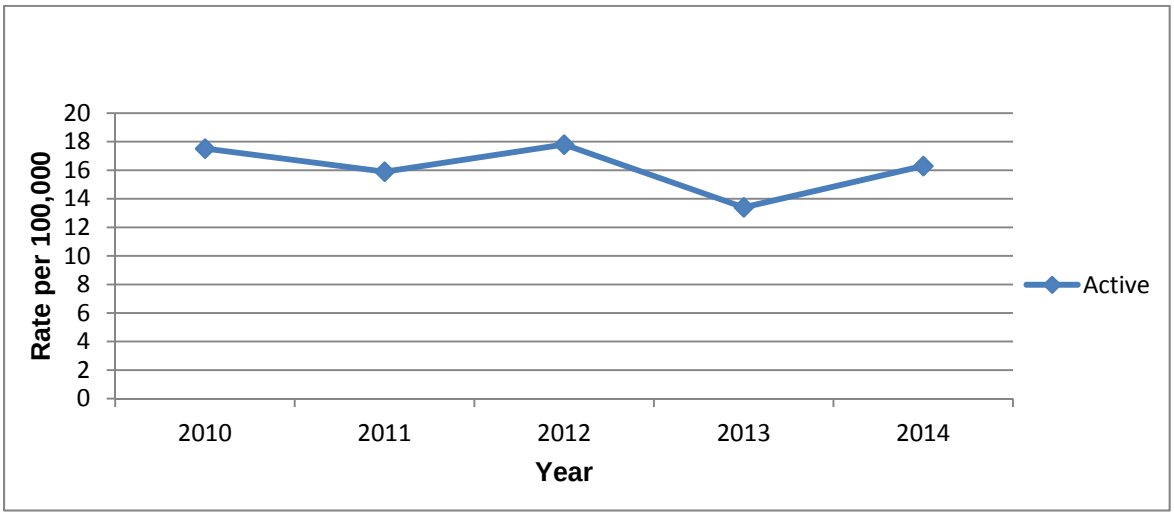

Figure B-13. Navy Suicide Rates by Component[301,302]

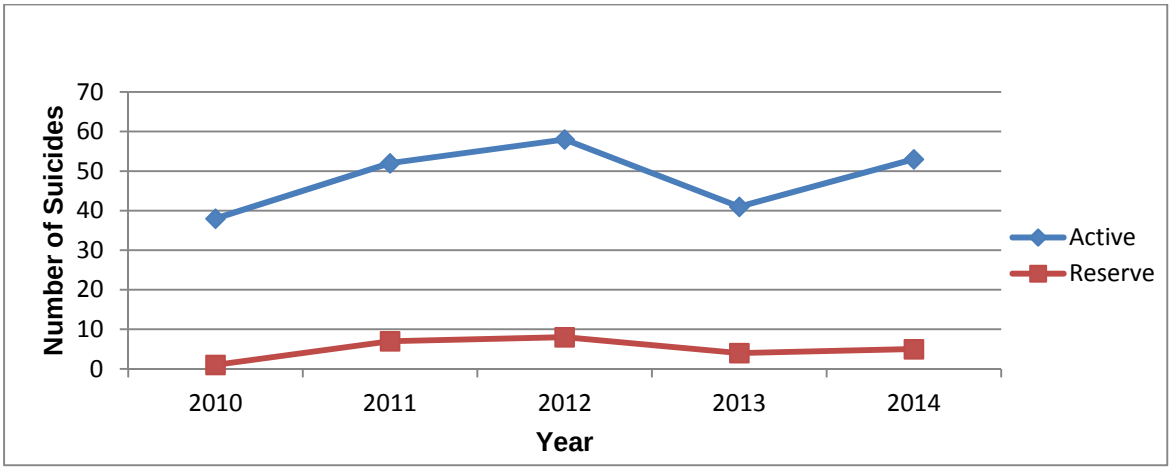

Figure B-14. Navy Suicide Numbers by Component[303]

[300] Note: The Navy does not have a National Guard Component.

[301] T2, *DoDSER 2014 Annual Report*; and T2, *DoDSER 2010 Annual Report.*

[302] The number of Navy Reserve Component suicides was too low for a rate to be calculated in DoDSERs.

[303] T2, *DoDSER 2014 Annual Report*; and T2, *DoDSER 2010 Annual Report.*

G. Air Force Suicides by Component

The Air Force Active Duty suicide rate dipped slightly from 2012 to 2013, but increased in 2014.[304] In 2013, the rate was 14.4 and in 2014, it was 18.5.[305] In 2012, the only year for which the number of Air Force National Guard suicides was high enough to calculate a suicide rate, the National Guard rate was about four points higher than the Active Component at 19.1 and 15.0, respectively.[306] Figure B-15 shows the suicide rates of the Air Force by Component. Since the number of Reserve and National Guard Component suicides was too low for a rate to be calculated in DoDSERs, except in 2012, Figure B-16, which shows raw numbers of suicides, is provided for reference. Numbers of suicides in the Air Force Reserve and National Guard Components were not reported in the 2014 DoDSER Annual Report.

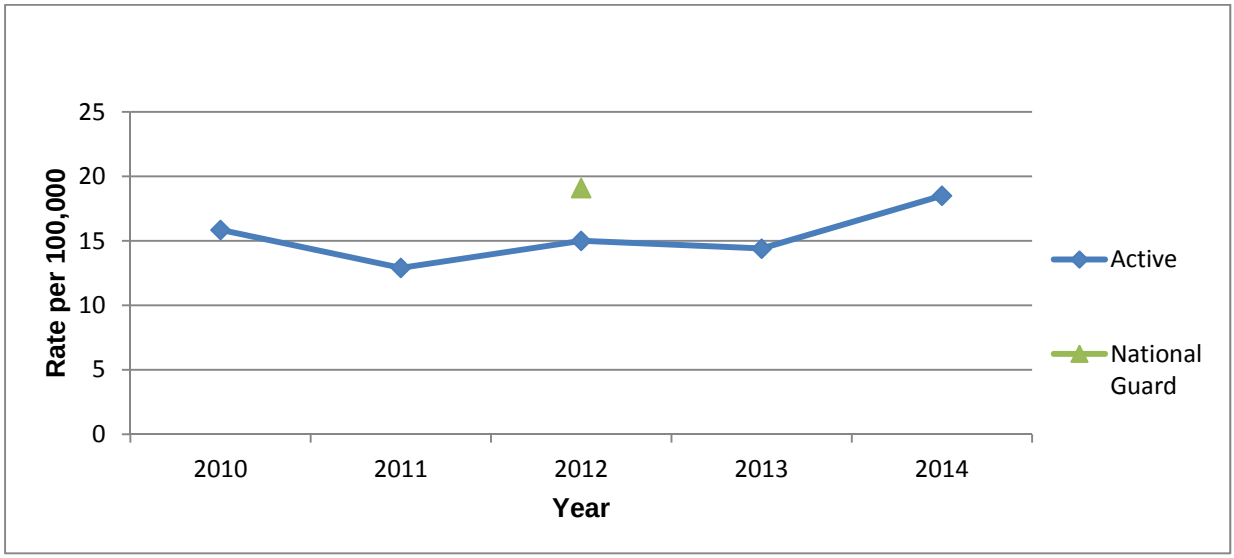

Figure B-15. Air Force Suicide Rates by Component[307,308]

[304] Ibid.

[305] Ibid.

[306] Ibid.

[307] Ibid.

[308] 2012 was the only year for which the number of Air Force National Guard suicides was high enough to calculate a suicide rate.

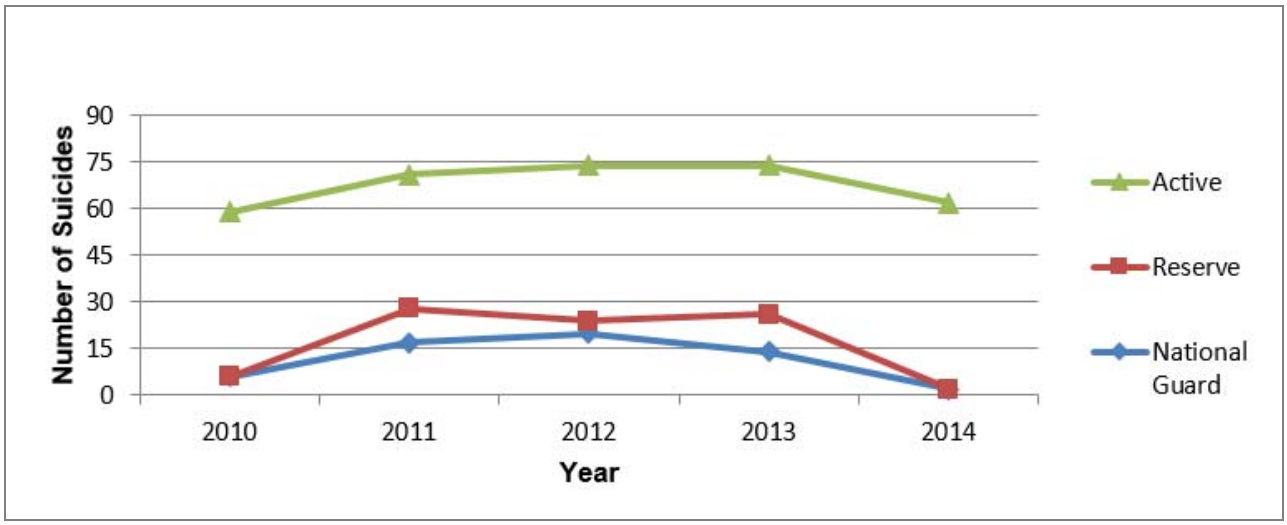

Figure B-16. Air Force Suicide Numbers by Component[309]

H. Marine Corps Suicides by Component

Marine Corps Active Duty suicide rates have decreased since 2012.[310] Figure B-17 shows the suicide rates of the Marine Corps by Component.[311] The number of Marine Reserve suicides was too low for DoDSER to calculate a suicide rate in this population. Figure B-18, which shows raw numbers of suicides, is provided for reference.

[309] T2, *DoDSER 2014 Annual Report*; and T2, *DoDSER 2010 Annual Report.*

[310] Ibid.

[311] Note: The Marine Corps does not have a National Guard Component.

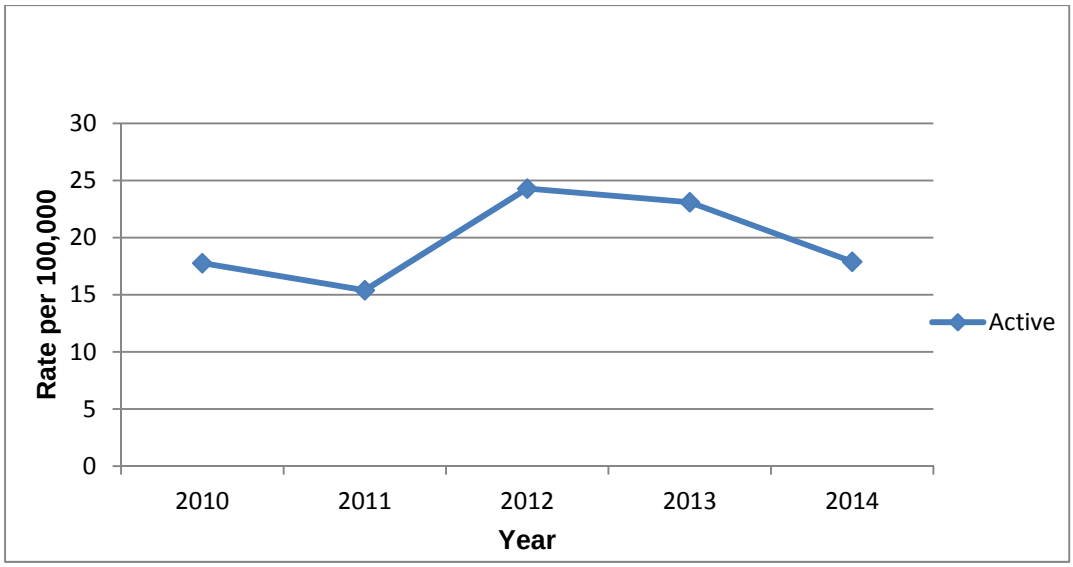

Figure B-17. Marine Corps Suicide Rates by Component[312,313]

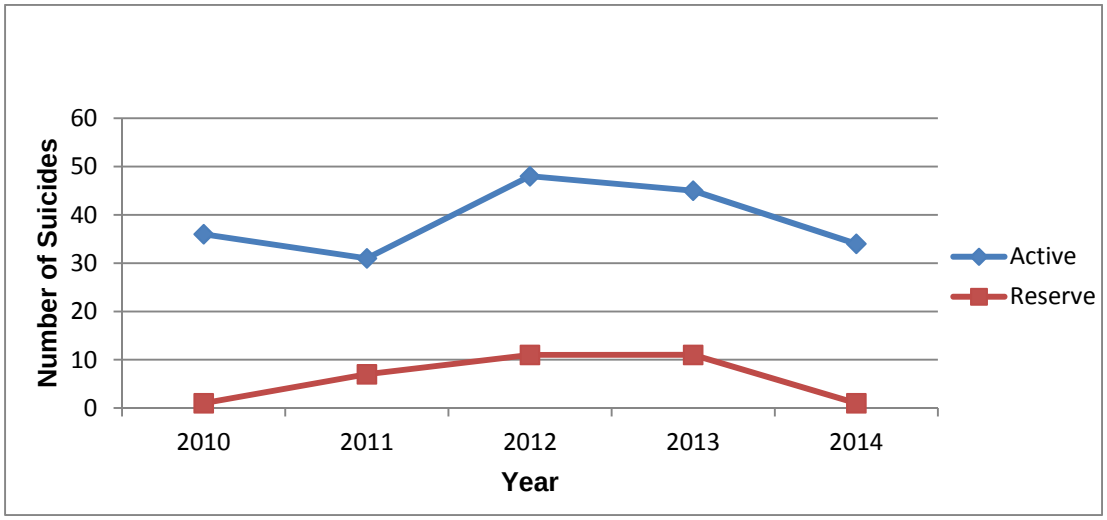

Figure B-18. Marine Corps Suicide Numbers by Component[314]

[312] T2, *DoDSER 2014 Annual Report*; and T2, *DoDSER 2010 Annual Report*.

[313] The number of Marine Reserve suicides was too low for DoDSER to calculate a suicide rate in this population.

[314] T2, *DoDSER 2014 Annual Report*; and T2, *DoDSER 2010 Annual Report*.

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Appendix C.
Interviews

DSPO Interviews

Crowley, William, Director, Research and Assessments

Dorr, Christopher, Data analyst

Franklin, Keita, Director

Hawkins, Malcom, Director, Current Operations

Morales, Walter, Director, Policy

Parisi, George, Deputy Director

Vasquez, Rennie, Director, Plans and Policy Oversight

Walsh, Adam, Director, Research and Program Evaluation

Walsh, Tasanee, Director, Data and Surveillance

Whitis, Dana, Suicide analyst

DOD Stakeholder Interviews

Balocki, Marie, Deputy Director, Marine and Family Programs Division, U.S. Marine Corps

Barnes, Stacey, Director, Service Member and Family Readiness and Director, Psychological Health for Reserve Forces, Office for Reintegration Programs

Bates, Mark, Associate Director, Psychological Health Promotion, Defense Centers of Excellence for Psychological Health and TBI

Burcham, Brigadier General Margaret, Director for Manpower & Personnel, J1, Joint Chiefs of Staff

Burkhardt, Rear Admiral Ann, Director, 21st Century Sailor Office, U.S. Navy

Bush, Nigel, Acting Director, Defense Centers of Excellence, National Center for Telehealth & Technology

Casciotti, John, Associate Deputy Counsel, DOD Office of General Counsel

Cox, Kenneth, Army STARRS LS

Davidson-Wolfe, Yonette, Suicide Prevention Program Manager, U.S Marine Corps

Denton, Brigadier General Ivan, Director, Manpower and Personnel, National Guard Bureau

Dismore, Lieutenant Colonel (LTC) Larry, Chief, Wellness Programs, National Guard Bureau

Edwards, Chief Master Sergeant (CMSgt) Reginald, Senior Enlisted Advisor, Family and Employer Programs and Policy

Elenberg, Captain (CAPT) Kimberly, Operation Live Well, Office of the Executive Director, Force Resiliency

Fedrigo, John, Deputy Assistant Secretary, Reserve Affairs and Airman Readiness, U.S. Air Force

Fisher, CAPT Michael, Director, Suicide Prevention Program, N171 (21st Century Sailor Office), U.S. Navy

Flynn, Cathy, Program Research, Office of Family Readiness Policy, Military Community and Family Policy

Greenberg, Jeff, Suicide Prevention Program office, U.S. Air Force

Guzman, Fernando, Suicide Prevention Program Manager, U.S. Marine Corps Reserves and Director, Embedded Health Prevention Committee

Haldeman, David, Readiness and Transition Directorate, Manpower and Reserve Affairs, Office of the Assistant Secretary of the Navy

Harrell, Margaret, Executive Director, Force Resiliency

Holton, Steve, Suicide Prevention Program Manager, U.S Navy

Huleatt, William, Office of Family Readiness Policy

Knapp, LTC Charles, Office of Manpower & Personnel, J1, Joint Chiefs of Staff

Lane, Randy, Resilience Directorate, U.S. Army

Lasko, Wendy, Suicide Prevention Program Manager, U.S. Army

Linkh, David, Suicide Prevention Program Manager, U.S. Air Force

Love, Linda, Branch Head, Behavioral Health, U.S. Marine Corps

Ludtke, Scott, Project Director, Army STARRS LS

McFarling, Les, Chief of Science and Research Integration, Resilience Directorate, U.S. Army

McGurk, LTC Dennis, Director, Military Operational Medicine Research Program

Miles, Caroline, N171 (21st Century Sailor Office), U.S. Navy

Miller, CAPT Julie, N171 (21st Century Sailor Office), U.S. Navy

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Nadder, Lieutenant Commander (LCDR) John, Readiness and Transition Directorate, Manpower and Reserve Affairs, Office of the Assistant Secretary of the Navy

Nassauer, Katherine, Portfolio Manager, Psychological Health and Resilience, Military Operational Medicine Research Program and Military Suicide Research Consortium

Pinkston, Brian, U.S. Air Force Reserves

Pruitt, Larry, Defense Centers of Excellence, National Center for Telehealth & Technology

Robertson, Katherine, Family Advocacy Program Manager, Office of Family Readiness Policy, Military Community and Family Policy

Rushin, Edward, Resource Management, Sexual Assault Prevention and Response Office

Saunders, Sharyn, Director, U.S. Army G-1/ODCS

Schonberg, David, Suicide Prevention Program Manager, Air National Guard

Schwartz, Rear Admiral Erica, Director, Health, Safety & Work-Life (CG-11), U.S. Coast Guard

Silva, COL Seferino, Medical Forces Advisor to Air Force Surgeon General, U.S. Air Force Reserves

Smith, Jack, Director, Health Services Policy and Oversight, OASD Health Affairs

Stephens, LCDR Sam, Behavioral Health Branch, U.S. Marine Corps

Stock, Audra, Assistant Branch Head, Prevention and Clinical Services, U.S. Marine Corps

Thornquist, Mary, Mental Health Strategic Plan Initiative, Defense Centers of Excellence for Psychological Health and TBI

Thoumaian, CAPT Armen, Deputy Chief for Program Evaluation and Improvement, Defense Centers of Excellence for Psychological Health and TBI

Twiford, Colonel (COL) James, Chief of Staff, Sexual Assault Prevention and Response Office

Ubelhor, Lieutenant Colonel (Lt Col) David, Chief Mental Health Consultant to the Command Surgeon General and Suicide Prevention Program Manager, U.S. Air Force Reserves

Williams, Rosemary, Deputy Assistant Secretary of Defense, Military Community and Family Policy

Non-DOD Stakeholder Interviews

Benson, Jack, National Action Alliance for Suicide Prevention

Kulp, Amy, Interim Executive Director, American Association of Suicidology

McKeon, Richard, Substance Abuse and Mental Health Services Administration

Pearson, Jane, Chair, Suicide Research Consortium, National Institute of Mental Health

Reed, Jerry, Vice President and Director, Center for the Study and Prevention of Injury, Violence, and Suicide, Education Development Center, Inc.

Reger, Mark, University of Washington

Ruocco, Kim, Chief External Relations Officer for Suicide Prevention and Postvention, Tragedy Assistance Program for Survivors

Thompson, Caitlin, National Mental Health Director, Suicide Prevention and Community Engagement, Department of Veteran Affairs

Zeller, Eileen, Center for Mental Health Services, Suicide Prevention Branch, Substance Abuse and Mental Health Services Administration

Appendix D.
DOD Task Force Foundational Recommendations and Implementation Efforts [315]

The following are the foundational recommendations of the DOD Task Force:

1. Create a "Suicide Prevention Policy Division" at OSD within the Undersecretary of Defense for Personnel & Readiness (USD(P&R)) to standardize policies and procedures with respect to resiliency, mental fitness, life skills, and suicide prevention. The office will provide standardization, integration of best practices, and general oversight, serve as a change agent, and establish an ongoing external review group of non-DoD experts to assess progress. Furthermore, this office will provide guidance from which the Services can design and implement their suicide prevention programs.[316] *(Focus Area 1*)
2. Keep suicide prevention programs in the leadership lane and hold leaders accountable at all levels for ensuring a positive command climate that promotes the well-being, total fitness, and "help seeking" of their Service Members. A significant focus on developing better tools to assist commanders in suicide prevention must be undertaken. *(Focus Area 1)*
3. Reduce stress on the force. The pace of operations in today's military exceeds the ability of Service Members to be restored to their optimal state of readiness. There is a supply and demand mismatch that creates a cumulative negative impact on the force. Reduce stress by ensuring the quantity and quality of dwell time allows for individual restoration as the force is reconstituted over and over again. This will allow Service Members to reestablish relationships and connectedness. If necessary, either grow the size of the force to ensure additional uniformed end-strength to meet the demand or reduce the mission demand. *(Focus Area 2)*
4. Focus efforts on Service Member well-being, total fitness (of the mind, body, and spirit), and development of life skills and resiliency to increase protective factors and decrease risk factors. This is the pinnacle of primary prevention. *(Focus Area 2)*
5. Develop a Comprehensive Stigma Reduction Campaign Plan that attacks the issue on multiple fronts to encourage help-seeking behavior and normalizes the care of the "hidden wounds" incurred by Service Members. *(Focus Area 1)*
6. Strengthen strategic messaging to enhance positive communications that generate the behaviors and outcomes desired rather than highlighting the negative messaging about

[315] DOD Task Force, *The Challenge and the Promise*, 47-49.

[316] Ibid., 47.

today's challenges. The focus of messaging must migrate from speaking solely about the "tragedy" of suicide and the "actions" being taken to messages that reduce stigma, encourage help-seeking, portray concerned leadership, and inspire hope by showing that help really works. *(Focus Area 2)*

7. Develop skills-based training in all aspects of training regarding suicide prevention. The current awareness and education efforts about suicide prevention are adequate, but skills-based training is deficient, especially among buddies, family members, first-line supervisors, clergy, and behavioral health personnel. *(Focus Area 2)*
8. Incorporate program evaluation in all suicide prevention programs to determine the effectiveness of each program in obtaining its intended outcome. *(Focus Area 4)*
9. Coordinate and leverage the strengths of installation and local community support services for both Active and Reserve Component Service Members. Community health and access to quality, competent services are essential to suicide prevention. *(Focus Area 3)*
10. Ensure continuity and the management of quality behavioral healthcare, especially while in transition periods, to facilitate a seamless transfer of awareness, management, and treatment as Service Members change locations. Transitions need to be actively managed and tools must be developed to actively manage them. *(Focus Area 3)*
11. Mature and expand the DoDSER to serve as the main surveillance method to inform future suicide prevention efforts. Further standardize data collection processes. Robust surveillance will produce data that allow us to anticipate and avoid future occurrences of that event before the individual or population (or unit) reaches a crisis point. *(Focus Area 4)*
12. Standardize suicide investigations and expand their focus to learn about the last hours, days, and weeks preceding a suicide or attempted suicide. Pattern suicide investigations on aviation accident safety investigation procedures and use the safety investigation process as a model to develop a standardized suicide investigation process. *(Focus Area 4)*
13. Support and fund ongoing DoD suicide prevention research to enhance knowledge and inform future suicide prevention efforts, and to incorporate evidenced-based solutions. Focused research in suicide prevention for Service Members is essential to identifying best practices, decreasing variation in prevention practices, and in achieving desired outcomes. *(Focus Area 4)*

Based on the DOD Task Force's recommendations, OUSD(P&R) developed an implementation plan, reported to Congress in 2011, to guide the DOD suicide prevention

effort.[317] The plan indicated that of the DOD Task Force's 76 recommendations, 36 required new DOD actions; 34 had actions planned, underway, or complete; and the six remaining did not merit any action by DOD.[318] The SPGOSC was then tasked to prioritize and group the 36 recommendations requiring actions.[319] The SPGOSC developed nine priority groups based on the implementation plan; the corresponding Focus Areas are noted in parentheses after each group: [320]

1) Group (G)1 – Issue Policy Directive (*Focus Area 1)*
2) G2 – Increase fidelity of data and data processing (*Focus Area 4)*
3) G3 – Develop a program evaluation process (*Focus Area 4)*
4) G4 – Improve strategic messaging and resilience (*Focus Areas 1, 2)*
5) G5 – Develop means reduction policy (*Focus Area 1, Rec 25)*
6) G6 – Conduct a comprehensive training evaluation (*Focus Areas 2, 4)*
7) G7 – Evaluate access and quality of behavioral health care (*Focus Area 3)*
8) G8 – Review and standardize investigations (*Focus Area 4)*
9) G9 – Develop a comprehensive research strategy (*Focus Area 4)*

Table D-1 highlights the relationship among the DOD Task Force Focus Areas, Foundational Recommendations, Implementation Plan Targeted Recommendations for Action, and Implementation Priority Groups.

[317] Jacqueline Garrick, *Briefing on Defense Suicide Prevention Office Initiatives*, November 18, 2013.

[318] Department of Defense, *Response to Congress on Section 733 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009, Phase 2 Response to Department of Defense Task Force Report on Prevention of Suicide by Members of the Armed Forces*, September 2011, 1.

[319] Defense Suicide Prevention Office, *Annual Report for Fiscal Year 2013*, 9.

[320] Jacqueline Garrick, *Briefing on Defense Suicide Prevention Office Initiatives*, November 18, 2013.

Table D-1. Correlations Among DOD Task Force Report Elements

DOD Task Force Report Focus Area	DOD Task Force Foundational Recommendations	Implementation Plan, DOD Task Force Targeted Recommendations for Action	DOD Task Force Implementation Priority Group (G)
1. Organization and Leadership	1, 2, 6	1-3, 6, 10, 12, 13, 14, 16, 18, 19, 23-25	G1, G4, G5
2. Wellness Enhancement and Training	3, 4, 5, 7	27, 32, 33	G4, G6,
3. Access to, and Delivery of, Quality Care	9, 10	36, 39, 42, 47, 48, 52, 55, 60-64	G7
4. Surveillance, Investigations, and Research	8, 11, 12, 13	67-70, 74-76	G2, G3, G6, G8, G9

Priority Group 1 worked on issuance of a Policy Directive. This was accomplished with the June 2013 release of *DOD Directive (DODD) 6490.14, Defense Suicide Prevention Program,* the first DOD-wide comprehensive policy on suicide prevention. This DODD assigned responsibilities for the Defense Suicide Prevention Program. The directive applies to all DOD Components; describes the responsibilities, governance structures, and functions; and provides standardized definitions. It lays out DSPO's placement within P&R operating under the authority, direction, and control of the DHRA Director, with policy oversight from the Deputy Assistant Secretary of Defense (DASD) Readiness. The directive was updated on April 1, 2016, to reflect an evolution of roles and responsibilities as well as organizational changes within OUSD(P&R). Namely, that P&R had established OEDFR under the direction and control of USD(P&R). Among other areas of responsibility, OEDFR provided policy oversight for DSPO, in lieu of DASD Readiness.[321] The DODD also formally established two governance structures for the overarching DOD program: the SPGOSC and the SPARRC.[322] The SPARRC had existed previously, under the auspices of the Defense Health Agency; with this DODD, it, as well as the SPGOSC, moved under the auspices of DSPO.

Priority Group 2 focused on increasing the fidelity of data and data processing. The primary accomplishment of this group was to improve military suicide rate reporting in two respects: making the military rate calculation consistent with the CDC's methodology and basing the rate on populations by Service Component regardless of duty status. This helped ensure that Reserve and National Guard members (the Reserve Component) were accurately represented along with

[321] As noted, in late 2016, DSPO's reporting structure changed to ASD (Readiness) due to the closing of the OEDFR.

[322] Department of Defense, *DOD Directive 6490.14, Defense Suicide Prevention Program*, June 2013.

Active Duty, including suicides of Reserve and National Guard members who were not on Active Duty orders at the time.[323] These modifications are captured in the March 2014 USD(P&R) Memorandum, "Standardized Department of Defense Suicide Data and Reporting." Additional accomplishments in this realm included DOD publication of quarterly suicide data for all Service Components, DSPO collaboration with the Defense Manpower Data Center and the VA to develop the VA/DOD Suicide Data Repository to inform surveillance of military suicide for longitudinal research, and review and standardization of suicide investigations.[324] DSPO also experimented with a predictive analytics effort, the Wellness Assessment and Risk Nexus (WARN) initiative, borrowing from the Army Study to Assess Risk and Resilience in Service members initiative.

Priority Group 3 focused on development of a program evaluation process. DSPO led an initiative to develop a DOD-wide approach in collaboration with the Services and other stakeholders utilizing a methodology developed by the office of Cost Assessment and Program Evaluation. The group first developed a programmatic definition for a *suicide prevention program* and designated three categories of program types: Level 1: Direct Suicide Prevention; Level 2: Indirect Suicide Prevention; and Level 3: Suicide Prevention Enabler Program. Each of the Service Suicide Prevention Program Managers then mapped suicide prevention programs within a single DOD strategy map to identify gaps and overlaps in programming. Next, DSPO partnered with the Services to develop Measures of Effectiveness to evaluate suicide prevention efforts; the MOE effort is an ongoing initiative. DSPO also engaged in two cost-related program analytic efforts, initially developing an electronic planning, programming, budgeting, and execution tool to track requirements and funding; then, coordinating with the Services to develop a separate cost model for program evaluation.[325]

Priority Group 4 focused on improving strategic messaging and reducing stigma. There were several efforts undertaken to address this goal. DSPO temporarily took over the Vets4Warriors peer-to-peer helpline from the National Guard in 2013, which provided assistance to Active and Reserve members and their families. DSPO also worked with the VA to promote the Military Crisis Line call center, embarking on a "nation-wide help-seeking campaign in FY13 to expand access to the MCL/VCL." DPSO also engaged in a series of outreach events toward this end and continues to do so.[326] Finally, in support of the stigma reduction effort, DSPO initiated a public information campaign to educate Service members on policies that exclude reporting certain types of mental healthcare on the Standard Form (SF)-86, used by the DOD for security clearance applications and renewals.[327]

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[323] DSPO, *Annual Report for Fiscal Year 2013*, 14.

[324] Ibid., 14.

[325] Ibid., 15-16. DSPO has terminated these two cost-related initiatives in its second phase of operations.

[326] Ibid., 18-19.

[327] Ibid., 19.

Priority Group 5 focused on developing a means reduction policy. Based on the data that firearms are the primary method for suicide among Service members, and almost half of the suicides reported in the CY2012 DoDSER involved privately owned firearms, DSPO stood up a Means Reduction Working Group in FY2013 to examine the issue and explore policy options, briefing the SPARRC and SPGOSC on its findings. The Means Reduction Working Group continued to meet in CY2016. One of its deliverables was a checklist of suggestions for commanding officers on processes for voluntarily securing privately owned firearms of at-risk Service members.[328] Another effort DSPO engaged in toward this end was a large-scale distribution of gun locks to military installations in FY2013. More recently, DSPO established contacts to collaborate with the National Rifle Association.[329] DSPO also examined prescription drug misuse in attempted suicides, establishing a working group with the DHA Pharmacy Operations Directorate to explore avenues for reducing inappropriate Service member access, to include DOD implementation of a medication take-back program.[330]

Priority Group 6 focused on a comprehensive training evaluation in order to improve the standardization and fidelity of DOD suicide prevention training. DSPO led a Training Evaluation Working Group which engaged key stakeholders to include the Services and Service member families. The findings of this working group informed development of the Training Competency Framework, suicide prevention training guidance that identifies common core and sub-group competencies.[331]

Priority Group 7 focused on an evaluation of access to and quality of behavioral healthcare. Toward this end, DSPO led working groups with participation of the Services and the Office of the ASD(HA) to examine options to increase access to this care. Actions taken by the Services included placement of behavioral health providers in operational units, enhancement of caregiver mental health training, and policies to improve access to care for all Service members and their families. DSPO-led sub-working groups examined three specific areas in FY2013: embedding providers, enhancing the care continuum for Service member transitions, and metrics for quality of and access to care. [332]

Priority Group 8 focused on reviewing and standardizing investigations to better incorporate suicide-related information. Toward this end, DSPO led working groups to evaluate the suicide data collection processes for death investigations and to define what is collected in psychological autopsies.[333]

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[328] DSPO website, *Suggested Actions for Commanding Officers*, http://www.dspo.mil/Portals/113/Documents/Suggested-Actions-for-COs.pdf.

[329] See Appendix E for a schematic of recent Means Safety Working Group translation initiatives.

[330] DSPO, *Annual Report for Fiscal Year 2013*, 21-22.

[331] Ibid., 24-25; DSPO interview, September 28, 2015.

[332] DSPO, *Annual Report for Fiscal Year 2013*, 25.

[333] Ibid., 27.

Priority Group 9 focused on development of a comprehensive research strategy for military suicide prevention. Toward this end, DSPO stood up a Research Working Group in partnership with RAND and the Military Suicide Research Consortium to: 1) Inventory DOD suicide prevention research aligned to the NSSP, as well as metrics for evaluating research; and 2) Identify the research studies that can be translated into improving military suicide prevention as part of the Translation and Implementation of Evaluation and Research Studies framework.[334] Following that effort, DSPO's research strategy development efforts drew on RAND's recommendations on research gaps/priorities, the Military Operational Medicine Research Program's National Action Plan, and the NAASP's Research Prioritization Plan.[335] Most recently, in the 2015-2016 timeframe, DSPO led the collaborative effort with key stakeholders to develop the DSSP and, subsequently, held a Research Summit to develop priorities for a DOD Research Action Plan in support of the DSSP's Goal 12 "Promote and support Department of Defense research and suicide prevention" and its affiliated objectives.[336] DSPO also developed the Defense Suicide Prevention Research Analysis Tool to catalog military, Federal, and non-Federal research on suicide prevention related to the military. The topic of suicide prevention research is addressed in greater detail in Chapter 6 of this report.

[334] DSPO, *Annual Report for Fiscal Year 2012*, 23; and DSPO, *Annual Report for Fiscal Year 2013*, 28.

[335] DSPO, *Annual Report for Fiscal Year 2013*, 29.

[336] In particular, objective "12.1 Develop and periodically update the DOD Suicide Prevention Research Agenda with comprehensive input from relevant national and DOD stakeholders." *Department of Defense Strategy for Suicide Prevention* (Washington, D.C.: DOD, December 2015), 3.3.

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Appendix E.
Survey Questions and Metrics

Table E-1. DEOCS DSPO-Specific Questions

Question Number	Question Text	Question Type
1	**These days, I think I am a burden on people in my life**	6-level Likert item
2	**These days, I feel like I belong**	6-level Likert item
3	**These days, I feel that there are people I can turn to in times of need**	6-level Likert item
4	**My future seems dark to me**	6-level Likert item
5	**I know someone in my unit who has thought of, attempted, or died by suicide**	Yes/No

Table E-2. SOFS-A DSPO-Specific Questions

Question Number	Question Text	Question Type
82	**Please indicate your level of agreement with the following statement: the suicide prevention training I received in the past 12 months was effective in preparing me to handle a possible suicide prevention situation**	5-level Likert item with N/A option
83	**How much do you agree or disagree with each of the following statements:**	5-level Likert item
a	I have the necessary knowledge of risk factors and behaviors to determine whether a person I work with is in need of help	
b	I have the skills and abilities to take appropriate action if a person I work with is in need of help	
84	**How much do you agree or disagree with each of the following statements? Individuals who need mental health care (e.g., for depression, suicidal thoughts, addiction) would <u>not</u> seek help because of…**	5-level Likert item
a	Negative impact to career or progress	

b	Loss of privacy/confidentiality	
c	Fear of being perceived as “broken” by a chain of command or peers	
d	Lack of confidence in the resources available to solve their problems	
e	Lack of confidence in the chain of command	
f	Not knowing who to turn to	
g	Other	
85	**How much do you agree or disagree with each of the following statements?**	5-level Likert item
a	I tend to bounce back quickly after hard times	
b	I have a hard time making it through stressful events	
c	It does not take me long to recover from a stressful event	
d	It is hard for me to snap back when something bad happens	
e	I usually come through difficult times with little trouble	
f	I tend to take a long time to get over set-backs in my life	
86	**What is your level of awareness of each of the following support services?**	Degree of familiarity and use
a	Military Crisis Line	
b	Veterans Crisis Line	
c	National Suicide Prevention Hotline	
d	Military OneSource	
e	Military & Family Life Counseling Program	
f	DSTRESS Line	
87	**How much do you agree or disagree with the following statement? In the past 12 months, I have been aware of military suicide prevention campaigns (e.g., posters, websites, public service announcements, advertisements).**	5-level Likert item
88	**Which level of messaging would be <u>most</u> effective in presenting the suicide prevention message for each of the following?**	5-level Likert item
a	Posters in work areas	
b	Posters on local military installations	
c	Posters in common areas	
d	Online articles	

e	Newspapers, other than online	
f	Social media	
g	Television	
h	Movies	
89	**Have you ever in your life had thoughts of actually killing yourself?**	Yes/No
90	**[if Question 89 = "yes"] Have you ever in your life had thoughts of actually killing yourself during the following periods?**	Yes/No
a	Before joining the military	
b	Since joining the military	
c	Within the past 12 months	
d	Within 6 months before leaving for a deployment or another mission	
e	During a deployment or another mission	
f	Within 6 months after returning from a deployment or other mission	
91	**[if Question 90 (b), (e), (f) = "yes"] Going back to the time when you thought about killing yourself since joining the military, have you ever thought about how you might actually do it (e.g., taking pills, shooting yourself) or worked out a plan of how to kill yourself?**	Yes/No
92	**[if Question 91 = "yes"] Have you ever in your life made a suicide attempt (e.g., purposely hurt yourself with at least some intention to die)?**	Yes/No
93	**[if Question 92 = "yes"] Did you make a suicide attempt during the following periods?**	Yes/No
a	Before joining the military	
b	Since joining the military	
c	Within the past 12 months	
d	Within 6 months before leaving for a deployment or another mission	
e	During a deployment or another mission	
f	Within 6 months after returning from a deployment or other mission	
94	**[if Question 93 (e), (f) = "yes"] Since joining the military, have you ever talked to anyone about your thoughts or attempts to kill yourself?**	Yes/No, but considered it/No
95	**[if Question 94 = "yes"] Who did you**	Mark all that apply

	talk to about these thoughts or actions?	
	Spouse or significant other	
	Parent or parental figure	
	Sibling	
	Family member other than a spouse, significant other, parent, parental figure, or sibling	
	Friend who is not in the military	
	Military friend not in my chain of command	
	Someone in my chain of command	
	Mental health professional at a military facility (e.g., psychologist, psychiatrist, clinical social worker, other mental health counselor)	
	Civilian mental health professional at a civilian medical facility (e.g., psychologist, psychiatrist, clinical social worker, other mental health counselor)	
	General medical doctor at a military facility	
	General medical doctor at a civilian facility	
	Chaplain, pastor, rabbi, or other spiritual counselor	
	Someone at a military-run suicide helpline (e.g., Veterans Crisis Line, Military Crisis Line, Military OneSource)	
	Someone at a civilian-run suicide helpline (e.g., National Suicide Prevention Lifeline, 1-800-SUICIDE)	
	Some other individual/resource not listed above	
96	**[if Question 94 = "no, but I considered talking to someone"] If you were to talk with someone about these thoughts or actions, who would you talk to?**	Mark all that apply; same 15 options as Question 95
97	**[if Question 94 = "no"] You indicated that you did not talk to someone about your thoughts or attempts to kill yourself, why did you choose not to talk to anyone?**	Mark all that apply
	I did not know where to get help	
	I did not trust mental health professionals	
	It was difficult to arrange the time to talk to someone (e.g., child care issues, could not get time off from work)	
	I was concerned it would cost too much	

	money
	I was embarrassed
	I was concerned it might impact my security clearance now or in the future
	I thought my coworkers and/or superiors would have less confidence in my if they found out
	I was concerned it would negatively affect my career
	I thought my friends and family would have less respect for me if they found out
	I did not think my treatment would be kept confidential
	I was concerned that any prescribed medications would have too many side effects
	I would think less of myself if I could not handle it on my own
	I received treatment or therapy previously and did not think it was effective
	I did not want anyone to interfere

Table E-3. DSPO-Identified Metrics

Suicide Prevention Staffing Level	The proportion of suicide prevention positions that are staffed as determined by the Service's own criteria and requirements.
DOD Media Quality	Measure DOD media compliance with established evidence-based safe reporting guidelines on suicide. Event scoring is currently based on media professional guidelines established by the World Health Organization jointly with the International Association for Suicide Prevention.
DOD Media Quantity	Monitor the volume of DOD media articles published about DOD suicide events and DOD suicide prevention.
Universal Training Level	The proportion of the force that has received its required annual suicide prevention training.
Public Media Quality	For DOD suicide articles, measure public media compliance with established evidence-based safe reporting guidelines on suicide.
Public Media Quantity	Monitor the volume of public media articles published about DOD suicide events and DOD suicide prevention.
Hospitalization Activity	Measure of the volume of hospitalizations

	resulting from suicide attempts to identify high activity areas that may need targeted prevention services.
Counseling Client Volume	Measure of DOD service population use of non-medical services related to suicide prevention. The number of service-hours provided in the measure period by type of service (Military OneSource, MFLC, MCL).
Mental Health Patient Volume	Measure of DOD service population use of medical services related to mental health.
Means Lethality	Measure of the degree of danger to life of each method of suicide.
Personal Firearms Use	Measure of the propensity of suicide attempters to choose firearms as a means of suicide. The idea is that a decrease in firearm use will result in a decrease in deaths by suicide.
Chaplain Staffing Level	The proportion of chaplain billets that are staffed as determined by the Service's own criteria and requirements.
Chaplain Training Level	The proportion of chaplains that have received specialized training as determined by the Service's own criteria and requirements. Specialized training may include Applied Suicide Intervention Skills Training (ASIST) or other gatekeeper training requirements above the universal training requirement.
Postvention Performance Index	Measure of the statistical evidence indicating the presence of suicide clusters.
Data Submission Quality	Measure of the timely availability and completeness of surveillance data.
Research Translation Index	Measure of the output of recently completed DOD suicide research studies based on peer review publishing, piloting of a new activity, and translatability to a suicide prevention program or policy.
Program Evaluation Activity Index	Measure of the extent to which the Services' suicide prevention programs are evidence-informed.

Appendix F.
Organizations in the Suicide Prevention Research Arena

A. American Association of Suicidology

The American Association of Suicidology (AAS), led by interim Executive Director Amy Kulp, is a non-profit membership organization "to promote the understanding and prevention of suicide and support those who have been affected by it."[337] AAS' mission includes advancing "suicidology as a science; encouraging, developing, and disseminating scholarly work in suicidology"; and "promot[ing] research and training in suicidology."[338]

AAS has received Federal grant funding from SAMHSA, the Federal Railroad Administration (FRA), the Federal Transit Administration (FTA), and DSPO.[339]

In its undertakings with DOD, AAS has worked with almost every branch of the military.[340] It has: helped the Services develop suicide prevention programs, developed suicide prevention training, conducted suicide autopsies, and trained Services on how to conduct autopsies.[341] Currently, AAS, in partnership with DSPO and the University of Utah National Center for Veterans Studies, is providing free suicide prevention training webinars for mental healthcare providers and Service members and families.[342] AAS began developing these webinars after responding to an RFP and winning a contract from DSPO to conduct a project on education, training, and marketing for the Reserves and National Guard.[343]

B. American Foundation for Suicide Prevention

Led by Chief Executive Officer (CEO) Robert Gebbia, the American Foundation for Suicide Prevention (AFSP) is, according to its website, the largest private funder of suicide prevention research.[344] AFSP's main funding appears to come from private donations, although it is not clear from its website or other materials if this is the sole source of the organization's funding.

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[337] American Association of Suicidology (AAS), *Our Mission*, http://www.suicidology.org/about-aas/mission.

[338] Ibid.

[339] Non-DOD stakeholder interview, February 10, 2016.

[340] Ibid.

[341] Ibid.

[342] US Military Matters, http://usmilitarymatters.org.

[343] Non-DOD stakeholder interview, February 10, 2016.

[344] American Foundation for Suicide Prevention (AFSP), *Research*, https://afsp.org/our-work/research.

AFSP's purpose is to raise awareness, fund scientific research, and provide resources and aid to those affected by suicide.[345] It is committed to finding better ways to prevent suicide, creating a culture that is smart about mental health, and bringing hope to those affected by suicide.[346]

The AFSP suicide research priority areas are defined every two years.[347] The suicide research priority areas for 2014-2016 include the high risk period following discharge from an inpatient hospital or emergency department and assessment and/or intervention in primary care settings.[348] AFSP also encourages applications that address the priorities set forth by the NAASP Research Prioritization Task Force (RPTF), discussed in this Appendix.[349]

C. Army Study to Assess Risk and Resilience in Service members Longitudinal Study

The Army STARRS LS is led by co-principal investigators Dr. Robert Ursano, Uniformed Services University of the Health Sciences, and Dr. Murray Stein, University of California, San Diego.[350]

Army STARRS LS is funded by DOD, the Army, NIMH, and DHA.[351]

The focus of the Army STARRS LS is on risk reduction and resilience-building for suicide, suicide-related behavior, and other mental/behavioral issues in the military.[352] It was "designed to include longitudinal follow-up studies of more than 72,000 Soldiers who participated" in the original Army STARRS project.[353] The study aims to "produce further actionable findings and enable data- and science-based answers for the questions of health, resilience, and manpower management of the Army of the future."[354]

D. Congressionally Directed Medical Research Programs

The Congressionally Directed Medical Research Programs (CDMRP) is a DOD-funded program created to "foster novel approaches to biomedical research in response to the expressed

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345 AFSP, *About AFSP*, http://afsp.org/about-afsp.

346 AFSP, *Our Work*, http://afsp.org/our-work.

347 AFSP, *Grant Information*, http://afsp.org/our-work/research/grant-information.

348 Ibid.

349 Ibid.

350 Army Study to Assess Risk and Resilience in Service members Longitudinal Study (Army STARRS LS), http://starrs-ls.org/#/.

351 DOD stakeholder interview, December 10, 2015.

352 Army STARRS, *About*, http://starrs-ls.org/#/about.

353 Ibid.

354 Ibid.

needs of its stakeholders — the American public, the military, and Congress."[355] It funds "the full pipeline of research development, including basic, translational, and clinical research."[356] According to its website, the CDMRP invests in groundbreaking research, targets critical gaps, reviews grant applications, involves consumer advocates throughout the program cycle, supports the next generation of researchers and scientists, and fosters collaboration and synergy.[357]

CDMRP is funded through DOD via annual Defense Appropriations Acts.[358]

The CDMRP has Defense Medical Research and Development and Psychological Health/Traumatic Brain Injury research programs, but its research is not specifically focused on or dedicated to suicide.[359] The CDMRP funds the MOMRP Joint Program Committee (JPC) for Psychological Health, Mild Traumatic Brain Injury, and Suicide Prevention and Counseling Research, as described further in section A.3.f."[360]

E. Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury National Center for Telehealth & Technology

The National Center for Telehealth & Technology (T2), led by Dr. Brian Grady, is a component center of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE).[361] DCoE T2's mission is "to lead the innovation of health technology solutions for psychological health and traumatic brain injury, and deliver tested, valued health solutions that improve the lives of our nation's warriors, veterans, and their families."[362]

DCoE T2 is funded by the DHA.[363] Additionally, research projects conducted by T2 "have been competitively funded by CDMRP and the Telemedicine and Advanced Technologies Research Center (TATRC)."[364] DCoE T2's research spans many topics, including:

- Use of virtual reality in clinical practice
- Detection of suicide risk factors

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[355] Congressionally Directed Medical Research Programs (CDMRP), *About Us*, http://cdmrp.army.mil/aboutus.shtml.

[356] Ibid.

[357] Ibid.

[358] CDMRP, *About Us: Funding Process*, http://cdmrp.army.mil/about/fundingprocess.shtml.

[359] CDMRP, *Defense Medical Research and Development*, http://cdmrp.army.mil/dmrdp/default.shtml; and CDMRP, *Psychological Health/Traumatic Brain Injury*, http://cdmrp.army.mil/phtbi/default.shtml.

[360] CDMRP, *Psychological Health/Traumatic Brain Injury*, http://cdmrp.army.mil/phtbi/default.shtml.

[361] Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) National Center for Telehealth & Technology (T2), *Leadership*, http://t2health.dcoe.mil/about-leadership; and DCoE T2, *About T2*, http://t2health.dcoe.mil/about.html.

[362] DCoE T2, http://t2health.dcoe.mil/.

[363] DCoE T2, *About T2*, http://t2health.dcoe.mil/about.html.

[364] DCoE T2, *T2 Research*, http://t2health.dcoe.mil/research.html.

- Impact of deployment on psychological health
- Use of technology to improve health outcomes
- Service member assessments of technology-based approaches to care[365]

Additionally, one of DCoE T2's key lines of effort is the development of mobile applications to "support 24/7 access to behavioral health tools and critical support systems."[366] These mobile apps are frequently piloted in a small population before being rolled out large-scale and, thus, also make up part of DCoE T2's research portfolio.

F. Military Operational Medicine Research Program

The Military Operational Medicine Research Program (MOMRP), a U.S. Army Medical Research and Materiel Command (USAMRMC) research program, is led by Captain (CAPT) Doug Forcino, U.S. Navy.[367] MOMRP's portfolio covers "four main areas: injury prevention and reduction, psychological health and resilience, physiological health, and environmental health and protection."[368] Per MOMRP's website, "MOMRP Psychological Health and Resilience research is focused on prevention, treatment, and recovery of Soldiers and Families behavioral health which are critical to force health and readiness."[369] Topics addressed by the MOMRP Psychological Health and Resilience research component include suicide, post-traumatic stress disorder, family separation, and family violence.[370]

MOMRP is funded by DHA and the Assistant Secretary of the Army, Acquisition, Logistics, and Technology (ASA(ALT)).[371] MOMRP funds research solely through RDT&E funds.[372]

Two possible distinctions exist to delineate the responsibilities of MOMRP and DSPO. First, some stakeholders see the type of funding of each office as a dividing line between their portfolios of research. While MOMRP is funded solely through RDT&E funds, DSPO is funded solely through O&M funds. The other potential distinction between the research portfolios of DSPO and MOMRP is the focus of the research funded and facilitated by each office. An employee at DSPO, who is well versed in the suicide prevention research field, described DSPO

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[365] Ibid.

[366] DCoE T2, *T2 Programs Overview*, http://t2health.dcoe.mil/programs.html.

[367] Jane Pearson, Katherine Nassauer, and Lisa Brenner, *Multiple Approaches to Measuring Suicide Research Progress: Updates from the National Research Action Plan & The Prioritized Suicide Research Agenda Portfolio Analyses*, Briefing at the AAS 2014 Conference, 32.

[368] Military Operational Medicine Research Program (MOMRP), https://momrp.amedd.army.mil/.

[369] MOMRP, *Psychological Health and Resilience*, https://momrp.amedd.army.mil/psych.html.

[370] Ibid.

[371] DOD stakeholder interview, December 16, 2015.

[372] Ibid.

as being more focused on public health, community-based interventions, and universal aspects of training, while MOMRP is more focused on the clinical aspects of research.[373]

G. Military Suicide Research Consortium

The Military Suicide Research Consortium (MSRC) is led by Dr. Thomas Joiner, Florida State University, and Dr. Peter Gutierrez, Rocky Mountain Mental Illness Research, Education and Clinical Centers (MIRECC) for Suicide Prevention.[374] The MSRC is funded by DHA and managed by MOMRP.[375] It is part of an ongoing effort to integrate and synchronize DOD and civilian efforts to implement a multidisciplinary research approach to suicide prevention.[376]

- MSRC is currently funding studies on the following topics:
- Stress and suicide
- Group therapy for suicidal veterans
- Predicting suicide risk in a military population
- Improving marriages to decrease suicide risk
- Improving inpatient-to-outpatient transition
- Behavioral sleep intervention for prevention of suicidal behaviors in veterans
- Anger reduction treatment to reduce suicide risk
- Improved Virtual Hope Box
- Suicide warning signs
- Suicide bereavement in veterans and military families
- Brain imaging to study suicide risk
- Taxometric investigation of suicide
- Military continuity project
- Window to hope
- Brief intervention for short-term suicide risk reduction in military populations
- Preventing suicide by decreasing anxiety and improving mood
- Looking for cognitive differences in suicidal veterans

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[373] DSPO interview, January 8, 2016.

[374] Military Suicide Research Consortium (MSRC), *About the Military Suicide Research Consortium*, https://msrc.fsu.edu/about-msrc.

[375] Ibid.

[376] MSRC, https://msrc.fsu.edu.

- Toward a gold standard for suicide risk assessment for military personnel[377]

H. National Action Alliance for Suicide Prevention

The National Action Alliance for Suicide Prevention (NAASP), co-chaired by Robert Turner, Union Pacific Corporation, and Dr. Carolyn Clancy, VA, is a public-private partnership advancing the NSSP.[378] Of the NAASP's 10 task forces, one is focused on research prioritization and another is focused on military and veterans.[379] The Secretariat of the NAASP is located at the Education Development Center, Inc. (EDC).[380]

NAASP is funded by the Department of Health and Human Services (HHS) SAMHSA.[381]

In 2014, the NAASP RPTF released a document outlining the research areas that showed the most promise in helping to reduce the rates of suicide attempts and deaths in the next five-to-ten years.[382] The NAASP defined its research priorities in this report in terms of six questions and 12 aspirational goals. These questions and goals are discussed in further detail in Appendix I. Additionally, the RPTF is discussed in more detail in Appendix G.

I. Suicide Prevention Resource Center

The Suicide Prevention Resource Center (SPRC), led by Dr. Jerry Reed, EDC, is "the nation's only federally supported resource center devoted to advancing the NSSP."[383] The SPRC provides "technical assistance, training, and materials to increase the knowledge and expertise of suicide prevention practitioners and other professionals serving people at risk for suicide."[384] It also seeks to "promote collaboration among a variety of organizations that play a role in developing the field of suicide prevention."[385]

Funded by HHS SAMHSA, SPRC is located at EDC.[386]

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[377] MSRC, *Funded Research Projects*, https://msrc.fsu.edu/funded-research.

[378] National Action Alliance for Suicide Prevention (NAASP), *About Us*, http://actionallianceforsuicideprevention.org/about-us.

[379] NAASP, *Overview of Action Alliance Task Forces*, http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/TF-overview-chart-ROI-2014-10-24.pdf.

[380] NAASP, *Secretariat Staff*, http://actionallianceforsuicideprevention.org/staff.

[381] NAASP, *About Us*, http://actionallianceforsuicideprevention.org/about-us.

[382] NAASP, *Research Prioritization*, http://actionallianceforsuicideprevention.org/task-force/research-prioritization.

[383] Suicide Prevention Resource Center (SPRC), *About SPRC*, http://www.sprc.org/about_sprc.

[384] Ibid.

[385] Ibid.

[386] Ibid.

The SPRC maintains a BPR and provides technical assistance, training, and materials to researchers in the suicide prevention arena.[387] The BPR is discussed in more detail in Appendix H.

J. Veterans Integrated Service Network 19: Rocky Mountain Mental Illness Research, Education and Clinical Centers for Suicide Prevention

Mental Illness Research, Education and Clinical Centers (MIRECC) were "established by Congress with the goal of researching the causes and treatments of mental disorders and using education to put new knowledge into routine clinical practice in the VA."[388] The Veterans Integrated Service Network (VISN) 19: Rocky Mountain MIRECC for Suicide Prevention, led by Dr. Lisa Brenner, is a VA MIRECC with the mission "to study suicide with the goal of reducing suicidal ideation and behaviors in the Veteran population."[389] To achieve this, the work of the Rocky Mountain MIRECC is focused on "promising clinical interventions, as well as the cognitive and neurobiological underpinnings of suicidal thoughts and behaviors that may lead to innovative prevention strategies."[390]

VA's Mental Health Services is the principal funder of the Rocky Mountain MIRECC.[391]

The Rocky Mountain MIRECC categorizes its research on a continuum from "understand" to "screening and assessment" to "treatment."[392] Figure F-1 shows the research continuum developed and used by the Rocky Mountain MIRECC as depicted on its website.

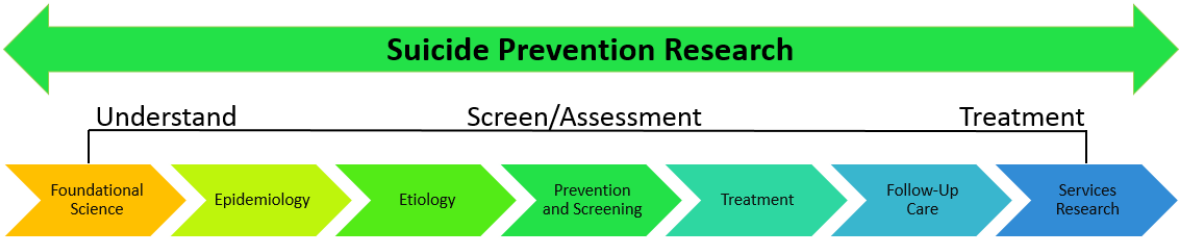

Figure F-1. Rocky Mountain MIRECC Research Continuum[393]

[387] SPRC, *Best Practices Registry*, http://www.sprc.org/bpr.

[388] Department of Veterans Affairs (VA), *MIRECC and CoE*, http://www.mirecc.va.gov.

[389] VA, Rocky Mountain MIRECC for Suicide Prevention, *About Us*, http://www.mirecc.va.gov/visn19/aboutus.asp.

[390] Ibid.

[391] VA, *Specialized Mental Health Centers of Excellence Fact Sheet*, 2013, http://www.mirecc.va.gov/docs/Fact_Sheet-MHCoEs_Sept_2013.pdf.

[392] VA, *Rocky Mountain MIRECC for Suicide Prevention—Research Core*, http://www.mirecc.va.gov/visn19/research/index.asp.

[393] Ibid.

Studies currently being funded by the Rocky Mountain MIRECC fall into the following three overarching categories of the research continuum:

- Understand
  - The Relationship Between Suicidal Ideation and Thinking Under Stress
  - How Posttraumatic Stress Disorder [PTSD] can Affect Physical Injury and Traumatic Brain Injury
  - Brain Injuries, Decision-Making, PTSD, and How They Relate to Self-Harm Behaviors
  - Physical Activity Mental Health Outcomes and Suicidal Ideation
- Screening and Assessment
  - Measuring Suicide Risk with a Novel Approach
  - Can We Predict Future Self-Harm?
  - Examining How VA Providers Determine Suicide Risk in Veterans
  - Assessment of Cognitive Functioning as it Relates to Suicide Risk in Veterans with HIV/AIDS
- Treatment
  - Blister Packaging Medications
  - Longitudinal Assessment of Physical Activity and Suicidal Ideation
  - Home-Based Mental Health Evaluation: A Multi-Site Trial[394]

K. Veterans Integrated Service Network 2: Center of Excellence for Suicide Prevention

The Veterans Integrated Service Network (VISN) 2: Center of Excellence (CoE) for Suicide Prevention, led by Dr. Bruce Nelson, is a VA CoE with the mission to "integrate surveillance with intervention development through research to inform the implementation of effective Veteran suicide prevention strategies."[395]

VA's Mental Health Services is the principal funder of the CoE for Suicide Prevention.[396]

The CoE for Suicide Prevention is currently funding studies on the following topics:

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[394] VA, *Rocky Mountain MIRECC for Suicide Prevention—Research Core*, http://www.mirecc.va.gov/visn19/research/index.asp.

[395] VA, Veterans Integrated Service Network (VISN) 2: Center of Excellence for Suicide Prevention, *Mission*, http://www.mirecc.va.gov/suicideprevention.

[396] VA, VISN 2: Center of Excellence for Suicide Prevention, *History of the Center*, http://www.mirecc.va.gov/suicideprevention.

- Opioid Misuse and Overdose Risk Patterns in Recent Veterans
- Motivational Interviewing to Prevent Suicide in High Risk Veterans
- Facilitating Use of the Veterans Crisis Line in High Risk Patients
- Increasing Treatment Seeking among At-Risk Service Members Returning from Warzones
- Motivational Interviewing to Prevent Suicide in High Risk Veterans
- RCT of Behavioral Activation for Depression and Suicidality in Primary Care
- Yoga for Sleep in Cancer: The Role of Circadian, Physical and Immune Function
- Cognitive Rehabilitation for Gulf War Veterans' Illnesses
- Managing Sleep Symptoms & Modifying Mechanisms of Traumatic Stress
- Veterans in Transition: Returning to the Community after a Community Living Center Stay.[397]

Discussed in more detail in Appendix I are five key research goals and priorities identified by the CoE for Suicide Prevention.

[397] VA, VISN 2: Center of Excellence for Suicide Prevention—Research, *Research Projects*, http://www.mirecc.va.gov/suicideprevention/research.asp.

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Appendix G.
Cross-Cutting Efforts in Suicide Prevention Research—Working Groups, Steering Committees, and Advisory Bodies

A. American Foundation for Suicide Prevention Research Connection Program

American Foundation for Suicide Prevention (AFSP) Research Connection Program is "intellectually stimulating for a general audience where a researcher showcases AFSP-funded research. The events give an in-depth look at the fascinating science behind suicide prevention and allow the community to engage in conversation with a leader in the field."[398] Events are typically held through local AFSP chapters.

B. Army Study to Assess Risk and Resilience in Service Members Longitudinal Study Steering Committee

The Army STARRS LS steering committee is tri-chaired by DHA Research, Development, and Acquisition (RDA), NIMH, and the Deputy Undersecretary of the Army. MOMRP and DSPO are members of the committee.[399]

C. Army STARRS Translation Working Group

The Army STARRS translation working group meets monthly to determine if findings from Army STARRS can be applied and implemented across the Services. DSPO recently became a member of the group.

D. Defense Means Safety Task Force

The Defense Means Safety Task Force was formed following DSPO's November 2015 summit on research to address means safety in DOD.[400] The task force is led by the Director of DSPO and includes members from academia, the CDC, J1, MOMRP, SAMHSA, NIMH, SPRC, and the VA.[401] The mission of the task force is to "provide targeted recommendations for policy, programs, and practices to improve the effectiveness of lethal means safety towards reducing suicide."[402] The task force has the objectives to:

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[398] AFSP, *Research Connection Program*, https://afsp.org/our-work/research/research-connection-program.

[399] DOD stakeholder interview, December 16, 2015.

[400] As described in *Outcomes of Research Summit: Identifying Gaps in Practice.*

[401] Ibid.

[402] Keita Franklin, *DSPO: Defense Means Safety Task Force Overview, Outcomes, and Ongoing Efforts*, July 2016.

- Refine the DOD lethal means safety policy
- Develop DODI policy guidance on lethal means safety training programs
- Synchronize DOD lethal means safety research and activities
- Ensure creation of and updated DOD lethal means safety policies, programs, and practices[403]

The task force has experienced a great deal of success in translation, as evidenced in Figure G-1. In six months, the group was stood up, data and research were examined to scope the problem, the context of the problem was assessed, recommendations were developed, and a plan for implementation was established. For example, it has identified studies that have found a 91 percent reduction in suicides when interventions have focused on restricting access to lethal means, as well as several studies that have found no empirical support for the notion that a different method of suicide will be used if guns are not available.[404] Currently, DSPO and the Defense Means Safety Task Force are working to implement pilot studies resulting from the recommendations put forth by the task force.

[403] Ibid.

[404] Ibid. And, a Harvard study has found that about 90 percent of those who initially attempt suicide by overdosing, hanging, or cutting their wrists do not die by suicide. In contrast, 90 percent of suicide attempts using a firearm result in death. As reported by Steven Petrow, "With Guns, Suicide is a Sure Thing," *The Washington Post*, September 13, 2016, E1, E5.

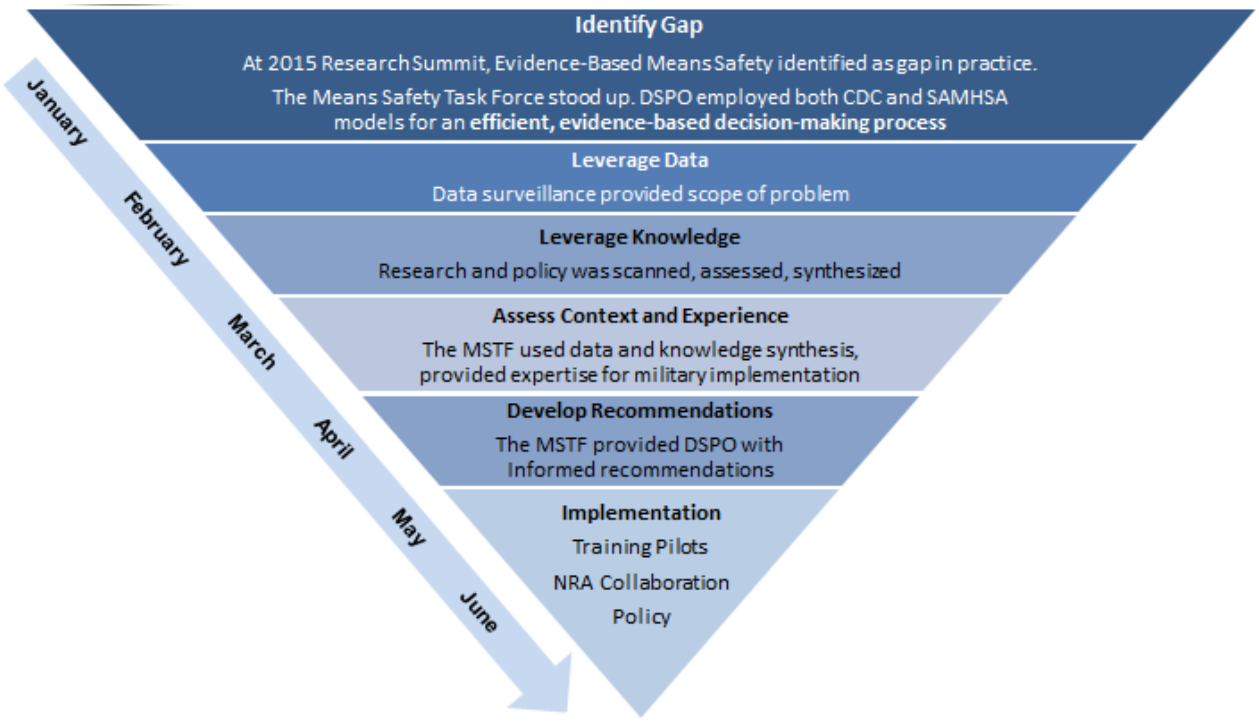

Figure G-1. Defense Means Safety Task Force (MSTF) Translation Progress[405]

E. Federal Working Group on Suicide Prevention

The Federal Working Group on Suicide Prevention consists of members from the Departments of Defense, Health and Human Services, Homeland Security, Justice, Education, Transportation, and Veterans Affairs.[406] The Working Group was created in 2006, is currently led by Dr. Richard McKeon, SAMHSA, and often serves as an advisory body to the NAASP.[407]

F. Military External Advisory Board

The Military External Advisory Board (MEAB) is an advisory board to the MSRC led by Lieutenant Colonel (LTC) Dennis McGurk, MOMRP.[408] The MEAB expedites the review of proposals submitted to the MSRC and supports the MSRC in the identification of gaps in current literature on military suicide.[409]

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[405] Keita Franklin, *DSPO: Defense Means Safety Task Force Overview, Outcomes, and Ongoing Efforts*, July 2016.

[406] NAASP, *Federal Working Group on Suicide Prevention*, http://actionallianceforsuicideprevention.org/fwg.

[407] Ibid.

[408] MSRC, *About the Military Suicide Research Consortium*, https://msrc.fsu.edu/about-msrc.

[409] MSRC, *Project Structure*, https://msrc.fsu.edu/about-msrc/project-structure.

G. Military Operational Medicine Research Program Joint Program Committee for Psychological Health, Mild Traumatic Brain Injury, and Suicide Prevention and Counseling Research

The MOMRP Joint Program Committee (JPC) is an advisory board led by CAPT Doug Forcino, U.S. Navy.[410] It consists of members from requirements, science and technology, advanced development, and user community groups across each of the Services, United States Special Operations Command (SOCOM), and other funding agencies (e.g., VA, DCoE). DSPO is a member of the JPC.[411]

H. Military Suicide Research Consortium CORE-D Project

The MSRC CORE-D project is focused on the dissemination and implementation of research. DSPO plans to conduct weekly meetings with this MSRC team to coordinate and execute the translation of suicide prevention research into Service-level suicide prevention programs.

I. National Action Alliance for Suicide Prevention Advisory Bodies

1. Impact Group

The Impact Group is an advisory group led by Dr. Eric Caine, University of Rochester, and Dr. Jane Pearson, NIMH. It provides technical assistance to the NAASP on priority development, develops implementation tools, and assesses the impact of proposed suicide prevention initiatives.[412] Members of the Impact Group include Dr. Richard McKeon, SAMHSA; Rajeev Ramchand, RAND Corporation; and Jerry Reed, EDC.[413]

2. National Strategy for Suicide Prevention Implementation Assessment Advisory Group

The NSSP Implementation Assessment Advisory Group is a group led by the U.S. Surgeon General (or proxy) and Dr. Dan Reidenberg, Suicide Awareness Voices of Education (SAVE), that periodically assesses the implementation of the revised NSSP.[414] Members of this advisory group include Dr. Eric Caine, University of Rochester; Dr. Richard McKeon, SAMHSA, Dr. Jane Pearson, NIMH; and a representative from DSPO.[415]

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[410] MSRC, *About the Military Suicide Research Consortium*, https://msrc.fsu.edu/about-msrc.

[411] DOD stakeholder interview, December 16, 2015.

[412] NAASP, *Impact Group*, http://actionallianceforsuicideprevention.org/impactgroup.

[413] Ibid.

[414] NAASP, *NSSP Implementation Assessment Advisory Group*, http://actionallianceforsuicideprevention.org/nssp-implementation-assessment-advisory-group.

[415] Ibid. The DSPO representative listed on this site is Bill Crowley, who has since left DSPO.

3. Zero Suicide Advisory Group with Data Panel

The Zero Suicide Advisory Group (ZSAG) with Data Panel is an advisory group led by David Covington, RI International, and Dr. Mike Hogan, Hogan Health Solutions.[416] It is designed to help implement Goals 8 (promote suicide prevention as a core component of healthcare services) and 9 (promote and implement effective clinical and professional practices for assessing and treating those at risk for suicidal behaviors) of the NSSP.[417] Members of the ZSAG include Dr. Richard McKeon, SAMHSA.[418]

4. National Action Alliance for Suicide Prevention: Research Prioritization Task Force

The NAASP RPTF was an effort to "develop a prioritized approach for allocating funds and monitoring future suicide research to ensure that available resources target research with the greatest likelihood of reducing suicide morbidity and mortality."[419] Its goal was to "develop an agenda for research that has the potential to reduce morbidity (attempts) and mortality (deaths) each, by at least 20% in 5 years, and 40% or greater in 10 years, if implemented successfully."[420] The NAASP RPTF was led by Phillip Satow, the Jed Foundation, and Dr. Thomas Insel, NIMH.[421] Throughout the course of the work of the RPTF, six key questions "were explored to identify the state of the science, pathways for progress, and specific objectives." Twelve aspirational goals were also identified. A full listing of these questions and goals is provided in Appendix I.

J. National Council for Suicide Prevention

The National Council for Suicide Prevention (NCSP) is a coalition of nine national organizations working to help advance the NSSP, encourage use of performance measures, and share information and resources.[422] Members of the National Council include SAVE, the Trevor Project, Samaritans USA, AFSP, the Jason Foundation, the JED Foundation, and AAS.[423]

K. Suicide Prevention Resource Center Steering Committee

The Suicide Prevention Resource Center (SPRC) steering committee is an organization focused on "strengthening the SPRC's collaborative relationships within the suicide prevention

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[416] NAASP, *Zero Suicide Advisory Group (ZSAG), with Data Panel*, http://actionallianceforsuicideprevention.org/ZeroSuicideAdvisoryGroup.

[417] Ibid.

[418] Ibid.

[419] NAASP RPTF, *A Prioritized Research Agenda for Suicide Prevention*, 7.

[420] NAASP RPTF, *U.S. National Suicide Prevention Research Efforts*, 5.

[421] NAASP RPTF, *A Prioritized Research Agenda for Suicide Prevention*, 4.

[422] National Council for Suicide Prevention (NCSP), http://www.thencsp.org.

[423] Ibid.

community, sharing members' observations about current and emerging trends in the suicide prevention field as they affect diverse populations and contexts, alerting SPRC to upcoming challenges or opportunities in the field, and advising SPRC on its current and future strategic directions."[424]

L. Suicide Prevention and Risk Reduction Committee

The Suicide Prevention and Risk Reduction Committee (SPARRC) is DOD's action officer level working group on suicide prevention, established in 1999 as a result of a White House initiative.[425] The DOD Directive on the Defense Suicide Prevention Program provided additional guidance on the SPARRC as a governance structure to be chaired by DSPO. Since 2015, the SPARRC has been chaired by the DSPO's Deputy Director.[426]

M. Suicide Prevention General Officer Steering Committee

The Suicide Prevention General Officer Steering Committee (SPGOSC) is DOD's General Officer-level steering committee on suicide prevention co-chaired by the Director of DSPO and the Assistant Secretary of Defense for Health Affairs (ASD(HA)). The DOD Directive on the Defense Suicide Prevention Program provided additional guidance on the SPGOSC as a governance structure.[427]

[424] SPRC, *About SPRC*, http://www.sprc.org/about_sprc/steering-committee.

[425] DOD Task Force, *The Challenge and the Promise*, 12-13.

[426] DODD 6490.14, *Defense Suicide Prevention Program*, June 18, 2013, 11; and DSPO interviews, September 22, 2015, and September 28, 2015.

[427] DODD 6490.14, *Defense Suicide Prevention Program*, June 18, 2013, 11.

Appendix H.
Non-DSPO Initiatives to Survey, Catalog, or Coordinate Research

A. National Action Alliance for Suicide Prevention Research Prioritization Task Force *Suicide Prevention Research Efforts: 2008-2013 Portfolio Analyses* Report

The portfolio analyses outlined in this report were conducted by the NIMH on behalf of the NAASP. These analyses were part of the RPTF effort to develop a prioritized research agenda and "sought to determine how recently funded U.S. research studies, supported by both public (federal) and private (e.g., industry, foundations) entities, could benefit and/or be leveraged by the RPTF prioritized research agenda."[428] The portfolio analyses were conducted to "assess the 'state of the science' for suicide prevention."[429] This report "was developed to prioritize what research steps and pathways are needed to help reduce the suicide deaths and attempts in the U.S. and to identify strengths and gaps in the U.S. research portfolio."[430]

B. National Guideline Clearinghouse

The National Guideline Clearinghouse (NGC) is an initiative of the DHHS Agency for Healthcare Research and Quality. Its mission is to "provide physicians and other health professionals, health care providers, health plans, integrated delivery systems, purchasers, and others an accessible mechanism for obtaining objective, detailed information on clinical practice guidelines and to further their dissemination, implementation, and use."[431]

C. Portfolio Coding Tool

The Portfolio Coding (PFC) Tool, developed and funded by the NIMH, enables the National Institutes of Health (NIH) and other institutes to catalog, classify, and analyze Federally funded research efforts. NIMH provided $1M of funding to develop the PFC and worked collaboratively with Federal partners involved in the research arena to input their data.[432] The PFC can only be accessed by registered users.[433]

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[428] NAASP RPTF, *U.S. National Suicide Prevention Research Efforts: 2008–2013 Portfolio Analyses*, 6.

[429] Ibid.

[430] Ibid.

[431] National Guideline Clearinghouse (NGC), *About*, http://www.guideline.gov/about/index.aspx.

[432] Non-DOD stakeholder interview, April 27, 2016.

[433] Email from Becky Kurikeshu, NIMH.

D. RAND *Developing a Research Strategy for Suicide Prevention in the Department of Defense: Status of Current Research, Prioritizing Areas of Need, and Recommendations for Moving Forward* Report

This RAND study, funded by OUSD(P&R), investigated the current research activities in the DOD and proposed a new research strategy. The objective of this study was to "provide guidance that DoD could use to develop the recommended unified, strategic, and comprehensive plan. The study was organized around three overarching research aims: (1) catalog research being conducted on suicide prevention that is directly relevant to military personnel, (2) examine whether current research maps onto DoD's strategic research needs related to suicide prevention, and (3) ensure that any proposed DoD research strategy aligns with the national research strategy and is integrated with DoD's data, surveillance, and program evaluation strategies."[434]

E. Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices

SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) "is an evidence-based repository and review system designed to provide the public with reliable information on mental health and substance abuse interventions."[435] The NREPP was developed to help the public learn about evidence-based interventions available for implementation and to promote the usage of scientifically established interventions.[436] Rankings provided by the NREPP "take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework."[437]

F. Suicide Prevention Resource Center's Best Practices Registry

SPRC's Best Practices Registry (BPR) is funded by SAMHSA and run by EDC. The purpose of the BPR is to "identify, review, and disseminate information about best practices that address specific objectives of the National Strategy for Suicide Prevention [NSSP]."[438] The BPR is split into three sections: (1) evidence-based programs; (2) expert and consensus statements; and (3) adherence to standards. According to the BPR website, "in essence, the BPR is three

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[434] Rajeev Ramchand, et al., *Developing a Research Strategy for Suicide Prevention in the Department of Defense: Status of Current Research, Prioritizing Areas of Need, and Recommendations for Moving Forward*, (Santa Monica, CA: RAND Corporation, 2014), http://www.rand.org/pubs/research_reports/RR559.html, xv.

[435] Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP), http://nrepp.samhsa.gov/01_landing.aspx.

[436] SAMHSA NREPP, *About NREPP*, http://nrepp.samhsa.gov/02_about.aspx.

[437] Ibid.

[438] SPRC, *Best Practices Registry*, http://www.sprc.org/bpr.

registries in one. The three sections do not represent levels, but rather they include different types of programs and practices reviewed according to specific criteria for that section."[439]

G. University of Pennsylvania Center for Evidence-based Practice

The University of Pennsylvania Center for Evidence-based Practice (CEP) "performs assessments of health care technologies defined broadly."[440] These assessments include a systematic review of the evidence and a close collaborative relationship with key stakeholders to ensure the most valid and actionable report possible is produced.[441] CEP includes "research analysts who perform evidence reviews, a health economist, biostatistician, clinical liaisons, librarians and administrators" and "is guided by an executive board and an advisory board of academic and administrative leaders at Penn."[442]

[439] Ibid.

[440] University of Pennsylvania Center for Evidence-based Practice (CEP), *About Us*, http://www.uphs.upenn.edu/cep/about_us/index.html.

[441] Ibid.

[442] Ibid.

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Appendix I.
Research Taxonomies

A. National Action Alliance for Suicide Prevention Research Prioritization Task Force's Six Guiding Questions and 12 Aspirational Goals

In 2014, the NAASP RPTF released a document outlining the research areas that showed the most promise in helping to reduce the rates of suicide attempts and deaths.[443] The identified research priorities, which were defined using the six guiding questions listed below, are one example of a taxonomy for the characterization of suicide prevention research. NAASP also identified 12 aspirational goals linked to the six guiding questions developed.[444]

- Why do people become suicidal?
  - Aspirational Goal 1: Know what leads to, or protects against, suicidal behavior, and learn how to change those things to prevent suicide.
- How can we better or optimally detect/predict risk?
  - Aspirational Goal 2: Determine the degree of suicide risk (e.g., imminent, near-term, long-term) among individuals in diverse populations and in diverse settings through feasible and effective screening and assessment approaches.
  - Aspirational Goal 3: Assess who is at risk for attempting suicide in the immediate future.
- What interventions are effective? What prevents individuals from engaging in suicidal behavior?
  - Aspirational Goal 4: Ensure that people who are thinking about suicide but have not yet attempted, receive interventions to prevent suicidal behavior.
  - Aspirational Goal 5: Find new biology treatments and better ways to use existing treatments to prevent suicidal behavior.
  - Aspirational Goal 6: Ensure that people who have attempted suicide can get effective interventions to prevent further attempts.
- What services are most effective for treating the suicidal person and preventing suicidal behavior?

[443] NAASP, *Research Prioritization*, http://actionallianceforsuicideprevention.org/task-force/research-prioritization.

[444] The six questions are provided in NAASP RPTF, *U.S. National Suicide Prevention Research Efforts: 2008–2013 Portfolio Analyses*, 5. The 12 aspirational goals are identified in Pearson, et al., *Multiple Approaches to Measuring Suicide Research Progress*, 7-8.

  - Aspirational Goal 7: Ensure that health care providers and others in the community are well trained in how to find and treat those at risk.
  - Aspirational Goal 8: Ensure that people at risk for suicidal behavior can access affordable care that works, no matter where they are.
  - Aspirational Goal 9: Ensure that people getting care for suicidal thoughts and behaviors are followed throughout their treatment so they don't fall through the cracks.
  - Aspirational Goal 10: Increase help-seeking and referrals for at-risk individuals by decreasing stigma.
- What other types of preventive interventions (outside health care systems) reduce suicide risk?
  - Aspirational Goal 11: Prevent the emergence of suicidal behavior by developing and delivering the most effective prevention programs to build resilience and reduce risk in broad-based populations.
  - Aspirational Goal 12: Reduce access to lethal means that people use to attempt suicide.
- What new and existing research infrastructure is needed to reduce suicidal behavior?

The NAASP has defined two priorities in addition to the six guiding questions listed above:

- Transform health care systems to significantly reduce suicide.
- Change the public conversation around suicide and suicide prevention.[445]

B. The Defense Strategy for Suicide Prevention Four Strategic Directions and 13 Goals

After adopting the NSSP, developed by DHHS in June 2014, DSPO collaboratively developed a strategy for suicide prevention specifically for the DOD. In 2015, the USD(P&R) released the DSSP, which contains four strategic directions and 13 goals.[446] These strategic directions and goals, especially those for surveillance, research, and evaluation, may also act as a taxonomy for the characterization of suicide prevention research.

- Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities
  - Goal 1: Integrate and coordinate suicide prevention activities across the Department of Defense.

[445] Ibid.

[446] DOD, *Department of Defense Strategy for Suicide Prevention.*

  - Goal 2: Implement research-informed communication efforts within the Department of Defense that prevent suicide by changing knowledge, attitudes, and behaviors.
  - Goal 3: Educate the Military Community on the protective factors against suicide that also promote resilience, and recovery in the Department of Defense.
  - Goal 4: Encourage responsible media reporting and portrayals of Military Community suicide and mental illnesses and promote the accuracy and safety of online content related to suicides in the Department.
- Strategic Direction 2: Clinical and Community Preventive Services
  - Goal 5: Develop, implement, and monitor effective Department of Defense programs that promote resilience, and prevent suicide and related behaviors.
  - Goal 6: Promote efforts within the Department of Defense to reduce access to lethal means of suicide among individuals with identified suicide risk.
  - Goal 7: Provide Military Community service providers and Military Healthcare service providers evidence based training on the prevention of suicide and related behaviors.
- Strategic Direction 3: Treatment and Support Services
  - Goal 8: Promote suicide prevention as a core component of Military Healthcare services.
  - Goal 9: Promote and implement effective clinical and professional practices in the Military Healthcare System for assessing and treating those identified as being at risk for suicidal behaviors.
  - Goal 10: Provide support and quality services for those in the Military Community affected by suicide deaths and attempts and implement community-wide postvention strategies to help prevent subsequent suicides.
- Strategic Direction 4: Surveillance, Research, and Evaluation
  - Goal 11: Improve the timeliness and usefulness of Department of Defense surveillance systems relevant to suicide prevention, and improve the ability to collect, analyze, and use this information for improving Department suicide prevention efforts.
  - Goal 12: Promote and support Department of Defense research on suicide prevention.

– Goal 13: Evaluate the impact and effectiveness of Department of Defense suicide prevention interventions and systems in order to synthesize and disseminate the findings.[447]

C. National Action Alliance for Suicide Prevention Suicide Prevention Research Categories

In the RAND report, *Developing a Research Strategy for Suicide Prevention in the Department of Defense: Status of Current Research, Prioritizing Areas of Need, and Recommendations for Moving Forward*, authors categorized military suicide prevention research studies using NAASP and MOMRP categories established by their respective Continuums of Care.[448] The NAASP categories used in the report, another potential taxonomy for the characterization of suicide prevention research, are:

- Prevention of reattempts
- Enhanced continuity of care
- Provider and gatekeeper training
- Affordable, accessible, and effective care
- Psychosocial interventions for those at risk
- Risk and protective factor interactions
- Stigma reduction
- Population-based risk reduction/resilience-building
- Prediction of imminent risk
- Improved biological interventions
- Reduction in access to lethal means
- Population-based screening[449]

D. Military Operational Medicine Research Program Suicide Prevention Research Categories

The MOMRP categories used in the aforementioned RAND report also pose a potential taxonomy for the characterization of suicide prevention research. These categories are:

- Prevention education and training

[447] Ibid., i-ii.

[448] Ramchand, et al., *Developing a Research Strategy for Suicide Prevention in the Department of Defense,* 8.

[449] Ibid., 10.

- Early screening/intervention
- Assessment
- Treatment
- Recovery and return to duty
- Postvention
- Epidemiology and/or basic science/neurological mechanisms[450]

E. Veterans Integrated Service Network 2: Center of Excellence for Suicide Prevention Five Research Goals and Priorities

The VISN 2: CoE for Suicide Prevention has identified the following five research goals and priorities:

- Continually enhance a leading edge suicide surveillance system;
- Identify target populations and settings for future intervention;
- Shape the development of effective interventions;
- Develop novel suicide prevention training programs and disseminate new knowledge related to prevention;
- Facilitate information exchange and collaboration to align our efforts with others.[451]

Additionally, the CoE for Suicide Prevention prioritizes research and interventions that:

- Reach large populations of veterans (e.g., primary care, media campaigns);
- Address targets that cut across disorders and populations (e.g. sleep difficulties);
- Address targets that occur upstream from suicidal behavior and are conceptualized as preventative;
- Focus on women Veterans, Veterans outside VHA care, and/or OEF/OIF/OND[452] Veterans;
- Address firearm safety.[453]

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[450] Ibid., 8 - 10.

[451] VA, *VISN 2: Center of Excellence for Suicide Prevention—Research, "Research Goals,"* http://www.mirecc.va.gov/suicideprevention/research.asp.

[452] Note: Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), Operation New Dawn (OND).

[453] VA, *VISN 2: Center of Excellence for Suicide Prevention—Research, "Research Goals,"* http://www.mirecc.va.gov/suicideprevention/research.asp.

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Appendix J.
Illustrations

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Appendix K.
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Appendix L.
Abbreviations

AAR	After Action Report
AAS	American Association of Suicidology
AC	Active Component
ACE	Ask, Care, Escort
ACT	Ask, Care, Treat
AFMES	Armed Forces Medical Examiner System
AFSP	American Foundation for Suicide Prevention
Army STARRS	Army Study To Assess Risk and Resilience in Service members
Army STARRS LS	Army Study To Assess Risk and Resilience in Service members Longitudinal Study
ASA(ALT)	Assistant Secretary of the Army (Acquisition, Logistics and Technology)
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ASIST	Applied Suicide Intervention Skills Training
BAA	Broad Agency Announcement
BHMC	Building Healthy Military Communities
BoG	Board of Governors
BPR	Best Practices Registry
CAPE	Cost Assessment and Program Evaluation
CAPT	Captain, U.S. Navy
CDC	Centers for Disease Control and Prevention
CDMRP	Congressionally Directed Medical Research Programs
CEO	Chief Executive Officer
CEP	Center for Evidence-based Practice
CID	Criminal Investigative Division
CoE	Center of Excellence
COI	Community of Interest
COMDTINST	Commandant Instruction
CY	Calendar Year
DCAS	Defense Casualty Analysis System
DCoE	Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
DEERS	Defense Enrollment Eligibility Reporting System
DEOMI	Defense Equal Opportunity Management Institute
DEOCS	Defense Equal Opportunity Management Institute Organizational Climate Survey
DHA	Defense Health Agency
DHA(RDA)	Defense Health Agency (Research, Development, and

	Acquisition)
DHRA	Defense Human Resource Activity
DHHS	Department of Health and Human Services
DHS	Department of Homeland Security
DMDC	Defense Manpower Data Center
DOD	Department of Defense
DODD	Department of Defense Directive
DODI	Department of Defense Instruction
DoDSER	Department of Defense Suicide Event Report
DON	Department of the Navy
DONSIR	Department of the Navy Suicide Incident Report
DPH	Director of Psychological Health
DRAP	Defense Research Action Plan for Suicide Prevention
DSPO	Defense Suicide Prevention Office
DSPRAT	Defense Suicide Prevention Research Analysis Tool
DSSP	Defense Strategy for Suicide Prevention
DTM	Directive-Type Memorandum
EDC	Education Development Center, Inc.
FAC	Family Assistance Center
FACAT	Family Advocacy Community Assistance Team
FAP	Family Advocacy Program
FR2	Force Risk Reduction
FRA	Federal Railroad Administration
FTA	Federal Transit Administration
FY	Fiscal Year
GAO	Government Accountability Office
GO/FO	General Officer/Flag Officer
HA	Health Affairs
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HQMC	Headquarters Marine Corps
ICD	Interace Control Document
IDA	Institute for Defense Analyses
IPT	Integrated Planning Team
IT	Information Technology
JPC	Joint Program Committee
LGBT	Lesbian, gay, bisexual, and transgender
LS	Longitudinal Study
LTC	Lieutenant Colonel
M2	MHS Mart
MCFP	Military Community and Family Policy
MCL	Military Crisis Line

MCL/VCL	Military Crisis Line/Veterans Crisis Line
MDR	Military Health System Data Repository
MEAB	Military External Advisory Board
MHS	Military Health System
MIP	Marine Intercept Program
MIPR	Military Interdepartmental Purchase Request
MIRECC	Mental Illness Research, Education, and Clinical Centers
MOA	Memorandum of Agreement
MOE	Measure of Effectiveness
MOMRP	Military Operational Medicine Research Program
MOU	Memorandum of Understanding
MSRC	Military Suicide Research Consortium
MSTF	Means Safety Task Force
MVMD	Military Veterans Mortality Database
NAASP	National Action Alliance for Suicide Prevention
NATO	North Atlantic Treaty Organization
NCHS	National Center for Health Statistics
NCSP	National Council for Suicide Prevention
NDAA	National Defense Authorization Act
NDI	National Death Index
NDI+	National Death Index Plus
NGC	National Guideline Clearinghouse
NIMH	National Institute of Mental Health
NIH	National Institutes of Health
NREPP	National Registry of Evidence-based Programs and Practices
NSSP	National Strategy for Suicide Prevention
ODMEO	Office of Diversity Management and Equal Opportunity
OEDFR	Office of the Executive Director for Force Resiliency
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OLW	Operation Live Well
O&M	Operations and Maintenance
OND	Operation New Dawn
OSD	Office of the Secretary of Defense
OUSD(P&R)	Office of the Under Secretary of Defense for Personnel & Readiness
PE	Program Element
PFC	Portfolio Coding
PHI	Protected Health Information
PII	Personally Identifiable Information
POC	Point of Contact
POM	Program Objective Memorandum

P&R	Personnel and Readiness
RACE	Recognize Distress, Ask, Care, Escort
RC	Reserve Component
RCCPDS	Reserve Components Common Personnel Data System
RCT	Randomized Controlled Trial
RDT&E	Research, Development, Test, and Evaluation
RFP	Request for Proposal
RMD	Resource Management Division
RPTF	Research Prioritization Task Force
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPRO	Sexual Assault Prevention and Response Office
SAVE	Suicide Awareness Voices of Education
SDR	Suicide Data Repository
SES	Senior Executive Service
SESS	Suicide Event Surveillance System
SF	Standard Form
SME	Subject Matter Expert
SOFS-A	Status of Forces Survey of Active Duty Members
SOCOM	Special Operations Command
SP	Suicide Prevention
SPARRC	Suicide Prevention and Risk Reduction Committee
SPGOSC	Suicide Prevention General Officer Steering Committee
SPPM	Suicide Prevention Program Manager
SPRC	Suicide Prevention Resource Center
SSA	Service Self-Assessment
SSA	Social Security Administration
SSN	Social Security Number
STAARS	Study To Assess Risk and Resilience in Service members
TATRC	Telemedicine and Advanced Technologies Research Center
TIERS	Translation and Implementation of Evaluation and Research Studies
T2	National Center for Telehealth & Technology
UMAPIT	Unit Marine Awareness Integrated Prevention Training
URI	Unit Risk Inventory
USAF	United States Air Force
USAMRMC	United States Army Medical Research and Materiel Command
USCG	United States Coast Guard
USDA	United States Department of Agriculture
USMC	United States Marine Corps
USN	United States Navy
USUHS	Uniformed Services University of the Health Sciences
VA	Department of Veterans Affairs

VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WARN	Wellness Assessment and Risk Nexus
WHO	World Health Organization
ZSAG	Zero Suicide Advisory Group

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REPORT DOCUMENTATION PAGE			Form Approved OMB No. 0704-0188

1. REPORT DATE (DD-MM-YY)	2. REPORT TYPE	3. DATES COVERED (From – To)
xx-11-16	Final	

4. TITLE AND SUBTITLE

Strengthening the Contributions of the Defense Suicide Prevention Office to DOD's Suicide Prevention Efforts

5a. CONTRACT NO.

HQ0034-14-D-0001

5b. GRANT NO.

5c. PROGRAM ELEMENT NO(S).

6. AUTHOR(S)

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5d. PROJECT NO.

5e. TASK NO.

BE-6-3848

5f. WORK UNIT NO.

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)

Institute for Defense Analyses
4850 Mark Center Drive
Alexandria, VA 22311-1882

8. PERFORMING ORGANIZATION REPORT NO.

IDA Paper P-8248
Log: H 16-001218

9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES)

Defense Suicide Prevention Office
The Office of the Under Secretary of Defense for Personnel and Readiness
4800 Mark Center Drive, Room 05J25
Alexandria VA 22350

10. SPONSOR'S / MONITOR'S ACRONYM(S)

DSPO

11. SPONSOR'S / MONITOR'S REPORT NO(S).

12. DISTRIBUTION / AVAILABILITY STATEMENT

Approved for public release; distribution is unlimited.

13. SUPPLEMENTARY NOTES

14. ABSTRACT

Using a multi-step organizational assessment framework, this report provides an organizational analysis and programmatic review of the Defense Suicide Prevention Office (DSPO). It reviews DSPO's mission, describes how DSPO has evolved as an organization, and offers IDA's identification of DSPO's value-added functions and how well they are being performed. These functions are: strategy and policy; collaboration and advocacy; outreach and education; program evaluation; data management; support for research; and resource management. As DSPO moves toward an evidence-based management framework, this report suggests enhancements in three specific areas: program evaluation mechanisms; access to suicide data and DSPO's reporting obligations; and possible mechanisms for DSPO to guide and apply research on suicide prevention. Finally, IDA has assessed DSPO's organization and staffing with respect to its necessary functions and deliverables.

15. SUBJECT TERMS

suicide prevention; Defense Suicide Prevention Office (DSPO); organizational effectiveness; program evaluation and metrics; research support; communication; outreach; advocacy; data management

16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NO. OF PAGES	19a. NAME OF RESPONSIBLE PERSON
a. REPORT	b. ABSTRACT	c. THIS PAGE			Mr. George Parisi
U	U	U	U	212	19b. TELEPHONE NUMBER (Include Area Code) (703) 614-8772

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