EXECUTIVE SUMMARY

TASK FORCE VISION STATEMENT

A military force fit in mind, body, and spirit that wins the battle against suicide and stands ready to answer the Nation's call.

Background

Section 733 of the National Defense Authorization Act (NDAA) for fiscal year 2009 directed the Secretary of Defense to "establish within the Department of Defense a Task Force to examine matters relating to prevention of suicide by members of the Armed Forces" and "submit to the Secretary (of Defense) a report containing recommendations regarding a comprehensive policy designed to prevent suicide by members of the Armed Forces." Thus, the Department of Defense (DoD) Task Force on the Prevention of Suicide by Members of the Armed Forces (hereafter referred to as the Task Force) was established, comprising seven DoD and seven non-DoD professionals with expertise in national suicide prevention policy, military personnel policy, research in the field of suicide prevention, clinical care in mental health, military chaplaincy and pastoral care, and military families. Task Force members were appointed in July 2009, with one military and one civilian member serving as co-chairs for the group. Major General Philip Volpe, initially the Deputy Commander of Joint Task Force, National Capital Region Medical (JTF CapMed), and later the Commanding General of the Army's Western Regional Medical Command, was appointed as the military co-chair of the Task Force. Ms. Bonnie Carroll, Director of the Tragedy Assistance Program for Survivors (TAPS), was elected as the civilian co-chair.

The first step in reaching this vision is the production of this report, a culmination of reviews of data, studies, and programs; discussions with Service Members, families, and care providers; and analyses of site visits information, research, and expert opinion. In this report, the Task Force members have presented their findings and best consensus recommendations for effective suicide prevention for Service Members within the DoD. We are confident that the recommendations will make a difference by strengthening the force through total fitness, thereby helping to prevent suicide. Action must follow this report, and the recommendations must be implemented with a sense of urgency if we are to address the worrisome trend of increasing suicide by members of the Armed Forces. This report is a call for more effective action.

Introduction

More than 1.9 million warriors have deployed for Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), two of our Nation's longest conflicts (IOM, 2010). The physical and psychological demands on both the deployed and non-deployed warriors are enormous. In the 5 years from 2005 to 2009, more than 1,100 members of the Armed Forces took their own lives, an average of 1 suicide every 36 hours. In that same period, the suicide rates among

Marines and Soldiers sharply increased; the rate in the Army more than doubled. Numerous commissions, task forces, and research reports have documented the "hidden wounds of war"—the psychological and emotional injuries that have so affected our military members and their families. The years since 2002 have placed unprecedented demands on our Armed Forces and military families. Military operational requirements have risen significantly, and manning levels across the Services remain too low to meet the ever-increasing demand. This current imbalance places strain not only on those deploying, but equally on those who remain in garrison. In the judgment of the Task Force, the cumulative effects of all these factors are contributing significantly to the increase in the incidence of suicide and without effective action will persist well beyond the duration of the current operations and deployments. Heightened concern regarding this increase in suicides has led to development of scores of initiatives across the DoD to reduce risk.

The Task Force acknowledges the significant efforts made by the military Services. The Services have substantially increased their focus and investments in suicide prevention over the years to meet current requirements. This is evident at the highest levels of leadership in the military Departments. This Task Force has witnessed commitment, creativity, and compassion by uniformed and civilian employees across the Services in attempting to address this looming crisis. While lauding the level of this extraordinary effort, the Task Force concluded that the urgency to respond to the challenge of suicide may have driven the Services to deploy many of these initiatives without the benefit of strategic planning, evaluation, standardization, or plans for sustainment. The Task Force also found other unintended consequences of this rush to deploy critical programs. For instance, the Task Force discovered wide variations in the implementation of many initiatives, many programs that overlapped, creating unnecessary inefficiencies, and prevention opportunities that were missed because of gaps between programs. Furthermore, many programs were misunderstood by Service Members, their families, and commanders in the field. Finally, the Task Force concluded that the remarkable efforts of the Services seemed to lack the consistency and power that could have been achieved had the policies directing the programs been centrally developed by the Office of the Secretary of Defense (OSD). The Task Force concluded that current Service efforts would benefit from a comprehensive suicide prevention strategy, coordinated throughout DoD. This strategy should include additional leader accountability to foster a command climate promoting Service Member well-being and fitness. Command climates must continue to evolve to ensure the positive and engaged support of every Service Member in distress and view this support as a vital part of mission readiness and mission success.

Throughout history, the United States military has often led the Nation in addressing emerging concerns. Specifically, the Defense Advanced Research Projects Agency's (DARPA) Bio-Revolution programs develop and leverage advances in all areas of biological and medical sciences to improve DoD capabilities (Beard, 2008). In the past 15 years, in a similar fashion, the military Services have taken a leading role in the Nation's suicide prevention efforts and more recently have coordinated with other federal agencies to advance this work.

Suicide prevention presents a significant challenge to the country at large. Unfortunately, those who could provide the most help in understanding why people die by suicide are those who

have taken their own lives and are no longer with us. However, those who have made near-lethal suicide attempts can provide important insights as well. They describe myriad factors that contributed to their inability to find another strategy to cope with their seemingly hopeless situation. After decades of research, there is still much that is not understood about the causes of suicide and effective approaches to prevent it. What we do know is that there is no single common cause, but rather dozens of known factors that increase one's risk for suicide. These risk factors interact in complex ways with other factors that are protective against suicidal behaviors. Therefore, solutions to the suicide problem must be, by definition, multifaceted and designed to reduce risk and increase protective factors. These solutions should be directed toward achieving the Task Force's vision of enhancing wellness, promoting total fitness, and sustaining a military force fit in mind, body and spirit. There must be a renewed focus at the troop level and a sense of urgency at all levels, especially in strategic planning, to interrupt the trend and save lives by preventing suicide.

Findings and Recommended Strategic Initiatives

The Task Force commends the Armed Forces for the suicide prevention initiatives it has undertaken and knows of no other employer that has focused as much attention and resources on suicide prevention. However, the Task Force found that the current vast expansion of suicide prevention initiatives across the Services was developed rapidly and separately by each Service for immediate execution. These initiatives could benefit from reengineering to improve suicide prevention efforts. The rapid establishment of these initiatives resulted in a lack of the cohesion and coordination that normally would have come through a focused strategic planning process. Furthermore, the Department's organization and structure for suicide prevention is not optimized. It lacks a designated policy office in OSD, essential for policy standardization and centralized surveillance. The Task Force also found that multiple deployments and long deployments have taken a toll on the force and its families, eroding the well-being (fitness) and resilience of the force. This assessment is based on a review of each Service's suicide prevention programs as well as Service and DoD policies, research data, additional data sought specifically by the Task Force, public testimony from experts and advocates, and site visits to 19 military installations throughout the continental United States. The Task Force heard from well over 2,000 individuals. Service Members (junior enlisted, non-commissioned officers [NCO], and officers), family members, commanders, behavioral health professionals, clergy, and military community support services personnel were given the opportunity to provide their input.

The Task Force arrived at 49 findings and 76 targeted recommendations which are discussed in Section 7 of the body of this report. A list of these recommendations can also be found at the end of the Executive Summary. The findings fall into four primary Focus Areas: Organization and Leadership; Wellness Enhancement and Training; Access to, and Delivery of, Quality Care; and Surveillance, Investigations, and Research.

The findings in each Focus Area drive a set of Strategic Initiatives, and for each Strategic Initiative, there are a set of actionable recommendations. We have also provided a set of

Foundational Recommendations that generally aggregate several of the more targeted recommendations and which are critical to the success of the broader set of recommendations.

Focus Area 1: Organization and Leadership

Overview: The Task Force believes that suicide prevention begins with a comprehensive strategy that has the support of leaders at every level. The strategy will assist the office of the Undersecretary of Defense for Personal and Readiness (USD(P&R)) develop a coherent policy. Effective organizational structure is essential to develop enterprise-wide policy as well as procedural standardization and oversight. To enhance suicide prevention efforts, and maintain a lasting impact, DoD must organize appropriately, in conjunction with the Services. Suicide prevention is a leadership responsibility from the most senior leaders down to front-line supervisors (first-line leaders). Distressed Service Members must be led to the best available "helping agent" through a positive and supportive command climate. A culture of total fitness, should allow early identification and intervention opportunities before a member becomes suicidal. This focus area addresses the need for a functional organization with an engaged and informed leadership to ensure unity and clarity of effort in preventing suicide within the Services.

Summary of Findings: Although the Services are adapting to changing suicide prevention demands, the absence of an adequately staffed and resourced OSD policy office on suicide prevention leads to significant challenges to unity of effort. Similarly, the Service suicide prevention program offices are not sufficiently staffed and resourced to meet the demand. The Services provide numerous morale, quality of life, counseling, intervention, health and community services on installations and within units. Despite their availability, community support services, medical treatment facilities and unit leadership are often "stovepiped" on installations, leading to poorly integrated approaches for effective suicide prevention, particularly for those Service Members at high risk. Command climate surveys, which are utilized by commanders (although inconsistently) are not well designed to assess behavioral health risk in the unit. In general, commanders are not provided the tools they need to: detect, measure, and track unit-level suicide risk factors; identify individuals who are high risk; and inform local prevention activities. Military cultural norms, while beneficial for survival and mission accomplishment on a battlefield, can sometimes stifle responsible help-seeking behavior; the effect is a less fit force more vulnerable to suicide. Messages from some leaders regarding suicide, suicide prevention, resilience, health and Warrior readiness frequently do not sufficiently support suicide prevention efforts: Strategic communications are often not focused on positive prevention messages and thus there are missed opportunities to encourage help seeking and overcome stigma. The Task Force also found that occasionally leadership environments (usually at the junior supervisory and sometimes at the mid-grade level) resulted in discriminatory and humiliating treatment of Service Members who responsibly sought professional services for emotional, psychological, moral, ethical, or spiritual matters, which not only deters help seeking but also reinforces the stigma.

Detailed findings and discussion can be found in Section 7 of the report beginning on page 45.

Strategic Initiatives:

1.A. Create, restructure, and resource suicide prevention offices at OSD, the Services, installations, and unit level to achieve unity of effort.

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

1.C. Develop strategic communications that promote life, normalize "help-seeking behaviors," and support DoD suicide prevention strategies.

1.D. Reduce stigma and overcome military cultural and leadership barriers to seeking help.

1.E. Standardize suicide prevention policies and procedures.

These Strategic Initiatives drive 25 targeted recommendations that can be found in Section 7 of the full report and are listed at the end of this Executive Summary.

Focus Area 2: Wellness Enhancement and Training

Overview: Military life, particularly in wartime, is inherently stressful on individuals and presents a unique challenge to maintaining wellness. Efforts to enhance well-being, mental fitness, resiliency, and the development of life skills in Service Members will have significant impact on preventing suicide. These efforts must include all areas of fitness: physical, psychological, family, social, spiritual, financial, vocational, and emotional. DoD and the Services must continue to expend substantial effort to mitigate stressors by supporting programs that strengthen protective factors in these domains. Stress on the force *must* be reduced. In addition, skills-based training is imperative to preventing suicide. When individuals exhibit signs of distress, peers, leaders, and family members must be able to recognize the danger and respond with appropriate support, including referral to intervention services. This focus area addresses the need to meet the issue of overall well-being and resiliency, not just by reducing stress, but also by providing the programs and training necessary to maintain and enhance both mental and physical health of Service Members and their families.

Summary of Findings: Heightened operational tempo, repeated deployments and insufficient quantity and quality of dwell time have had a cumulative fatiguing effect on Service Members, and a degradation of the overall fitness and readiness of the force. Service Members have been incredibly resilient and have met the challenges of functioning at maximum throttle year after year, but they need more than an occasional pit stop; they need an "off season" period to recover, restore and renew their well-being. Furthermore, suicide prevention training programs throughout the force have had less than optimal effectiveness because they lack a strategic approach and do not provide enough skills-based training. The Task Force found evidence that the Services have recently strengthened their emphasis on prevention and early intervention through such efforts as resiliency training, comprehensive fitness and operational stress control, but there is still insufficient time devoted to enhancing critical life skills as well as comprehensive fitness. In addition, family members generally do not receive adequate

education and training in suicide prevention and they, above all, are the best "detectors" of subtle behavioral changes associated with suicidal risk. When training *is* offered to family members and friends, many obstacles prevent wider attendance. There is positive acceptance by Service Members of embedding behavioral health providers in operational units, which needs to be further exploited.

Detailed findings and discussion can be found in Section 7 of the report beginning on page 45.

Strategic Initiatives:

2.A. Enhance well-being, mental fitness, life skills, and resiliency.

2.B. Reduce stress on the force and on military families.

2.C. Transform suicide prevention training of Service Members, leaders, and families to enhance skills.

These Strategic Initiatives drive 10 targeted recommendations that can be found in Section 7 of the full report and are listed at the end of this Executive Summary.

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

Overview: An effective, multifaceted suicide prevention program must provide access to high-quality professional services across the entire health and wellness continuum. These services include assessment, diagnosis, counseling, and treatment. Services must be synchronized, and where appropriate, standardized. Because of the complex dynamics of suicidal individuals' behavior, strong lines of communication between service providers are essential and will be aided by quality electronic medical records and by electronic communications. A strongly linked chain of care depends on engaged leaders as well as highly competent first responders, crisis hotline workers, and emergency department personnel, as well as chaplains, primary care clinicians and behavioral health clinicians. Skill-based training programs that build essential competencies must be tailored for the various professional groups. A degree alone does not imply proper training to prevent suicide or to properly address suicidal behaviors. Continuity of care, particularly at times of transition, is absolutely critical. This focus area addresses the need to provide care that is both accessible and of high quality to Service Members and their dependents.

Summary of Findings: Although there has been some expansion in the number of behavioral health providers in all of the Services, timely access to quality behavioral healthcare for Service Members continues to be a challenge. Much of the challenge can be attributed to the fact that DoD medical treatment facilities suffer from the same wholesale shortage of behavioral health care providers as found across America in the civilian sector. In addition, despite the expansion of non-clinical support services, adequate coordination is inconsistent among both the support services and among the providers. Furthermore, Service Members in the Reserve Components face additional challenges when they lose easy access to myriad installation-based support and healthcare services because the Service Members are generally not physically collocated with military installations. Service Members and their families are often unaware of the available

resources for suicide-related problems. There is insufficient communication among clinical providers, support services personnel, and commanders, which impedes the delivery of effective care, continuity, and management of transitions. The Health Insurance Portability and Accountability Act (HIPAA) is often misunderstood and over-interpreted, thus creating additional, self-induced obstacles to sharing information that may prevent suicide, especially for at-risk Service Members. In addition, the current DoD electronic medical documentation platforms do not allow easy and systematic tracking of the care provided to high-risk suicidal Service Members. "Suicide watch" is ungoverned, not standardized, and largely ineffective, and those conducting suicide watch are not trained. Furthermore, there is insufficient training of behavioral health, primary care and emergency medical personnel, as well as chaplains, on evidence-based assessment, management, and treatment services for Service Members with suicide-related behaviors. Due to the variety of numerous hotline services for crisis intervention, there is confusion as to which to utilize in what circumstances. Additionally, the quality of many hotline services is suspect because there does not appear to be universal standards, oversight and accountability. Integration of behavioral health services into primary care settings, which could potentially produce benefits in overcoming stigma and providing necessary services, is underutilized. Across DoD, after a tragedy or significant personal loss, postvention is underutilized to assist family members, fellow Service Members and unit leaders through the aftermath of emotions and psychological impact, thus missing a key opportunity to intervene early, to teach life skills and build resiliency, and to prevent potential suicidal behaviors as well as other destructive behaviors. Additionally, family members noted that they became highly distressed when suicide investigations were conducted by officers with little or no family liaison training.

Detailed findings and discussion can be found in Section 7 of the report beginning on page 45.

Strategic Initiatives:

- 3.A. Ensure available and reliable access to high-quality behavioral healthcare.
- 3.B. Leverage and coordinate military community-based services, as well as local civilian community services (especially with respect to the Reserve Component).
- 3.C. Ensure continuity of behavioral healthcare, especially during times of transition, to ensure seamlessness of healthcare delivery and care management.
- 3.D. Standardize effective crisis intervention services and hotlines.
- 3.E. Ensure all "helping professionals" are trained in the competencies to deliver evidence-based care for the assessment, management, and treatment of suicidal behaviors.
- 3.F. Develop effective postvention programs to support families, Service Members, and unit leaders after a suicide.

These Strategic Initiatives drive 31 targeted recommendations that can be found in Section 7 of the full report and are listed at the end of this Executive Summary.

Focus Area 4: Surveillance, Investigations, and Research

Overview: The Task Force strongly believes that well-constructed surveillance is necessary to inform and shape future suicide prevention programs. For surveillance to be effective, it must be standardized, centrally driven, and reported from the Service-level to DoD in a timely, consistent, and reliable manner. Surveillance should be continuous and sustained. Investigations into individual suicides and suicidal behaviors in a standardized manner will significantly contribute to knowledge and understanding of causal factors and trends. Program evaluation is sorely needed for every initiative and program implemented by the Services to determine the effectiveness of that program in improving outcomes. Research must continue to advance the science of suicidology to learn more about suicide and effective prevention techniques.

Summary of Findings: DoD does not have an effective standardized approach to suicide surveillance with the current configuration of the Department of Defense Suicide Event Report (DoDSER), and it is suboptimized for informing the improvement of Service suicide prevention programs. The inability of the DoDSER to access the current Defense Medical Surveillance System (DMSS) further degrades its potential as a real-time, effective, surveillance tool. Moreover, the investigation of both suicide attempts and completed suicides is not standardized, hindering the ability to modify surveillance tools (i.e., DoDSER). Furthermore, investigations are usually completed to either determine the cause of death (in difficult cases) or to determine if criminal activity was involved in the death: Investigations are generally not done to improve suicide prevention programs or prevent future suicides. Program evaluation is not uniformly incorporated, thus the effectiveness of many programs cannot be determined. Because a gold standard has not been established for evaluation, the Task Force was unable to "grade" Service suicide programs. In addition, given currently available data, the Task Force could not establish an association between suicide risk and specific military role or occupation. Finally, because of a historical lack of research investment in suicidology, there is a gap in knowledge, specifically evidence-based knowledge, with respect to suicidal behaviors and suicide prevention practices.

Detailed findings and discussion can be found in Section 7 of the report beginning on page **Error! Bookmark not defined.**.

Strategic Initiatives:

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

4.B. Standardize investigations of suicides and suicide attempts to identify target areas for improving prevention policies, procedures, and programs.

4.C. Ensure all initiatives and programs have a program evaluation component.

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

These Strategic Initiatives drive 10 targeted recommendations that can be found in Section 7 of the full report and are listed at the end of this Executive Summary.

Foundational Recommendations:

These Foundational Recommendations are derived from the 76 targeted recommendations developed by the Task Force. They are considered critically important to the success of developing a comprehensive DoD suicide prevention model.

1. Create a "Suicide Prevention Policy Division" at OSD within 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.

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.

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.

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.

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.

6. Strengthen strategic messaging to enhance positive communications that generate the behaviors and outcomes desired rather than highlighting the negative messaging about 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.

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.

8. Incorporate program evaluation in all suicide prevention programs to determine the effectiveness of each program in obtaining its intended outcome.

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.

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.

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.

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.

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.

Concluding Remarks

Considerable effort has been expended by DoD, the Services, and innumerable caring and dedicated individuals across the world in support of Service Members and their families. The findings and recommendations herein are intended to guide DoD in its efforts to enhance the work already being done while ensuring a more fit and ready force for meeting the demands of serving in the military. It is our belief that implementation of the Task Force recommendations and strategic initiatives will save lives and will further propel DoD as a national leader in suicide prevention.

All Recommendations Listed by Focus Area and Strategic Initiative

RECOMMENDATIONS	
Focus Area 1: Organization and Leadership (25 Recommendations)	
Strategic Initiative 1A:	*Create, restructure, and resource suicide prevention offices at OSD, the Services, installations, and unit level to achieve unity of effort (Section 7.1.1).*
Recommendation 1	Build, staff and resource a central OSD Suicide Prevention Office that can effectively develop, implement, integrate, and evaluate suicide prevention policies, procedures, and surveillance activities. This office should reside within the Office of the Under Secretary of Defense for Personnel and Readiness and be granted the coordinating authority that enables strategic suicide prevention oversight from OSD, through the Services, and down to the unit level.
Recommendation 2	Prioritize resources to adequately staff, fund, and organize the headquarters-level suicide prevention offices, within each Service, to successfully meet all current requirements.
Recommendation 3	Services should require full-time civilian suicide prevention coordinators at all installations identified by major commands. Major commands must facilitate the consistent implementation of Service suicide prevention strategy down to the small unit level and installations must ensure appropriate resourcing of this position in order to fully support both DoD suicide prevention policy, and Service policy and programs.
Recommendation 4	Sufficiently resource suicide prevention coalitions that strategically integrate installation and major command suicide prevention efforts and informs the Service-level program office. This coalition should also function to coordinate support services through collaboration on overarching social/behavioral risk problems on the installation.
Recommendation 5	Require full-time suicide prevention program coordinators at each MTF (or regionalized when covering several non-hospital MTFs) to facilitate the standardized implementation of Service suicide prevention strategy on behalf of the MTF commander and ensure the adherence to standardized policies and practices.
Recommendation 6	Direct unit-level suicide prevention program officers to facilitate the implementation of Service policies.
Strategic Initiative 1B:	*Equip and empower leaders (provide them tools) to establish a culture that fosters prevention as well as early recognition and intervention (Section 7.1.2).*
Recommendation 7	Strengthen and reinvigorate the fundamentals of military garrison leadership at the unit level with a focus on supervisor-subordinate interactions and mentoring. Ensure that front-line supervisor training is mandatory, occurs prior to assuming a supervisory role, and includes critical skills building in interpersonal relationships.
Recommendation 8	Ensure that professional military education, ranging from basic training to Senior Service Schools, develops leaders with the interpersonal and leadership skills required to fulfill their leadership and mentoring responsibilities, as well as promotes the well-being and total fitness of the Service Members under their charge.
Recommendation 9	Maintain a sufficiently small front-line supervisor-to-subordinate ratio to ensure the person-centered leadership functions can occur.

RECOMMENDATIONS	
Recommendation 10	Add validated behavioral risk questions to unit climate surveys to help commanders detect relative elevations in behavioral risk across their military units and respond with appropriate preventive measures. Mandate the use of unit climate and risk surveys annually and upon accepting and relinquishing command.
Recommendation 11	Develop monthly risk reports from a multitude of sources and services to create a snapshot of the unit and the ability to compare a commander's unit with like units across the Service and at the installation, while also allowing for the identification of positive and negative trends with reference to risk behaviors by members in that unit.
Recommendation 12	Disseminate and enforce "zero tolerance" policies that prohibit prejudice, discrimination, and public humiliation towards individuals who are responsibly addressing emotional, psychological, relational, spiritual, and behavioral issues; as well as towards those seeking help to increase their psychological fitness and operational readiness. Support these policies by holding leaders and supervisors accountable and by sustained communications campaigns.
Strategic Initiative 1C:	*Develop strategic communications that promote life, normalize "help-seeking behaviors," and support DoD suicide prevention strategies (Section 7.1.3).*
Recommendation 13	Develop and implement sustainable training programs for PAOs serving Service leaders, senior leaders, and installation commanders in crafting health-promoting messages that support the goals and objectives of the Services' suicide prevention and health promotion programs; avoid counterproductive or dangerous messages whenever making statements or discussing suicide-related information or statistics.
Recommendation 14	Instruct PAOs to disseminate nationally recognized recommendations for reporting on suicide as they interact with news media on the subject of suicide.
Recommendation 15	Develop and disseminate communication guidelines to commanders for use in the wake of a local suicide event.
Strategic Initiative 1D:	*Reduce stigma and overcome military cultural and leadership barriers to seeking help (Section 7.1.4).*
Recommendation 16	Develop an aggressive Stigma Reduction Campaign Plan, communications effort, and implement policies to root out stigma and discrimination. Follow scientifically based health communications principles in these campaigns.
Recommendation 17	Promote values that encourage seeking the assistance of chaplains, healthcare, and behavioral healthcare professionals to enhance spiritual, physical, and psychological fitness.
Recommendation 18	Develop and implement campaigns to inculcate values and norms aligned with promoting the well-being, connectedness, and psychological and spiritual fitness of Service Members. Use well-planned, multi-year communications campaigns at the DoD and Service levels, employing the best of health communications science as part of that effort.
Recommendation 19	Target a specific component of the communications campaign to ensure that Service Members who hold security clearances and the mental health providers who see them are aware of policies that exclude reporting certain instances of mental health care on the SF-86.
Recommendation 20	Adjust manning levels, especially in elite units and certain military occupational specialties, to support developing and maintaining comprehensive fitness by all members.

RECOMMENDATIONS	
Recommendation 21	Infuse curricula for all levels of military specialty training with expectations that even the most effective Service Members will occasionally experience difficulties that require temporary interruptions in their qualifications for full duty. Teach that the responsibility of others in the unit is to support them during those times.
Recommendation 22	Discourage and refrain from use of the term "malingering" in association with suicide-related behaviors. Ensure DoD and Service suicide prevention policies and guidelines eliminate using the word "malingering".
Strategic Initiative 1E:	*Standardize Suicide Prevention Policies and Procedures (Section 7.1.5).*
Recommendation 23	Implement DoD and Service guidance for commanders and military recruit instructors that addresses the management of suicide-related behaviors during basic training.
Recommendation 24	Develop and implement a DoD-wide policy requiring immediate command notification and chain of care (or chain of custody) for individuals who become aware they are being investigated for a criminal or other serious offense, immediately after they confess to a crime, and/or soon after they are arrested and taken into custody.
Recommendation 25	Establish clear DoD, Joint and Service guidance for removal and subsequent re-issue of military weapon and ammunition for Service Members recognized to be at risk for suicide. The guidance should emphasize a collaborative, team approach to the decision-making process and specify documentation requirements.
Focus Area 2: Wellness Enhancement and Training (10 Recommendations)	
Strategic Initiative 2A:	*Enhance well-being, mental fitness, life skills, and resiliency (Section 7.2.1).*
Recommendation 26	Improve access to, and promote utilization of, state-of-the-art training in critical life skills (e.g., financial management, communication, marriage and family relationships, anger management, and conflict resolution).
Recommendation 27	Expand the practice of embedding behavioral health providers in operational units. Conduct studies to determine the range of effective staffing ratios for embedded providers.
Strategic Initiative 2B:	*Reduce stress on the force and on military families (Section 7.2.2).*
Recommendation 28	Balance uniformed end-strength with operational requirements by either increasing military end-strength or decreasing operational commitments.
Recommendation 29	Provide sufficient, high-quality dwell time for redeploying Service Members in keeping with the most current military health research. Initial post-deployment dwell time should ensure an initial period (of at least several months) in which Service Members can restore their well-being, and should not include extended temporary duty (TDY) or extended "gear-up" training for the next deployment.
Recommendation 30	Reduce operations tempo and day-to-day work requirements on individuals and units to sustainable levels that support the wellness of Service Members and their families. Create white space in training schedules, especially in post-deployment periods.
Recommendation 31	Review in-garrison military training requirements with the goal of eliminating and/or combining training, thereby reducing the time burden on units and Service Members.

RECOMMENDATIONS	
Strategic Initiative 2C:	*Transform suicide prevention training of Service Members, leaders, and families to enhance skills (Section 7.2.3).*
Recommendation 32	Develop DoD and Service-level comprehensive suicide prevention training strategies. Develop and disseminate state-of-the-art training curricula addressing the specific knowledge, skills, and attitudes required of each sub-population in the military community. Incorporate industry-standard evaluation practices throughout the development and dissemination phases. Focus efforts on skills-based training.
Recommendation 33	Target and train families (including parents, siblings, significant others, and next of kin) as a suicide prevention training strategy, and consider it an important part of the chain of care for Service Members. Family members should be educated and trained to recognize the signs of stress and distress, to know whom to call for advice, and to understand how to respond in emergencies.
Recommendation 34	Develop strategies to locate and remain in contact with families during every phase of the deployment cycle. Develop and disseminate pre-deployment and reintegration education and training programs germane to suicide prevention for family members.
Recommendation 35	Proactively seek opportunities to collaborate with other federal agencies in their efforts to support military families.
Focus Area 3: Access to, and Delivery of, Quality Care (31 Recommendations)	
Strategic Initiative 3A:	*Ensure available and reliable access to high-quality behavioral healthcare (Section 7.3.1).*
Recommendation 36	Implement policies that optimize access to care for all Service Members which are specifically designed for behavioral health care, and monitor access standards closely for compliance.
Recommendation 37	Train all caregivers in the governing rules applicable to appropriate and necessary information sharing among providers, outside agencies, and with Service Members' commands.
Recommendation 38	Develop interdisciplinary treatment plans for Service Members at risk for suicidal behavior.
Recommendation 39	Implement coordination of care plans across longitudinal lines (e.g., permanent change of station, temporary change of station, deployment and redeployment transitions, temporary duty with other units, release from active duty, demobilization, confinement, hospitalization, and extended leave periods).
Recommendation 40	Establish multidisciplinary case management teams to ensure the highest quality of coordinated care by the team of commander, clinical provider, and non-clinical care provider.
Strategic Initiative 3B:	*Leverage and coordinate military community-based services, as well as local civilian community services (especially with respect to the Reserve Component) (Section 7.3.2).*
Recommendation 41	Optimize and coordinate community-based services to leverage their capabilities to enhance protective factors for Service Members.
Recommendation 42	Promote and utilize coordinated community outreach and awareness activities provided by clinicians and other installation-based care providers to improve access to care and reduce stigma.

RECOMMENDATIONS	
Recommendation 43	Encourage Service Members to have annual face-to-face "conferences" with chaplains for the purpose of resolving questions of guilt and to obtain referrals to appropriate caregivers for other concerns beyond the chaplain's scope of expertise and experience.
Recommendation 44	Develop a comprehensive policy to promote systematic and regular communication among clinical and non-clinical providers.
Strategic Initiative 3C:	*Ensure continuity of behavioral healthcare, especially during times of transition, to ensure seamlessness of healthcare delivery and care management (Section 7.3.3).*
Recommendation 45	Manage care across transition points and monitor Service Members identified as being at risk for suicide.
Recommendation 46	Assess Military OneSource capabilities to ensure a seamless transition of care system is established for suicidal or at-risk Service Members who utilize their services. This transitional care system needs to take into account challenges involving medical documentation, timeline of transition, and maximizing Service Member compliance with the transition plan.
Recommendation 47	Develop, evaluate, and more widely disseminate peer-to-peer and other programs that intentionally promote not only connectedness but also risk identification and response among Reserve Component Service Members.
Recommendation 48	Promote easy access to evidence-based treatments and community support services for post-deployment Reserve Component Service Members.
Recommendation 49	Ensure all Reserve Component Service Members receive face-to-face behavioral health checks post-deployment/post-demobilization and before being remobilized, with an emphasis on connecting them with professional services during the post-deployment phase.
Recommendation 50	Provide guidance on how behavioral health providers and commanders should best communicate with each other to promote effective suicide prevention practices for Service Members.
Recommendation 51	Establish and use interdisciplinary "human factors" type boards (emphasizing topics like physical, social, behavioral, psychological, nutritional, environmental, spiritual, and medical health) on all installations to coordinate suicide prevention care for at-risk Service Members.
Recommendation 52	Take steps to make "mental fitness" commensurate with "physical fitness" within military culture as a core value of military life. Ensure every Service Member receives a mental fitness assessment and appropriate wellness education as part of his or her periodic heath assessment.
Recommendation 53	Integrate behavioral health treatment teams into DoD primary care settings to overcome stigma and increase the likelihood of access to care; as well as to establish an early intervention approach to suicide prevention. Where this is not possible, train primary care providers and their staff in the assessment and management (and triage) of acute suicide risk patients.

RECOMMENDATIONS	
Recommendation 54	Develop a standard and systematic medical documentation system to identify high-risk patients and track the care provided. Continually review and update the record (documentation).
Recommendation 55	Suicide watch should be used only as a last resort and only until appropriate mental healthcare becomes available. Provide consistent guidance to units for these exceptional instances, as well as "just in time" training (e.g., online training). If units have a suicide prevention coordinator, the management of these rare instances could fall to that individual's responsibility. A suicide watch training program should be developed and similarly instituted.
Strategic Initiative 3D:	*Standardize effective crisis intervention services and hotlines (Section 7.3.4).*
Recommendation 56	Provide clear direction and consistent messaging regarding the promotion and usage of the National Suicide Prevention Lifeline 1-800-273-TALK (8255) as a national suicide prevention hotline resource available to all Service Members and their families, as well as the use of local crisis hotlines (or information lines) focusing on specific populations.
Recommendation 57	Formalize existing interconnectedness of the DCoE Outreach Call Center, National Suicide Prevention Lifeline, and Military OneSource to enable each agency to quickly and effectively route calls to appropriate responders. Ensure ongoing quality review and quality improvement efforts focused on emergency rescue situations, follow-up referrals for callers at-risk, and linkages with community providers of crisis services (e.g., mobile outreach teams).
Recommendation 58	Optimize the availability of suicide hotline services to deployed Service Members using the same National Suicide Prevention Lifeline number to ensure best response capabilities.
Strategic Initiative 3E:	*Ensure all "helping professionals" are trained in the competencies to deliver evidence-based care for the assessment, management, and treatment of suicide-related behaviors (Section 7.3.5).*
Recommendation 59	Develop clinical practice guidelines to promote the utilization of evidence-based practices for the assessment, management, and treatment of suicide-related behaviors.
Recommendation 60	Dedicate sufficient mental health resources to military health facilities to allow for timely mental health assessment and treatment.
Recommendation 61	Train all military healthcare providers (including behavioral health providers) and chaplains on evidence-informed suicide risk assessment, management, and treatment planning. Create and provide continuing education tailored to their specialty and area of expertise.
Strategic Initiative 3F:	*Develop effective postvention programs to support families, Service Members, and unit leaders after a suicide (Section 7.3.6).*
Recommendation 62	Incorporate postvention programs targeted at the decedent's military unit, family and community after a tragedy or loss to reduce the risk of suicide. Postvention efforts must address Service Members affected by a significant loss, especially after a fallen comrade's death in combat or in garrison when the unit is impacted. Unit-level postvention efforts must focus on effective debriefing and prevention when they are impacted by a significant tragedy or loss.
Recommendation 63	Train first responders, chaplains, casualty notification officers, and family interviewers on how to best respond to suicide and suicide-related events when working with families or next of kin.

RECOMMENDATIONS	
Recommendation 64	Provide families with comprehensive emotional support following the death of a loved one by suicide. All those affected, including significant others and battle buddies, should have access to resources that will help them cope with traumatic grief, such as the peer-based support organization Tragedy Assistance Program for Survivors (TAPS) and the Department of Veterans Affairs (VA) Vet Centers. These organizations offer free services to all who are grieving, with focused support for suicide loss.
Recommendation 65	Ensure that Service criminal investigation agencies are staffed appropriately with family advocates trained in communicating with family members whose loved ones might have died by suicide. Maintain effective communication with surviving family members during the investigative process.
Recommendation 66	Develop a consistent DoD policy on memorials that encourages remembrance based on how the Service Member lived, rather than the manner of death. Use WHO/IASP guidelines to avoid increasing risk through glamorizing death, and SPRC recommendations for conducting memorial services.
Focus Area 4: Surveillance, Investigations, and Research (10 Recommendations)	
Strategic Initiative 4A:	*Conduct comprehensive surveillance aimed at identifying individuals at-risk and informing prevention efforts (Section 7.4.1).*
Recommendation 67	Structure DoD to implement surveillance efforts in a standardized manner, with a core focus on informing and improving suicide prevention activities. The DoDSER must be matured, expanded, and refocused to fulfill this surveillance role.
Recommendation 68	Standardize DoDSER surveillance throughout the DoD, including specification of qualifications of surveyor and required training.
Recommendation 69	Facilitate consistent and fluid access to DMSS by DoDSER for appropriate surveillance purposes that also allows for automatic filling of select data fields as appropriate. Aggregation of surveillance data reported using the DoDSER is intended to inform suicide prevention efforts across DoD and the Services through centralized offices at both levels, thus access to DMSS is essential.
Strategic Initiative 4B:	*Standardize investigations of suicides and suicide attempts to identify target areas for prevention policies, procedures, and programs (Section 7.4.2).*
Recommendation 70	Standardize the suicide investigation process across DoD with the sole focus being suicide prevention. The investigation process should be non-attributional, all-inclusive of the days and weeks preceding a suicide or suicide attempt, and be reported in a redacted form, from the Services to OSD, to maintain confidentiality.
Recommendation 71	Institute a modified psychological autopsy and root cause analysis protocol with a standardized process of reporting to a centralized office at the Service and OSD-level. The results of modified standardized investigative procedures can be used to refine and modify the DoDSER and improve surveillance methods. A modified investigatory protocol must include a focus on last days of life; development of a pathway to death that enables identification of potential points of intervention; interaction between person and environment; and access to all currently collected surveillance, as well as medical and personnel records.
Recommendation 72	Place investigative responsibilities in the Safety Division offices of each Service to leverage the expertise, external party team management experience, protected (confidential) approach, and effectiveness of aviation mishap investigations.

RECOMMENDATIONS	
Recommendation 73	Review legal protections and make recommendations to Congress, as necessary, to ensure protected status of investigations.
Recommendation 74	Recommend legislation to create procedures that facilitate the timely transfer and sharing of civilian autopsy findings on Service Members (Active Duty, Reserve Component, National Guard) with the Armed Forces Medical Examiner's Office. Evaluate the appropriateness and necessity of access to other civilian findings to improve the tracking of members of the Armed Forces at-risk.
Strategic Initiative 4C:	*Ensure that all initiatives and programs have a program evaluation component (Section 7.4.3).*
Recommendation 75	Every suicide prevention program initiated by DoD or the Services must contain a program evaluation component.
Strategic Initiative 4D:	*Support and incorporate ongoing research to inform evidence-based suicide prevention practices (Section 7.4.4).*
Recommendation 76	Create a unified, strategic, and comprehensive DoD plan for research in military suicide prevention: (1) ensuring that the DoD's military suicide prevention research portfolio is thoughtfully planned to cover topics in prevention, intervention, and postvention; and (2) assisting investigators by creating a DoD regulatory and human protections consultation board that is responsible primarily for moving suicide-related research forward in an expedited manner.

Detailed Findings, Discussions and Recommendations can be found in Section 7 of the full report.