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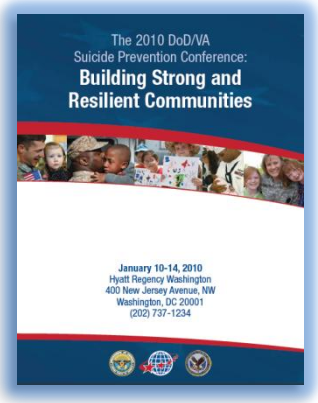
1.0 EXECUTIVE SUMMARY

On 10-14 January 2010, the Department of Defense (DoD) and the Department of Veterans Affairs (VA) sponsored a second annual joint conference to discuss the challenges posed by suicide in the service member and Veteran communities and to highlight innovative ways to address the issue. This is the only suicide prevention conference that specifically addresses suicide in the military and Veteran populations.



The purpose of the event was to focus on ways to:

- Increase suicide prevention, intervention, and postvention across departments, installations, and communities
- Disseminate available tools and information about support systems
- Provide knowledge on the current and future state of research
- Enhance the dialogue about suicide, prevention and related factors
- Discuss leading practices, evidence-based initiatives, and other innovative programs

Approximately 980 attendees, including representatives from the DoD, the VA, the Services, and Federal and civilian agencies, participated in the five-day conference. Emphasizing the widespread support for and emphasis on the issue of suicide prevention, keynote speakers included Secretary of the VA, Eric Shinseki; Performing the Duties of Assistant Secretary of Defense for Health Affairs, Ms. Ellen Embrey; Chairman of the Joint Chiefs of Staff, Admiral Mike Mullen; and his wife, Mrs. Deborah Mullen.

The conference featured a mix of large-group plenary sessions and breakouts divided into four tracks: Practical Applications and Tools; Clinical; Research; and Multi-disciplinary. Additionally, the final day allowed the individual military services, including the National Guard and Reserve Component, and the VA to meet in smaller working groups to discuss their respective mental health and suicide prevention issues. By the conclusion of conference, attendees received:

- Communications from Senior DoD and VA leadership about the need to proactively reach out to service members, Veterans, and families; reduce risk; and eliminate stigma
- Information about practical applications, tools, and research efforts relevant to suicide prevention for service members, Veterans, clinicians, and families
- Highlights of current suicide prevention practices being applied and future program development in DoD and VA, including practices outside the military, suicide nomenclature, role of telemental health, and clinical treatment approaches
- First-hand testimonies emphasizing the importance of recognizing when someone needs help, as well as ways for seeking help and encouraging others to do so, reducing stigma, and supporting those who seek help
- Information about ways to support those affected by suicide

2.0 PRECONFERENCE WORKSHOP SUMMARY: DAY 1 - SUNDAY, 10 JANUARY

Stark Raving Honesty
Presented by: Chaplain (CH) (Lt Col) Steven M. Torgerson, USAF
Summary of presentation unavailable, presenter declined to provide a copy of the speech to include in this report.

The VA Chaplain's Spiritual Role in Suicide Prevention/Bereavement Counseling for Veterans and their Family Members
Presented by: Rev. Joseph O'Keeffe, White River Junction VA Medical Center

Rev. O'Keeffe presented the unique skills and perspectives military chaplains bring to suicide prevention. These perspectives include:

- Tending to the wounds of the soul and conscious
- Dealing with guilt and being in the "forgiveness business"
- Being in a unique position to communicate hope
- Encouraging deeper relationships with a higher power

Rev. O'Keeffe reminded participants of the importance of spirituality in suicide prevention and recommended it be included as a part in all suicide prevention programs. It is critical to take a holistic approach to prevention. The experience of war causes grief and wounds to the soul and conscious. These injuries can be healed through conventional and spiritual counseling. Finally, he reminded participants the VA chaplains and VA mental health service providers to work closely together and to pay attention to suicidal cues and statements. Oftentimes, a simple, caring, life-promoting gesture can be critical in preventing suicide.

Reducing Risk and Promoting Warrior, Family and Community Healing Following a Suicide
Presented by: Kenneth Norton, LICSW, National Alliance on Mental Illness New Hampshire

Mr. Norton gave an overview of current suicide statistics including: 80% of suicide deaths in the US are white men, males die at a rate three times higher than women; women attempt suicide at rates four times higher than men, approximately 450 law enforcement personnel die by suicide annually nationally, Veterans account for one-fifth of the suicide deaths, and the US Suicide rate has increased from about 5% between 1999-2009. He further stated there is a high correlation between major mental illnesses and suicide (and suicide attempts). The US Center for Disease Control (CDC) estimates 90% of suicide deaths have either a mental illness or substance use disorder, and those individuals with Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) have a higher risk for suicidal behaviors.

Once a suicide has occurred it is important to initiate postvention activities. These activities support the healing process by reducing the risk of contagion, identifying any individuals at high risk of attempting suicide, and connecting them with the help they need. Mr. Norton explained exposure to a suicide may influence others (who may already be at risk) to take their life or attempt suicide. Having known someone who dies by suicide is one of the most significant risk factors for suicide. Teens and young adults are particularly prone to contagion and sensational media reports and inappropriate memorial services may contribute to contagion.

Mr. Norton further discussed that stigma, as it relates to suicide, is complex. Positive stigma prevents people from acting on suicidal impulses while negative stigma prevents people from seeking help or it can isolate family members. He stressed it is most important to encourage help-seeking and support people impacted by suicide.

He concluded by offering suggestions for appropriately covering suicide in the media to include:

- Providing information on where/how to get help (local and national) 800-273-TALK
- Emphasizing recent advances in treating mental illness and substance abuse
- Including information about warning signs
- Citing local efforts to prevent suicide

Andrew's Case: Anatomy of a Young Adult Suicide--Building Resiliency in Adolescents
Presented by: CAPT Edward Simmer, MD, USN, DCoE; Jeanne Blake, Works, Inc.; COL George Patrin, MD, USA; Pamela Patrin

This session chronicled a parent's tragic and moving account of their son Andrew's suicide. COL Patrin and his wife urged participants to view suicide prevention from the perspective of those who have lost a son. They further emphasized the importance of discussing lessons learned from past suicides, knowing the warning signs, and taking action immediately. The broader goal of this session was to provide those working with young adults new skills to help this at risk population. The *Words Can Work* organization shared a series of video clips, which stressed the importance of children having and engaging in open communications with a trusted adult.

3.0 PLENARY SESSION SUMMARIES

DAY 2 - MONDAY, 11 JANUARY

Opening Remarks and Welcome
Presented by: BG Loree Sutton, MD, USA, DCoE***;*** Ellen Embrey, Acting Principal Deputy Assistant Secretary of Defense for Health Affairs

BG Sutton welcomed all distinguished guests and speakers to the 2010 Suicide Prevention Conference and thanked all attendees for making this conference a priority. She emphasized that suicide is a public health challenge and encouraged the attendees to develop toolkits, combat stigma, and build peer to peer support groups.

Ms. Embrey welcomed all in attendance and praised the DoD and VA partnership in hosting this important event. She further stated suicide is not only personal, but a problem to all society. It is a tragedy because we do not know how to prevent this complex issue. It is important for everyone to understand the resources that are available. We must also increase sensitivity to warning signs and combat the stigma associated with seeking help. She then provided a list of suicide prevention programs currently administered by each of the service branches. Ms. Embrey concluded by emphasizing the DoD's desire to reduce suicide among the service members and Veterans.

Keynote Presentation
Presented by: Secretary of Veterans Affairs Eric Shinseki, Department of Veterans Affairs

Secretary Shinseki reminded attendees that suicide has always been a struggle for the VA and cited that 20% of all suicides are Veteran suicides. Service members suffer physical and emotional wounds. Some have issues of self worth after leaving active duty. He encouraged the attendees to work to build and maintain strong support systems where warning signs cannot be ignored.

Since 2003, the VA has taken the following steps to decrease suicide rates among Veterans:

- Hired 4,0000 new employees
- Added a suicide prevention coordinator to each VA outpatient clinic
- Began a suicide prevention awareness campaign
- Partnered with the Department of Health and Human Services (HHS) to improve the suicide prevention hotline
- Increased access to counselors and programs
- Introduced a suicide prevention chat feature on the VA website
- Established suicide prevention protocols

Secretary Shinseki noted that the VA is encouraged by the decreased suicide rates in the Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veteran population.

Challenge, Triumph and Change
Presented by: MAJ (Ret) Ed Pulido, USA

MAJ (Ret) Pulido's story has been featured on CNN and in TIME magazine. On October 1, 2004, his left leg was amputated at Brooke Army Medical Center. He began to worry about supporting his family and ultimately had suicidal thoughts. Through the support of his family and never feeling forgotten by his community, he was able

to "see the light at the end of the tunnel". His personal mantra is that he did not lose his leg, but rather sacrificed it for the country.

Why People Die by Suicide
Presented by: Thomas Joiner, PhD, Florida State University

Dr. Joiner gave an overview of the key reasons people die by suicide. The habituation of dangerous activities desensitizes people and allows them to build up the courage to commit lethal self injury. He explained, when self-injury and other dangerous experiences become unthreatening and mundane – when people work up to the act of death by suicide by getting used to its threat and danger – that is when we might lose them because they have developed the acquired ability to enact lethal self-injury. He cited the example of rock star Kurt Cobain's suicide in the early 1990's as a clear example of this behavior. Cobain initially felt that guns were barbaric and wanted nothing to do with them. Later, he agreed to go with his friend to shoot guns, but would not get out of the car. On later excursions, he got out of the car, but would not touch the guns. On still later trips, he agreed to let his friend show him how to aim and fire. He died by self-inflicted gunshot wound in 1994 at the age of 27. Dr. Joiner also cited that anorexic women die by suicide at high rates because their histories of self-starvation habituate them to pain and inure them to fear of death, and they therefore make high lethality attempts with high intent-to-die.

Dr. Joiner further explained that the group of people who desire suicide is much larger than those that are capable of suicide. This group can be subdivided into two categories of people wishing to die by suicide: those who have a sense of perceived burdensomeness and those who have a thwarted sense of belonging. Those who consider themselves a burden consider their death to be more valuable to their family members and loved ones than their life, while those with a thwarted sense of belonging are seeking to escape the pain and loneliness their life causes them. For those with a thwarted sense of belonging, the key to survival may be in the form of a winning sports team. Dr. Joiner gives cited research that found a correlation between winning sports teams and a decrease in suicide rates. He concluded that prevention of acquired ability, burdensomeness, or thwarted belongingness will prevent serious suicidality. He concluded that creating a sense of belonging may be the most malleable and most powerful form of prevention.

DAY 3 - TUESDAY, 12 JANUARY

Theater of War

The Theater of War was presented to all attendees. The Theater of War provides a series of dramatic readings from Sophocles' stories about Ajax and Philoctetes in the Peloponnesian wars. The readings are then followed by a 45 minute panel discussion with individuals sharing their responses to the readings and their personal stories with combat stress and psychological and physical injury. These ancient plays depict the timelessness of the psychological and physical wounds inflicted upon Soldiers by war. This approach to exploring the wounds of war also leverages the power of art in evoking emotional connections with the topic and greater sense of connection in the intimacy of a theater setting.

The objectives of presenting these plays to military audiences are four-fold:

- De-stigmatize psychological injury by placing it in the larger context of an ancient warrior culture
- Create a space for dialogue about the challenges faced by combat Veterans and those who support them
- Develop a powerful tool for military and medical combat stress training
- Serve as an advocacy platform, generating compassion, understanding and support for those who have served in the American Armed Forces

Suicide Prevention in the VA
Presented by: Ira Katz, MD, PhD, VA

Dr. Katz described the contrast between the VA and DoD approaches to suicide prevention. He explained that within the VA system individuals are seen on an as-needed basis and caregivers are focused on predisposition

factors. In the DoD system, individuals are seen daily and commanders and caregivers are focused on precipitating factors and acute stressors. Based on these differences, each organization takes a unique approach to suicide prevention. Within the VA, there has been significant emphasis placed on improving mental health care for Veterans and their families. The VA has invested in the implementation of the VA Comprehensive Mental Health Strategic Plan. As a result of this investment, they have seen increased productivity from VA mental health providers and expanded training and capacity for evidence based psychotherapies.

Dr. Katz reviewed the findings of the Serious Mental Illness Education and Clinical Centers:

- Mental health conditions increase risk of suicide, but the effect of PTSD may be related to its co-occurrence with other conditions
- Chart diagnoses associated with TBI are also associated with increased risk of suicide

In conclusion, Dr. Katz announced the next steps the VA will be taking to prevent suicide. These included assigning a principle mental health provider for every patient who sees more than one provider, monitoring suicide rates in the OEF/OIF Veteran population, guarding against changing public opinion of the conflicts, and continuing to support VA suicide prevention programs and hotline.

DAY 4 - WEDNESDAY, 13 JANUARY

Military Suicides…Not Simply a Mental Health Issue
Presented by: ADM Mike Mullen, CJCS, USN and Deborah Mullen

ADM Mullen and his wife, Deborah, shared their thoughts and concerns on the issue. He stated the subject of suicide is one of tremendous difficulty There have been many people who have worked on this issue diligently for many, many years and now with the rise in the numbers in all the services since these wars, DoD officials have started to investigate the causes and get to a point where we can prevent and more clearly understand suicide.

ADM Mullen urged the audience to focus on "dwell time" which is the time at home between deployments. He stated, "I know at this point in time, there does not appear to be any scientific correlation between the number of deployments and those who are at risk, but I'm just hard-pressed to believe that's not the case. I know we are and hope to continue to look [at deployments] first to peel back the causes to get to the root of this."

The suicide rate in all four services was higher than the national average, with 52 Marines and 48 Sailors taking their own lives in 2009, according to the individual services' annual reports. As of November, 147 Soldiers had fallen to suicide. The final 2009 figures for the Army are expected to be released 14 JAN. Air Force officials reported 41 active-duty suicides, a rate of 12.5 per 100,000 in 2009.

ADM Mullen advocated for better overall training for service members, during the deployment-readiness cycle. Training for troops and their family members must start from the day they swear in.

Suicide among military family members also is a growing concern for the military. Mrs. Mullen said that although much focus has been given to suicide prevention for service members and assistance for survivors of suicide victims, more must be done for the families. Family members also need training to build resilience and learn how to deal with the stress of deployments. She urged the group to consider families when working through these challenging problems. She concluded by stating, "We need to get our arms around the number of suicide attempts and actual suicides and the impact on the family." [1]

Mind Fitness: Mindfulness and Potential Application for Suicide Prevention
Presented by: Elizabeth Stanley, PhD, PTSD Survivor

Dr. Stanley shared her story of PTSD and how it has made her stronger today. She emphasized the importance of building resilience to prevent suicide. She further discussed the concept of mindfulness and the parallels

[1] Excerpts taken from USAF Website, http://www.af.mil/news/story.asp?id=123185434

between physical and mental fitness. Dr. Stanley stressed that practicing mindfulness can enhance social and emotional intelligence as well as help decrease stigma.

Caring Too Much: The Human Face of Compassion Fatigue
Presented by: CAPT Joan Hunter, MSW, RN, National Guard Bureau; J. Elizabeth Perkins, PhD, Michigan National Guard

CAPT Hunter discussed the signs and symptoms of compassion fatigue. She explained why it is important to pay attention to current life stressors in the lives of staff and how to be a flexible and emotionally supportive manager. She reminded participants that it is also imperative to recognize the warning signs within themselves. These include anger, chronic lateness, and frequent headaches. Some tools for building personal resilience include daily exercise, healthy eating habits, sleep, social support, maintaining emotional distance, and setting boundaries when helping others.

DAY 5 - THURSDAY, 14 JANUARY

Police Organization Provides Peer Assistance (POPPA)
Presented by: Bill Genet, Founder, Police POPPA; Frank Dowling, MD, Medical Advisor, Police Organization Provides Peer Assistance

Every year more police officers die by suicide then by line of duty deaths. In 2009, for the first time since 2001, more Soldiers died from suicide than by combat related injuries. Police officers and Soldiers share this grim statistic. Mr. Genet believes there is much the two groups can learn from each other. Similar to military culture, stigma prevents police officers from seeking care. They are afraid:

- Their career may be negatively impacted
- They may be stigmatized by peers
- They may feel weak or as if they have failed
- Of the mental health system

POPPA began in 1996 and is a confidential peer assistance program. POPPA has a 24/7 hotline and also provides psychological referrals, high risk assessments, and fosters an environment where it is encouraged to seek care. To date the hotline has received over 12,000 calls and has prevented over 80 suicides.

Suicide Prevention and Risk Reduction Committee (SPARRC)/VA/Services Updates
Presented by: CDR Janet Hawkins, SPARRC Chair, USPHS, DCoE; Walter Morales, USA; LCDR Bonnie Chavez, PhD, USN; CDR Aaron D. Werbel, PhD, USMC; Lt Col Mike Kindt, USAF; John S. Reibling, USCG; Jan Kemp, PhD, VA

SPARRC: Currently, the SPARRC is working on several projects. The committee is engaged in the RAND Research Project, which will review and catalogue suicide prevention activities. The SPARRC website is currently under development. This website will create a clearinghouse for suicide prevention information, innovations, and approaches. The committee has also come to agreement on the DoD Suicide Event Report (DoDSER). This standardized suicide data collection format will allow data to be compared across service branches. Finally, the SPARRC is also working on a Department of Defense Instruction (DoDI) with policy recommendations for suicide prevention, data collection, and reporting.

VA Update: The VA estimates there are approximately 32,000 Veteran suicides each year. The VA employs the following basic strategy; suicide prevention requires ready access to high quality mental health services that are supplemented by programming which increases education and awareness. Current resources include: national Suicide Prevention Coordinators, local Suicide Prevention Coordinators and teams, a hotline call center, a public information campaign, three centers of excellence, and the Office of Research and Development.

US Army Update: The Army found high risk Soldiers combined with inexperienced leaders results in an increase in high risk behaviors such as suicidal behavior, violence, sexual assault and substance abuse. To combat these issues, the Army established a task force in March 2009, published a comprehensive program review and developed the Comprehensive Soldier Fitness Program. The Army remains focused on these issues

and will be conducting further studies, expanding the task force, and establishing metrics to measure program success.

US Navy Update: While 84% of the Navy has been trained on suicide prevention, 73% of Navy suicides showed no use of support services 30 days prior to death. This concerning fact has triggered the Navy to aggressively market its ACT (Ask, Care, Treat) suicide prevention campaign. This campaign reminds sailors that the warning signs of suicide are not always obvious. As the Navy's suicide prevention programs continue to grow they are reaching out to include families in education and awareness and are seeking to build a more resilient force.

US Marine Corps (USMC) Update: The USMC Noncommissioned Officer (NCO) suicide prevention course includes a 30-minute introduction movie, documentary video clips, personal stories, and interactive workshops. This program has shown promise in preventing suicides as the number of suicides has fallen since its start in August 2009. Other suicide prevention training and education is incorporated throughout a Marine's career as reinforcement of this program and the ethos to "never leave another Marine behind".

US Air Force Update: The Air Force Suicide Prevention Programs (AFSPP) includes 11 elements: leadership involvement, suicide prevention in professional military education, a guide for managing personal distress, community prevention services, community education and training, investigative interview process, clinical incident stress management, an integrated delivery system (IDS), a limited privilege suicide prevention program, an IDS consultative assessment tool, and the DoDSER. This program has been correlated with a 33% reduction in suicides and a 54% reduction in severe family violence. The Air Force continues to enhance these 11 elements to improve outcomes and service member health.

US Coast Guard (USCG) Update: The goals of the USCG suicide prevention program is to empower all to recognize signs and react, reduce stigma, and protect those who seek treatment. The program includes the following components: command climate, crisis response, limited command access to mental healthcare information, notification of hands-off criminal investigations, postvention, reporting, and timing. The USCG is particularly concerned about the lack of programming and funding for the Reserve Components and limited outreach and programs for family members.

4.0 TRACK 1: CLINICAL INTERVENTION SUMMARY

The Clinical Intervention track was coordinated by CDR Janet Hawkins, Director, Prevention Branch, Resilience and Prevention Directorate, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. The objectives of this track were to improve care and attention to suicidal Veterans and active duty personnel; to reduce suicidal behaviors by disseminating usable information about current innovations; and to share best practices in suicide risk assessment, intervention and follow-up for use, at the local and system level. Summaries of each presentation in the Clinical Intervention track follow below.

DAY 2 - MONDAY, 11 JANUARY

Safety Planning in Care of Suicidal Veterans
1000-1130
Presented by: Dr. Barbara Stanley, Columbia University, Dr. Greg Brown, VA, Dr. Glenn Currier, VA, and Dr. Kerry Knox, The VA Center of Excellence at Canandaigua

Dr. Stanley, Dr. Brown, Dr. Currier, and Dr. Knox highlighted SAFE VET, a unique project that was created in response to the Blue Ribbon Report. SAFE VET seeks to enhance the VA infrastructure by providing support and guidance for identifying high risk Veterans in community Emergency Departments, VA Emergency Departments, and Urgent Care Units. The SAFE VET project includes a Safety Planning Intervention program that reduces suicide risk, enhances coping, and increases treatment motivation and commitment. The program utilizes a patient-specific safety plan that is developed by the individual with the assistance/guidance of a clinician. The end result is a prioritized list of coping strategies and resources for use during a suicidal crisis, which quickly enhances a patient's sense of control to overcome suicidal urges and thoughts. It is important to recognize that a safety plan is not the equivalent to a no-suicide contract. A no-suicide contract is an agreement

that asks the patient to promise to stay alive without detailing steps to do so; whereas, a safety plan equips the patient with six concrete steps to take when they begin experiencing suicidal ideations. The SAFE VET intervention program can be applied in various settings, such as Emergency Departments, inpatient facilities, ongoing outpatient treatment facilities for individuals with suicidal crises, and crisis call centers. The session leader ended the presentation by emphasizing the need for periodic clinician follow-up with patients in order to address the change in circumstances and needs over time.

Decreasing Suicides in the Army
1600-1730
Presented by: COL Elspeth Cameron Ritchie, MD, MPH, Director, Behavioral Health Proponency Office, Office of the Army Surgeon General

COL Ritchie stressed that suicide rates are steadily increasing in all Army components, across all age groups, and among both male and female Soldiers. COL Ritchie explained that the Army has been actively working to decrease suicides, but their efforts keep getting thwarted as suicide rates continue to rise. She explained it is possible to identify high-risk individuals; however, it is usually the low- to moderate-risk individuals that commit suicide. Therefore, a comprehensive approach to suicide prevention is required, which includes the identification and treatment of high-risk mitigation efforts in the Army population. COL Ritchie discussed risk factors for suicide in Army personnel and reviewed Army suicide rate trends. She also elucidated past suicide mitigation approaches, stating that the Army is changing its perspective on suicide. COL Ritchie quoted General Peter W. Chiarelli, who announced on 29 MAR 2009 that "the Army's charter is more about holistically improving the physical, mental, and spiritual health of our Soldiers and their families than solely focusing on suicide prevention. If we do the first, we are convinced that the second will happen." She discussed the benefits of suicide risk assessments and evidence-based therapy and highlighted population-based strategies for suicide mitigation and several resiliency programs. COL Ritchie concluded by discussing continuing challenges and the way ahead for the Army.

DAY 3 - TUESDAY, 12 JANUARY

Training in the Collaborative Assessment and Management of Suicide
1345-1515
Presented by: Dr. David A. Jobes, Professor of Psychology and co-director of Clinical Training, The Catholic University of America (CUA),

Dr. Jobes explained that The Collaborative Assessment and Management of Suicidality (CAMS) is a suicide-specific therapeutic framework, which emphasizes the five core components of collaborative clinical care. The typical timeline for a complete course of therapy is approximately ten to twelve sessions across three months. Within this approach, it is necessary for the clinician to collaborate with the patient, allowing him or her to see the issue through the patient's eyes. Dr. Jobes stressed that the clinician needs to digest what the patient is telling them, using evidence-based questions to create a Crisis Response Plan. The focus of this plan it to highlight/emphasize the positive actions the patient can take to alleviate distress, rather than committing suicide. Dr. Jobes explained the CAMS framework is used until suicidality resolves. Patient adherence to CAMS requires thorough suicide risk assessments and problem-focused interventions that are designed to directly and indirectly decrease the likelihood of suicide.

Concluding his presentation, Dr. Jobes discussed the process improvement trial, which was conducted at the Brooke Army Medical Center in San Antonio, Texas. This trial's goal was to return Soldiers to functional and deployable status as soon as possible. In order to achieve this goal, a modified version of the evidence-based CAMS program, The Collaborative Assessment and Management of Suicidality Brief Index (CAMS-BI), was implemented to enhance clinical assessment/intervention with suicidal military patients. Dr. Jobes ended by explaining that follow-up contact will be made at regular intervals. Additionally, the CUA team will develop and maintain a website containing updated information that will be made available for all CAMS-BI engaged patients.

Substance Use and Suicide
1545-1715
Presented by: Dr. Ken Connor, VA

Dr. Connor explained a recent treatment intervention protocol, referred to as TIP 50, is available as a free Substance Abuse and Mental Health Services Administration (SAMHSA) workbook that can be ordered online. The workbook contains six clinical vignettes that represent realistic scenarios that substance use counselors handle on a regular basis. He noted that major depressive episodes are the most frequent co-occurring disorder seen in individuals with substance use disorders/diagnosis. Often times these episodes may be dismissed, as they have a tendency to be overshadowed by the substance use, resulting in an increased risk for suicide. Dr. Connor explained individuals with suicidal ideations are extremely ambivalent, which enables them to take their own life, often aided by alcohol or drugs. He indicated it is a clinician's task to help the patient through difficult periods by helping him/her create a bridge that ultimately allows them to feel alive again. Dr. Connor described interpersonal difficulties as a pre-cursor to suicide noting that among substance users, the most frequent interpersonal difficulty pertains to relationship issues. He concluded by explaining that TIP 50 contains an abundance of information that would be useful for those who work with individuals with a substance abuse disorder/diagnosis.

Blister Packaging Medication to Increase Treatment Adherence and Clinical Response: Impact on Suicide Related Morbidity and Mortality
1545 - 1715
Presented by: Dr. Peter M. Gutierrez, VA Rocky Mountain Network (VISN 19) Mental Illness Research, Education, and Clinical Center (MIRECC)

Dr. Gutierrez explained medication overdose accounts for substantial numbers of suicide-related behaviors. Additionally, non-adherence is a significant issue for individuals with mental illness as psychiatric problems linked to non-adherence lead to greater risks of hospitalizations, arrests, violence, and alcohol-related problems. The benefits of adherence include overall symptom improvement, decreased levels of distress, and greater ability to benefit from non-medicinal interventions such as psychotherapy. Dr. Gutierrez discussed the objectives of a study, which is being conducted to determine if patients in the Blister Pack (BP) condition had better treatment adherence with their regular prescription medications in comparison to patients in the Dispense as Usual (DAU) condition. The researchers are working to determine if patients in the BP condition will have fewer overdoses than patients in the DAU condition. They will also explore whether patients in the BP condition will report less symptom distress, fewer negative medical/psychiatric outcomes, and lower health care utilization. The goals of the current study are to enhance/inform suicide prevention techniques and provide data on a specific intervention to increase medication adherence and restrict access to lethal means. Study participants are comprised of 414 recently discharged patients from the psychiatric inpatient unit of the Denver VA Medical Center, who will be randomly assigned to either the BP or DAU condition. Participants will be assessed at baseline prior to discharge and monthly by telephone follow-up through self-report measures or interviews. Dr. Gutierrez concluded by describing the current status of the project. As of now, human subject approval has been obtained, the protocol has been prepared, and the process of staff hiring/training and participant enrollment is underway.

DAY 4- WEDNESDAY, 13 JANUARY

Suicide Risk Reduction—Building Skills Toward Prevention
1000-1130
Presented by: Dr. Mark William Viner, University of Nevada

Dr. Viner explained a suicide intervention medical model that incorporates a strong patient-clinician bond and medication management. Research has demonstrated that any lesion, head injury or damage to the pre-frontal cortex increases the risk of suicidal thoughts in a person and consequently increases the risk of suicide. Dr. Viner explained that neuro-imaging scans have shown there is a different level/type of brain activity for those who have suicidal thoughts, depression, or other mental illnesses. By monitoring the scans once treatment has been initiated, therapy and/or medication effectiveness can be determined. Dr. Viner indicated that those with the highest suicide are individuals with Bipolar I Disorder, Most Recent Episode Mixed, which is extremely difficult to treat. Lithium, a mood stabilizing drug, has been found to decrease the suicide rate from 1.78% to 0.25% per year; however, very few doctors know how to prescribe lithium effectively. Dr. Viner explained the relationship between multiple mental health disorders and suicide as well as general medical conditions and

suicide. He concluded by stressing the importance of monitoring patient medications and substance use more closely. He recommended that one of the next steps in this area include the potential for increasing regulations on highly addictive prescription drugs in an attempt to decrease suicide attempts.

Mind Fitness Training, Emotional Regulation and Long-term Suicide Prevention
1415-1530
Presented by: Dr. Elizabeth A. Stanley, Security Studies Program, Georgetown University and Mind Fitness Training Institute, and John Schaldach, Mind Fitness Training Institute

Dr. Stanley and Mr. Schaldach explained emotional dysregulation is the ability to recognize, tolerate, and modulate emotional responses, followed by choosing an appropriate response, rather than reacting to impulsive or habitual conditioning. Deficiencies in emotional regulation can lead to high risk or inappropriate behavior, interpersonal difficulties and isolation, perception of being a burden to others, and suicide. Emotion dysregulation fuels a constellation of factors that lead to suicide, a causal factor that is both common to all suicides and is present far in advance. They explained that teaching emotion regulation skills represent a unique leverage point for prevention efforts. Stress resilience training is a culturally effective way to teach emotion regulation. A majority of their presentation focused on Mindfulness-based Mind Fitness Training (MMFT), a stress resilience training tailored to the military population. MMFT provides two skill sets that support emotion regulation: mindfulness and stress resilience. A pilot study was conducted and demonstrated that practicing mind fitness techniques during the pre-deployment period safeguarded positive emotions while reducing negative emotions. Additionally, practicing mind fitness techniques during the pre-deployment period had a protective effect on the degree of perceived distress. Dr. Stanley and Mr. Schaldach concluded by stating pilot data suggests MMFT can enhance emotion regulation skills.

Challenges in Managing Suicide Risk in Combat Zones
1545-1715
Presented by: Dr. Craig J. Bryan, Assistant Professor/Research, Department of Psychiatry, University of Texas Health Science Center at San Antonio

Dr. Bryan explained combat exposure appears to be linked to suicide risk. The Interpersonal-Psychological Theory of Suicide (IPTS) suggests that combat exposure contributes to an acquired capability for suicide because individuals with combat exposure exhibit more fearlessness regarding death and habituation to pain. Dr. Bryan also stated that lethality is related more to availability of means than suicidal intent. Firearms were used with greater frequency for suicide among deployed personnel, 93% versus 52%, and decisions to commit suicide were sudden, with little time for intervention. Research has indicated that 24% of combat-exposed individuals made the decision to end their life within five minutes of the attempt, while 70% of individuals make the decision within an hour of attempt. When explaining the challenges faced in managing suicide risk in combat zones, Dr. Bryan stressed that adaptability and flexibility are key. It is important to recognize that context and setting are critical variables in risk management strategies; therefore, what works in the United States will not necessarily work in a combat zone. Since combat increases fearlessness of death and the capability for suicide, interventions should target the desire for suicide. As people have easy access to firearms and other lethal means in combat zones, restriction of such means is difficult, and therefore such attempts should use extreme caution. Dr. Bryan also noted that insomnia and agitation are common in combat zones and can be adaptive creating a need for customized and mission-appropriate interventions. He concluded by recommending that a suicide risk assessment approach be adopted in combat zones, as suicidal behaviors cannot be predicted.

5.0 TRACK 2: MULTI-DISCIPLINARY SUMMARY

The Multi-Disciplinary track was coordinated by Eileen Zeller, MPH, Special Advisor, Suicide Prevention, Substance Abuse and Mental Health Services, Suicide Prevention Branch, Rockville, Maryland. The objectives

of this session were to provide conference attendees with information about resources and best practices, grounded in public health, multi-disciplinary, and strength-based approaches, so they may be implemented at a local and system level to reduce suicidal behaviors. Summaries of each presentation in the Multi-Disciplinary track follow below.

DAY 2 - MONDAY, 11 JANUARY

Resiliency Programs in the National Guard: Views from Michigan and Kansas
1000-1130

- ***Resiliency Programs in the National Guard: Collaborative Views from Michigan***

Presented by: BG James R. Anderson, PhD, Michigan National Guard - ATAG, and Dr. John F. Greden, Executive Director, University of Michigan

BG Anderson began the presentation by presenting the mission and vision of the Michigan Army National Guard. The Michigan Army National Guard mission is to provide well trained and motivated forces to the Governor and Combatant Commanders in order to support Homeland Defense and the Global War on Terrorism, while abiding by the vision that they are citizen Soldiers trained to meet the challenges of the future. BG Anderson stated that 10,000 men and women in the Michigan Army National Guard have deployed since September 11, 2001 presenting a location graph to indicate that Army National Guard members are well dispersed throughout the state. He described how he used to be concerned about the training of units, but now focuses on the reintegration of Soldiers. Mid-way through the presentation, BG Anderson introduced Dr. Greden who highlighted the collaboration between Michigan State and the University of Michigan. Dr. Greden explained that collaboration is essential in the effort to prioritize citizen Soldiers. He noted that resources are less available to citizen Soldiers due to geographic dispersal and increased stigma. The theme of "changing culture by using culture" played a pivotal role in this session, emphasizing the importance of instituting programs that National Guard and Reservists feel comfortable with. The Buddy to Buddy program was highlighted, in which unit members act as mentors to one another, identifying those in need and encouraging their buddies to seek treatment. The presentation concluded with BG Anderson and Dr. Greden stressing the importance of using networks that are already in place to increase collaborations, preventing any citizen Soldier from being left behind.

- ***National Guard Warrior Care: A History and Way Ahead***

Presented by: MAJ Paul E. Gonzales, Kansas National Guard

MAJ Gonzales discussed the way ahead for the National Guard after reviewing best practices and investigating how younger Soldiers respond to care. MAJ Gonzales explained that this is a "joint" program that includes interactive lectures, practical exercises, testimonials, and self assessments. He stated that the way ahead includes the introduction of a National Guard Integrated Service Delivery Model, National Guard Infrastructure Support, and National Guard Best Practices. MAJ Gonzalez highlighted that within the training documents there is a Combat Operational Stress Continuum Decision Matrix card to help assess Soldiers, classifying them as ready, reacting, injured, or ill. When a leader identifies one or more indications within a Soldier, it is his or her responsibility to assist the Soldier in seeking help from a clinician or chaplain. MAJ Gonzales concluded with a discussion of the separate Warrior Care teams, comprised of social, emotional, physical, spiritual and family. He explained that these teams needed to be intertwined in order for National Guard resiliency to improve.

Suicide Prevention Resource Center: A National Resource for a National Imperative
1410-1535
Presented by: Dr. Jerry Reed, Suicide Prevention Resource Center, and Xan Young, MPH, Suicide Prevention Resource Center

Dr. Reed and Ms. Young highlighted the National Strategy for Suicide Prevention, which serves as the roadmap for the national suicide prevention effort in the country through the Suicide Prevention Center, hotlines, "Option 1", and informing lawmakers. The Suicide Prevention Research Center promotes the implementation of the National Strategy for Suicide Prevention and enhances the Nation's mental health infrastructure by providing states, government agencies, private organizations, colleges, universities, and suicide survivor and mental

health consumer groups with access to the science and experience that can support program development, implement interventions, and promote prevention through policies. They stated that the Resource Center's main functions include translating research into practice, providing expert consultation, delivering technical assistance, developing and disseminating training, gathering and disseminating resources, and managing the Best Practices Registry. The Suicide Prevention Resource Center's Best Practice Registry identifies, reviews, and disseminates information about suicide prevention best practices, which are all in alignment with specific National Strategy of Suicide Prevention objectives. Dr. Reed and Ms. Young discussed the need to develop and implement strategies to reduce the stigma associated with mental health, both in civilian and military communities. They concluded by highlighting the need to promote efforts to reduce access to lethal means and methods used for self harm.

Breaking the Cycle: Interventions for Justice-Involved Veterans
1410-1535
Presented by: Sean Clark, JD, Department of Veteran Affairs, CDR Dave Morrissette, PhD, SAMHSA, Honorable Robert T. Russell, Buffalo Drug Court, Kevin Casey, LICSW, Department of Veteran Affairs, and Mr. Jim Tackett, Connecticut Department of Mental Health and Addiction Services

The session discussed Veteran Jail Diversion Programs, which divert Veterans from jail by providing them with the alternative of appropriate, trauma-informed treatment, peer mentoring, and court supervision. This requires strong collaboration among the VA, the judicial system, police, and community-based family services. The speakers explained that benefits that arise from these types of programs include fewer jail days, fewer arrests, and decreased use of drugs and alcohol. In some instances, these programs have VA employees who personally escort Veterans to the local VA to determine the types of services that would best support them. They explained that many Veterans noted they would not have obtained these services on their own. The program began in 2007, after the results of the 2006 homeless survey showed that a majority of the homeless were Veterans with mental health and/or drug and alcohol use issues. The presenters noted that an increased amount of states are partnering with the VA in the judicial system to ensure that Veterans are receiving the quality services for which they are eligible. The presentation concluded by noting that greater outreach and funding would be beneficial and, furthermore, every American community should join and support this effort.

The Role of Law Enforcement in Preventing Suicide
1600-1730
Presented by: Dr. Thomas M. Kirchberg, VA Medical Center at Memphis, Dr. Randolph Dupont, Chair/Clinical Psychologist, Department of Criminal Justice, University of Memphis, and MAJ Sam Cochran, MPD CIT Coordinator (ret), Department of Criminal Justice, University of Memphis

The panel explained the role of The Memphis Police Department’s Crisis Intervention Team (CIT), which is a community partnership working with mental health consumers, families, law enforcement, and mental health providers. The CIT is composed of volunteer officers who are trained to work with people with mental illness and experienced in verbal de-escalation techniques. These individuals respond to crisis calls involving complex issues relating to mental illness. The presenters explained that a key element of this process is an officer's ability to identify a Veteran who is in an irrational, verbally or physically abusive state. In such an instance, the officer will ask "are you a Veteran?" which often helps to de-escalate situations. Veterans have indicated that they appreciate how CIT officers have intervened, demonstrated respect, and helped to maintain their dignity. Program outcomes included decreased arrests and use of force for people with mental illnesses; a decrease in patient violence and use of restraints in the Emergency Department; a decrease in officer injuries during crisis events; fewer “victimless” crime arrests; cost savings; and an increase in officer recognition and appreciation by the community. The Memphis CIT team trains police departments across the country, highlighting that continuing support and education for CIT officers is critical to maintaining the program. The program concluded with the presenters stressing that community support is critical in order for CIT to maintain its success.

DAY 3- TUESDAY, 12 JANUARY

Rural and Dispersed Populations: Building Capacity in Primary Care and in the Faith Community
1345-1515

- ***Partners in Care Program***

Presented by: COL William Sean Lee, Maryland National Guard

COL Lee explained the purpose of the Partners in Care program is to coordinate support for warriors and families through partnerships with local faith communities, to allow referrals to local faith communities without implied endorsement of a particular religion, and to expand the spiritual resources available to chaplains for warrior and family support. COL Lee explained that Partners in Care facilitates increasing capacity in rural and dispersed populations by coordinating concrete, practical support for warriors and families through partnerships with local faith communities. The program is voluntary and support is provided free of charge. Furthermore, assistance is offered equally to all referred individuals, regardless of religious affiliation. Each congregation agrees to provide support within their means, with no further obligation to or from the National Guard member and his/her family. COL Lee stated this as the main takeaway: the Memorandum of Understanding is what allows the Maryland National Guard to make referrals for a Guard member or family during a crisis of need. COL Lee concluded by discussing Partner requirements, which include an identified congregation or organizational point of contact and a list of current congregation or organization support services offered.

- ***Primary Care Suicide Prevention Tool Kit for Rural Primary Care***

Presented by: David A. Litts, OD, Director Science & Policy, Suicide Prevention Resource Center

Mr. Litts explained this toolkit was created for rural primary care because suicide rates are higher for nearly every demographic group in a rural versus a non-rural environment, noting that the gap between rural and urban suicide rates is widening. Mr. Litts stated that suicide decedents are twice as likely to see a primary care provider than a mental health provider prior to suicide. Therefore, it is essential that primary care physicians have a tool to identify at-risk patients. The Primary Care Suicide Prevention Model provides primary care providers the ability to assess patients and determine whether an intervention is appropriate. Mr. Litts concluded by explaining the six steps of the toolkit, which include (1) getting started, (2) educating clinicians and office staff, (3) mental health partners, (4) patient management, (5) patient education, and (6) resources.

Harnessing New and Social Media to Prevent Suicide
1545-1715

- ***Harnessing Social Media to Prevent Suicide***

Presented by: Eileen Zeller, MPH, SAMHSA

Ms. Zeller defined social media as digital media with user-generated content that promotes social interaction, connectedness, and belonging. Ms. Zeller stated 35% of online adults have social networking profiles with the percentage steadily decreasing by age. She explained social networking sites are often used to connect with friends, to meet people with similar experiences, and to seek health information and support. After providing background information on social media, Ms. Zeller explained that an entire generation of Americans have grown up with the internet and prefer to communicate electronically. She concluded by stressing that online conversations about suicide are occurring every day, stressing that the internet presents an opportunity for suicide prevention, intervention, and postvention.

- ***Connect/Frameworks Suicide Prevention Project: New Media and Implications for Suicide Prevention/Postvention***

Presented by: Kenneth Norton, LICSW, National Alliance on Mental Illness, New Hampshire

Mr. Norton discussed the impact of new technology, presenting an ecological model that encompasses the individual, peer/family, community, state, country, and world. He explained the role that email, YouTube, and social networking websites can play in both facilitating and hindering suicide attempts. Mr. Norton explained that social networking sites can be monitored for postings with information related to the death, a suicide pact, and other warning signs. It is important to recognize that social networking sites can serve as a connected community. Mr. Norton highlighted that although memorial pages posted on social networking sites can be supportive to survivors, they can also be a source for suicide contagion among vulnerable individuals. Therefore he also described the guidelines for appropriate posts to memorial sites, guidebooks, and electronic obituaries.

He concluded by stating that there is a need to recognize and close the cultural gap, prompting adults to become more technologically savvy in an attempt to better monitor others.

- ***Army National Guard Soldier Family Support Division***

Presented by: LTC Ashleah Bechtel, Army National Guard

LTC Bechtel discussed the active steps the National Guard is taking to monitor individuals through social network media. She explained that the National Guard communicates regularly through their Facebook page and Twitter account. LTC Bechtel also told sobering stories of how social media provides opportunities to identify and assist individuals who may be having suicidal thoughts, letting them know that someone cares. She provided the audience with the following three lessons learned: 1) a need to change with the times, 2) the ability to know your audience and provide ample opportunity to listen, and 3) there is a risk inherent to this business, which means you must monitor and create the capacity to provide immediate referrals. She concluded by highlighting that Facebook, MySpace, and other social networking sites notify the National Suicide Prevention Lifeline when users report that someone is expressing suicidal thoughts online.

DAY 4- WEDNESDAY, 13 JANUARY

Meeting the Behavioral Health Needs of Warrior/Citizens and their Families: A Multi-Disciplinary Panel 1000-1130

Presented by: Dr. Alfonso Bates, VA; CH (Lt Col) Mark D. Campbell, USAF; CAPT Virginia Torsch, USN; Craig Apperson, Washington National Guard; Lt Col David F. Ubelhor, USAF; Dr. Kelly Mohondro, DoD; Lt Col David D. Rabb, LICSW, VA

Throughout this session a multi-disciplinary panel reviewed various means available to meet the Behavioral Health Needs of Warrior/Citizens and their Families. Brief summaries of each panel member's key points are outlined below:

- Dr. Bates presented information on VA Centers, which provide readjustment counseling and outreach services to Veterans who served in any combat zone. VA Centers also offer services to Veteran family members for military related issues. Since September 2009, the VA Centers have assisted families of 1,656 fallen service members
- CH (Lt Col) Campbell discussed the chaplain's role in suicide prevention focusing on the importance of building a relationship of trust with the service member or family member. When service members speak with a chaplain, they have 100% confidentiality; however, there is a need for chaplains to build bridges with their mental health colleagues
- CAPT Torsch highlighted the Navy Reserve Psychological Outreach Program, which provides outreach phone calls, assistance to support centers, and Returning Warrior Workshops for individuals post-deployment. Additionally, Sailors with suicidal thoughts are referred to outreach coordinators, who support these individuals through referrals to mental health providers. Outreach coordinators also track completed suicides in the DoD Suicide Event Reporting system.
- Mr. Apperson spoke about the effort to establish a psychological health program for the National Guard, given the increase in frequent Guard deployments. He noted that the National Guard Bureau and SAMHSA recently signed a Memorandum of Understanding to enhance collaborative efforts between the agencies in meeting the mental health needs of "citizen warriors" There is still a need to continue promoting a consistent reporting system for known suicide attempts in order to track prevention and intervention practices. Lastly, it is essential to seek funding to sustain the program
- Lt Col Ubelhor highlighted the change in the Reserve and Guard from a strategic force to an operational force. He discussed the culture of the Reserve and Guard and presented his personal Stigma Reducing Campaign in which he explained that suicidal ideation is like the flu. Everyone is susceptible to it, so anyone can get it at a given time. It is essential to remain with at risk service members until the ideation is gone to ensure they improve.
- Dr. Mohondro urged Reserve service members who are not satisfied with Military OneSource to contact them and place a complaint, as 100% of complaints are followed up. She highlighted that individuals who take advantage of Military OneSource are referred to a community provider within 30 miles of their

home for a total of 12 free sessions per problem. She repeatedly stressed that this program is free, confidential, and available to Active Duty, Guard, Reserve, and family members
- Lt Col Rabb presented a continuum of mental health issues, from daily stress to operational stress to PTSD. He stressed that not everyone who returns from combat has PTSD. Lt Col Rabb concluded by explaining that part of leadership is creating a community, noting that the major challenges for leaders are centered on dealing with the behavioral health concerns of their troops and their troops' families

TAPS Survivor Panel: Lessons Learned on the Look Back
1415-1530
Presented by: Bonnie Carroll, Tragedy Assistance Program for Survivors (TAPS); Kim Ruocco, TAPS

Ms. Carroll provided background information on TAPS, which is a national non-profit Veterans service organization that provides support to everyone who has lost a loved one serving in the Armed Forces through peer-based emotional support, case work assistance, community-based grief support, and crisis intervention. Ms. Ruocco, TAPS, served as a moderator and introduced family members who had lost a loved one to suicide. Ms. Carolyn Colley, Ms. Stefanie Pelkey, Ms. Kimberly Twiggs, and Mr. Mike Bowman spoke candidly and shared heartfelt memories during the TAPS Survivor Panel: Lessons Learned on the Look Back. Key points and recommendations from their presentations included:

- It is essential that completed post-deployment evaluations are fully reviewed and assessed. People with suicidal ideations may not raise many flags about their condition; therefore, once they express the slightest indication of suicidal thoughts immediate action must be taken
- "If the Army had not discontinued its peer suicide prevention program in the 1990s, then my husband and other individuals might still be alive"
- Provision of education and availability of resources pre-, during, and post-deployment for families of individuals suffering from PTSD are essential in order for the family to act as a support system
- There needs to be more education in theater to help service members understand PTSD
- Funding needs to be allocated to research better ways to prevent and treat PTSD
- Increased follow up with all service members post deployment is necessary, especially for those in rural and remote areas
- It is essential to remove the stigma of service members asking for help

Senior Enlisted Panel
1545-1715
Presented by: SGM Brown, USA, SgtMaj Ronald Green, USMC, CMC Jack Goodhue, USCG, SgtMaj Sue Ghettig, USNG, SFC John Peavy, USNG, CMsgt Mark Stevenson, USAF, and CMC Johnny Walker, USN

Each service member provided a brief narrative to the audience before engaging in a thorough question and answer period. Key takeaways from this session are listed below:

- We must move from being reactive to being proactive by implementing prevention and resilience programs. Awareness is essential. The first step towards prevention is providing service members' families with education and resources
- Times have changed. The public is much more involved and welcoming of returning service members. This increased level of participation will make a huge difference in prevention measures and implementation of new initiatives
- We continue to talk about removing stigma; however, just saying we will not stigmatize this issue will not convince people to get help. We need to show them that it is normal to get help
- Although computer-based suicide prevention training might complement face-to-face training, it can never replace in-person training
- Leadership in all service branches need to understand generational differences, relate more to them, and become more approachable to younger service members. For instance, leadership needs to understand that social media is a preferred way for many of their troops to communicate and should familiarize themselves with this new form of medias
- Too often service members must wait months to get an appointment with a mental health provider. Mental health resources need to be readily available to service members

6.0 TRACK 3: RESEARCH SUMMARY

DAY 2 - MONDAY, 11 JANUARY

A Brief History of Nomenclature and Classification Systems in the Field of Suicidology
1000-1130

- ***A Brief History of Nomenclature and Classification Systems in the Field of Suicidology***

Presented by: Dr. Morton M. Silverman, Education Consultant, VISN MIRECC

Dr. Silverman explained that the field of suicidology is challenged by a lack of conceptual clarity about suicidal behaviors and a corresponding lack of well-defined terminology, which effects research and surveillance. Dr. Silverman indicated that there are numerous terms that refer to the same behavior. Some of the terms are incorrect and do not do justice to the seriousness of suicidal behaviors. As a result, interpreting the meaning of suicidal occurrences is more difficult, occurrences are often inappropriately classified, and occurrences are often missed. Therefore, the need exists for a nomenclature that is widely understood, comprehensive, and includes a wide range of behavioral terms that define the basic clinical phenomena of suicide and suicide related behaviors. Dr. Silverman explained the current suicidal nomenclature as a set of comprehensive, commonly understood terms that define the basic clinical phenomena of suicide and suicide-related behaviors. He ended his presentation by concluding that the purpose of a nomenclature is to enhance clarity and have applicability across clinical and research settings.

- ***Centers for Disease Control and Prevention***

Presented by: Dr. Alex E. Crosby, Centers of Disease Control and Prevention

Dr. Crosby shared the Centers of Disease Control definitions and recommended data elements for self- directed violence (SDV) surveillance. He provided background information on self directed violence, explaining that it was the 11th leading cause of death in 2006 in the US with a total of 33,300 suicides, noting that national statistics most likely underestimate the number of SDV victims by a significant amount. Dr. Crosby explained the necessity for surveillance systems and a standard definition for SDV surveillance. He also emphasized the importance of considering comprehensive terms for all self injury and having a more specific term for suicidal behavior. Dr. Crosby concluded by stating that surveillance definitions and criteria by necessity may be less exacting than research criteria.

- ***Self-Directed Violence Classification System***

Presented by: Dr. Lisa A. Brenner, VISN 19 Mental Illness Research Education and Clinical Center, Denver VA Medical Center and University of Colorado, Denver, School of Medicine

Dr. Brenner described an exercise that is often used to classify SDV. This exercise is a good starting point because it prompts people to talk about a wide range of behaviors and thoughts; however, it is not a way of assessing risk. Dr. Brenner presented a reference tool to the audience, explaining that when people think about suicide, the individual's intention to die is a key factor. Those that have intent to die are located on a suicidal continuum. She highlighted the modifiers for suicide which include intent, injury, interrupted by self, and interrupted by other. Dr. Brenner concluded by reviewing a DoD grant that is in the process of developing a self administered measure that includes 20 questions; the study will soon begin pilot testing.

The Role of Telemental Health in Suicide Assessment
1410-1535

Presented by: Dr. Linda Godleski, VHA Lead for Telemental Health; Associate Professor of Psychiatry, Yale University

Dr. Godleski provided a background history of telemental health (TMH), highlighting that TMH provides an ideal response to VHA mandates to provide remote specialty mental health care and to facilitate collaborations in geographically remote areas as well as, in "difficult to recruit areas" where circuit rider clinicians experienced a lack of travel funds. Dr. Godleski highlighted the concept of videoconferencing in telemedicine and how it expands access in remote areas, decreases the need and expense for travel, and often prevents hospitalization if an intervention is successful. She then discussed the Suicide Prevention Program 2007, which established suicide prevention centers, obtained funding for suicide prevention counselors, and instituted a 24 hour a day, 7 day a week Veteran suicide prevention hotline. Dr. Godleski concluded by discussing lessons learned and best practices, including the need to practice TMH within legal regulations, using judgments when selecting the patients, utilizing accepted suicide assessment parameters, addressing contingency plans, and training with case vignettes.

Review of the Literature—Evidence and Gaps in Suicide Prevention
1410-1535
Presented by: Dr. Kerry L. Knox, Director, VA Center of Excellence at Canandaigua and Associate Professor, University of Rochester, Department of Psychiatry

Dr. Knox shared the current CDC definitions of suicidal behaviors and explained that suicide is relatively infrequent. Although suicide accounts for 1.4% of all deaths in the US, and is the 11th leading cause of death for all ages, when studying any group over a period of time, the numbers of actual suicides will be low (overall, about 1 death per 10,000 individuals per year). Dr. Knox explained that there is not a simple way to predict who will die by suicide, noting that clinicians find it difficult to accept that an algorithm to determine when someone is at risk for suicide does not exist. She also stated that official suicide rates are often inaccurate and unreliable, especially since patients at risk for suicide are often excluded from clinical research studies. Dr. Knox concluded by presenting new and improved prevention strategies that show promise for military personnel and Veterans and indicate the need for improved accuracy in research studies focused on assessing suicidality.

An Empirical Perspective on Acute Versus Chronic Suicide Risk
1410-1535
Presented by: Dr. David Jobes, Professor of Psychology, CUA

Dr. Jobes began by discussing the pursuit of typologies in suicidology, noting that such typologies could inform prevention efforts as well as clinical assessments and treatments, highlighting that motivations for different suicidal individuals are not the same. Dr. Jobes introduced the CAMS system and reviewed core questions on the assessment form. He explained that assessment tools can be used to predict three distinct typologies (cross-sectionally) with an inpatient suicidal sample. Dr. Jobes stressed that all suicidal people are not the same, and it is important to determine what makes these groups different. He also highlighted the under-appreciated importance of suicidal ambivalence and the cognitive/emotional state of being torn between living and dying. People who feel comforted by suicide are very different than those who are fearful of suicide. He concluded that early intervention has been essential with younger populations such as college students; however, when people are older, it is more difficult to change their hopelessness. It is essential to study and understand the progression of suicidal thinking.

Suicide Screening
1535-1600
Presented by: Dr. David Rudd, University of Utah

Dr. Rudd discussed the R-SIS screening instrument, a 10-item scale useful for initial screening, clinical assessment and continuous tracking. He described the exploratory factor analysis conducted, focusing on suicidal desire and resolved plans and preparation. The screening instrument helps determine notion of action associated to ideation, which is typically increased in someone with a history of attempted suicide. He also stated that sleep problems are emerging as a significant warning for suicide. Dr. Rudd predicted that sleep

problems are going to emerge as significant in terms of factors contributing to death with the nature of sleep disturbance. He concluded by indicating his focus on disseminating the R-SIS screening tool.

A Review of the Literature of the Risk of Suicide in Military and Veteran Populations
1600-1730
Presented by: Dr. Han K. Kang, Environmental Epidemiology Service, Department of Veterans Affairs

Dr. Kang stated, there have been more than 31,000 suicides in the U.S. in 2005, noting suicide was the second leading cause of death for white males, 20-29 years old (n-3,479). Firearms are the most commonly used method (51%), followed by suffocation (34%), and poisoning (8%). Risk factors include previous attempt, depression or other mental illness, alcohol/drug abuse, physical illness, and feeling alone. After providing background information, Dr. Kang presented an overview of studies highlighting Suicide in Military and Veteran populations. He stated that the risk of suicide among Vietnam War Veterans and Gulf War Veterans, as a whole, is not significantly higher than non-deployed Veterans or than the comparable U.S. general population. Dr. Kang noted that level of combat trauma as indirectly measured by having PTSD and being wounded in action was associated with the risk of suicide among Vietnam Veterans. It was found that Veterans who sought healthcare from VA, especially for depression, experienced a significantly higher suicide risk compared to the U.S. general population. He noted that the risk of suicide among OEF/OIF Veterans is significantly higher than the comparable U.S. general population on follow-up through December 2007. The risk appears to be inversely related to the time elapsed since separation from active military duty (or return from Iraq or Afghanistan theaters). Dr. Kang concluded by stating that in view of the high percentage of returning OEF/OIF Veterans screening positive for one or more mental disorders, this group of OEF/OIF Veterans should be monitored closely.

DAY 3 - TUESDAY, 12 JANUARY

Evidence-Based Interventions for the Military and Veterans
1000-1130

- ***Research Efforts Toward Reducing Suicide Behavior Among Military Service Members and Veterans***

Presented by: COL Carl A. Castro, PhD, Director, Military Operational Medicine Research Program; Chair, Joint Technology Coordinating Group-5, U.S. Army Medical Research and Material Command, Military Operational Medicine Research Program,

COL Castro highlighted the Army strategic approach to suicide research and defined the responsibilities of the Research Area Director. He presented a graphical representation of Army Suicides from 2001 to the present, noting the steady increase since 2004. He explained that screening in the military is occurring through Post Deployment Health Assessment and Post Deployment Reassessment forms (PDHA and PDHRA) and that suicide surveillance work is done through the DoDSER. Information is provided to advisory councils who develop policy and coordination to decide what steps should be taken based on the data. It is essential that screening methods and suicide prevention training are validated. COL Castro also noted that current suicide research is collaborating with universities, academia, and the DoD. He concluded by explaining that it is essential to have evidence based, theory driven research approaches to taking care of Soldiers and further preventing suicide.

- ***Research on Suicide Prevention in the VA***

Presented by: Dr. Kerry L. Knox, Director, VA Center of Excellence (COE) at Canandaigua and Associate Professor, University of Rochester, Department of Psychiatry,

Dr. Knox's presentation focused on research efforts on suicide prevention in the VA, highlighting two centers that focus solely on suicide research: VISN 19 MIRECC in Denver, Colorado and the COE at Canandaigua. Dr. Knox highlighted population based initiatives in the VA, including Project ChildSAFE. She also discussed the Blue Ribbon Report and SAFE VET, a project created in response to the report, with the intent of developing a delivery system that will enhance the care of suicidal Veterans in both community and VA Emergency Departments. Dr. Knox then provided an overview of "A Brief Intervention to Reduce Suicide Risk in Military Service Members and Veterans," a project that is developing and adapting a single intervention for suicidal

individuals that can be used while on active duty and then as a Veteran. After discussing areas of clinical research in the COE, Dr. Knox concluded her presentation by explaining future directions. These include: (1) emphasis on establishing a evidence based database on programs and interventions for suicide specific to military and Veteran populations, (2) methodological approach to challenges of research in real world environments, (3) critical need to move scientific evidence forward coupled with the urgency to take immediate action to reduce deaths from suicide.

The Caring Letter Project: A Suicide Prevention Outreach Program
1545 - 1715
Presented by: Dr. David Luxton, National Center for Telehealth & Technology (T2) and Dr. Julie Kinn, T2

Dr. Luxton and Dr. Kinn explained that The Caring Letter Project is a suicide prevention outreach program that T2 is piloting at Fort Lewis, WA. Caring letters is the mailing of brief letters and reminders of available treatment to high risk suicide patients after they have left an inpatient psychiatry unit. Randomly selected suicide attempters (n=843) who refused treatment received "caring letters" from staff at regular intervals for four years. They noted the importance of these letters being a brief expression of care as well as non-demanding and explained why these letters may reduce suicide. The Caring Letters Project is a psychological intervention that has been shown to reduce suicide mortalities in a randomized clinical trial. It is a simple and inexpensive intervention to reduce suicide, reaching high-risk individuals that do not continue in care. Dr. Luxton and Dr. Kinn concluded by reporting next steps for the project, including the need for a replication study and testing the use of other technologies for caring contacts (such as texting and smart phone applications).

New Inpatient Cognitive Behavioral Approach for the Treatment of Military Service Members Following a Suicide Attempt
1545-1715
Presented by: Dr. Marjan G. Holloway, Uniformed Services University of the Health Science (USUHS)

Dr. Holloway discussed the suicide trends in the United States and highlighted the stages of prevention: primary, secondary, and tertiary. The primary stage involves preventing the onset of suicide behavior and promoting mental health. The secondary stage identifies persons at risk for suicide behavior and prevents exacerbation of symptoms. The tertiary stage treats persons with suicide behaviors and helps to return them to the highest level of functioning and reducing the likelihood of subsequent suicide behavior. Dr. Holloway highlights the neglect of suicidal individuals in PTSD psychotherapy trials and inpatient psychotherapy for suicide. She then explained the Intervention Development Stage Model of Research, indicating the rationale for proposed intervention, stating it was because suicide attempts constituted one of the strongest and clinically relevant risk factors for death by suicide. Dr. Holloway concluded her presentation by explaining the significant need for evidence based prevention practices for individuals with suicide behavior. Additionally, she stated that designed interventions for military personnel and families must address the specific and unique needs of the population.

DAY 4- WEDNESDAY, 13 JANUARY

Evidence-Based Interventions for the Military and Veterans: 1000-1130
Presented by: Dr. Gregory K. Brown, Philadelphia VAMC; Department of Psychiatry, University of Pennsylvania and Dr. Melanie S. Harned, Behavioral Research and Therapy Clinics, University of Washington
Approximate attendees: 70

Dr. Brown and Dr. Harned discussed the Dialectical Behavioral Therapy (DBT) Model, developed for the high risk for suicide individual with multiple mental disorders. This large and complex treatment focuses on solving the client's problem of having unbearable pain. They explained that the five main functions that DBT is intended to address include: 1) improving client's motivation, 2) improving capabilities, 3) structuring the environment to reinforce new behaviors, 4) making sure behavior generalizes, and 5) increasing skills and motivation of therapists. Modes of DBT include, group skills training, individual therapy, telephone coaching, and therapist consultation team. They highlighted that DBT targets suicidal behavior by decreasing life threatening behaviors and increasing behavioral skills such as mindfulness, interpersonal effectiveness, emotion regulation, distress, and self-management. After providing background information about DBT, they noted that five DBT studies

demonstrated that suicide attempts were lower in DBT than various control conditions in the five studies, indicating that DBT treatments are effective in reducing suicides. They concluded by discussing that people with PTSD are six times more likely to commit suicide. A current study focusing on PTSD is in clinical pre-testing.

RAND Study and National Institute of Mental Health (NIMH) Study
1415-1530

- ***Preventing Suicide Among Military Personnel: Overview of RAND Study***

Presented by: Dr. Rajeev Ramchand, RAND, Center for Military Health Policy Research

Dr. Ramchand provided an overview of suicide rates in the military, noting that the increase in the number of suicides among DoD personnel in the past eight years has generated concern among military leaders, policymakers, and the media. Dr. Ramchand stated that DoD patterns of suicide are similar to those in the civilian population, suggesting that effective programs in the civilian sector would also work in the DoD. He then discussed the risk factors for suicide in civilian and military sectors, noting that the literature demonstrates prior suicide attempts, mental illness, and substance use and associated disorders as three strong risk factors. Lastly, Dr. Ramchand elucidated an overview of the RAND study, examining efforts to prevent suicide among military personnel. To identify what the DoD and each service was doing to prevent suicide; RAND reviewed materials and policies reflecting on current practices, and conducted interviews with key stakeholders in the DoD and in each service. Dr. Ramchand concluded by discussing the forthcoming RAND report which will include, analyses of the epidemiology of suicide, characteristics of state-of-the-art prevention programs, DoD suicide prevention programs and how they compare with state-of-the-art, and conclusions and recommendations.

- ***Army STARRS: Army Study to Assess Risk and Resilience in Service Members***

Presented by: Dr. Robert K. Heinssen, Acting Director, Division of Sciences and Intervention Research, NIMH

Dr. Heinssen stated the purpose of the Army STARRS study is to develop data-driven methods for mitigating or preventing suicide behaviors and improving the overall mental health and behavioral functioning of Army personnel during and after their Army service. Dr. Heinssen explained that the University of Michigan, Harvard University, and Columbia University are collaborating with USUHS on several scientific projects. Dr. Heinssen stated that a historical analysis of Soldiers with and without suicidal behavior since 2004 is being conducted, using all data available on Active Duty Soldiers from 2004-2009. Additionally, a representative sample of 90,000 Active Duty Soldiers including mobilized Reserve and National Guard Soldiers will be surveyed and a longitudinal follow-up will be conducted on 15,000 Soldiers, selected on the basis of particular risk/profile characteristics. Special features of this program include a feedback loop between retrospective data analysis, case control studies, and prospective surveys. Dr. Heinssen explained that family-member and unit leadership informants will provide additional information about social environmental context (culture, cohesion, and stress). He concluded by elucidating to an evaluation of all current and future Army suicide prevention and treatment interventions, discussing the exploration of potential neurobiological risk and protective factors.

7.0 TRACK 4: PRACTICAL APPLICATION SUMMARY

DAY 2- MONDAY, 11 JANUARY

Real Warriors Campaign
1000-1130

Presented by: Jill Herzog, Program Manager, Real Warriors Campaign, MAJ Jeff Hall, USA, and SSgt Megan Krause, 450th Civil Affairs

Ms. Herzog explained that the goal of the Real Warriors Campaign is to: 1) communicate that there are a variety of resources to help service members; 2) create an understanding among service members and leadership; and 3) create an investment in mission readiness for the entire person, body, mind, and soul. The campaign involves vibrant social media platforms including videos on YouTube and TroopTube, a call center, live chat with operators online 24/7, a dedicated web site, outreach and media relation campaigns, Twitter, Facebook, and interactive message boards. Ms. Herzog then introduced MAJ Hall and SSgt Krause who spoke candidly about their battles with psychological wounds, focusing on how they are currently winning their personal battles through the support they received from their families and leaders. The presentation highlighted the need for reduced stigma among leadership in order to create a culture that encourages reaching out for help and utilizing mental health services.

Crisis Lines Interventions/Chatline and Social Networking
1410-1535
Presented by: Dr. Richard McKeon, SAMSHA, and Dr. Jan Kemp, VA,

Dr. McKeon discussed the National Suicide Prevention Lifeline which automatically routes calls to the closest center within a network of 135 crisis centers. Since it can take months to publicize a hotline number, the National Suicide Prevention Lifeline collaborated with DoD, SAMSHA, and the VA to create an easily accessible suicide hotline for Veterans. They stated that in 2009, over 625,000 calls were answered, noting that callers often reported that their distress, hopelessness, and suicidal intent decreased after the call. Furthermore, these reported feelings continued to decrease over time and 14% of suicide callers commented that the call saved their life. The presenters noted it is important to understand that solving such a complicated problem in one phone call is quite difficult. A majority of callers were given referrals, but only one in five followed-up to receive the services. Next, Dr. Kemp informed the audience of chatline and social networking services for suicide prevention created in July of 2009. She explained that the chatline is a one-on-one anonymous service that uses a secure website. To date, they have engaged over 2,465 chatters. Dr. Kemp highlighted that this group of chatters included 1,022 individuals who talked about suicide, 330 Veterans who were referred to the Suicide Prevention Hotline, and over 80 chat cases were categorized as rescues. Dr. McKeon and Dr. Kemp concluded this session by stressing that conversations are powerful and there is a continued need for alternative access mechanisms to increase opportunities for individuals to obtain help. There is evidence that indicates if mechanisms exist then people will use them.

The Two Year History of the National Veterans Suicide Hotline
1410-1535
Presented by: Dr. Caitlin Thompson, VA

Dr. Thompson provided background information about the evolution of the National Veterans Suicide Hotline, noting the immense growth that the hotline has experienced since it opened in July 2007. The National Veterans Suicide Hotline began with four phone lines and 14 responders, and now has expanded to include15 phone lines, receiving over 400 calls per day. The staff has also increased to include 123 hotline responders, 17 health technicians, six shift supervisors, one clinical care coordinator/psychologist, three administrative staff members, and three Active Duty Soldiers. All employees have a mental health background and are trained extensively with the Applied Suicide Intervention Skills Training model. Dr. Thompson explained that the goal of the hotline is not to provide therapy but rather to provide resources so that the Veterans can pursue treatment within their local communities. To better understand caller trends, the presenter noted that they analyzed 2,400 of the hotline logs and were able to identify the 14 primary reasons why individuals called the hotline. Dr. Thompson concluded by explaining that they are actively working to implement a policy to assist repeat callers by working with Suicide Prevention Coordinators to create a individualized Veteran treatment plan.

Reducing Risk and Promoting Warrior, Family, and Community Healing Following a Suicide
1600-1730
Presented by: Mr. Kenneth Norton, LICSW, National Alliance on Mental Illness New Hampshire

Mr. Norton began the presentation by explaining that suicide is a public health problem and needs to be put into a larger perspective, noting that suicide is one of the top four leading causes of death in people 10-44 years of age. Mr. Norton explained that there are 33,000 confirmed suicide deaths each year, 80% of which are white

males. Additionally, men commit suicide at a rate three times higher than women; whereas, women attempt suicide at a rate that is four times that of men. Within these statistics, Mr. Norton pointed out that Veterans accounted for one fifth of suicide deaths, notably highest among former Army and Marines. He stated that 35% of people who die by means of suicide leave a note. In addition, there is a high correlation between having major mental illnesses and committing suicide. Mr. Norton stressed that postvention, developing appropriate responses after a suicide, really is prevention as postvention goals are to promote healing, reduce the risk of contagion, identify those at risk, and connect at risk individuals to help. Mr. Norton then discussed the term "survivor" which refers to family, friends, and colleagues who have lost a loved one to suicide and presented an overview of terms that are preferred by survivors. After discussing the impact of the Suicide Ecological Model, Mr. Norton explained the Connect Comprehensive Public Health program which focuses on prevention, intervention, and postvention. He concluded his presentation by conveying the importance of promoting healing by providing support to survivors.

DAY 3- TUESDAY, 12 JANUARY

Identifying and Obtaining Existing Resources for Evaluating Suicide Among Veterans
1345 -1515
Presented by: Dr. Robert Bossarte, VA Center of Excellence at Canadaigua

Dr. Bossarte highlighted that suicide among Veterans has received an immense amount of attention, noting that studies of Veteran suicide rates and characteristics reveal inconsistent findings. Dr. Bossarte reminded audience members to use caution when interpreting reports of suicide among Veterans, as there are lingering questions about population composition and differences in risk characteristics. He explained that study methodologies may be responsible for the observed differences, leading to questions about data generalizability, reliability, and validity. Dr. Bossarte indicated that additional research is needed to clarify questions surrounding case ascertainment, noting that vital statistics may be an important source of information. He concluded his presentation by stressing that standardization across data sources through surveys is needed to ensure comparability.

Online Screening Tools
1345-1515
Presented by: Dr. Andrea Haas, Director of Prevention Projects, American Foundation for Suicide Prevention (AFSP)

Dr. Haas explained that since 1996 the United States military has used routine mental health screenings of personnel before and after operational deployments with the aim of identifying those who are at risk for mental health problems before deployment, in combat zones, and on their return home. Dr. Haas introduced AFSP's Interactive Screening Program (ISP), which is an anonymous, web-based, interactive method of outreach to persons with mental health issues that put them at risk for suicide. ISP connects at-risk individuals to a counselor who provides individualized online support. Dr. Haas stressed that the core aim of ISP is to address and resolve treatment barriers and resistances. ISP was pilot-tested with undergraduates at two universities, from 2002 to 2005, and is now available to all colleges and universities. As of Fall 2009, an estimated 82,000 Veterans were enrolled in colleges or universities under the Post 9/11 Veterans Educational Assistance Act. Dr. Haas stated targeted students are invited to participate in ISP via an email from a college official. This email provides a link to a secure, customized website where individuals are invited to complete an online stress and depression questionnaire. After the survey is complete, the system sends an email to an ISP counselor, who reviews the student's questionnaire and determines if the individual should be referred to mental health services. Dr. Haas concluded that this method is successful on multiple levels, as it can be used for both prevention and early intervention to ensure at-risk individuals receive timely referrals.

Operation S.A.V.E.: Suicide Prevention Training for Frontline Veterans Affairs Staff
1545 - 1715
Presented by: Dr. Jan Kemp, RN, Center of Excellence for Suicide Prevention

Dr. Kemp provided some history of the Operation S.A.V.E. program, noting that the Veteran population is 66% more likely to die by suicide, and male Veterans are more than twice as likely to die by suicide as compared to

non-Veterans. Operation S.A.V.E is a gatekeeper training program that prepares individuals to interact with someone who has suicidal ideations. The training includes skills and techniques to identify, encourage, and refer individuals for assessment and treatment. Operation S.A.V.E. is taught by suicide prevention coordinators, who are local nurses, social workers, and psychologists. Dr. Kemp explained that Operation S.A.V.E. is comprised of five modules: (1) a brief overview of suicide among the Veteran population, (2) myths and misinformation, (3) suicide risk factors, (4) S.A.V.E components, and (5) summary and evaluation. She indicated that training was well received by a diverse sample of clinical and non-clinical VA employees, who reported increased confidence in responding to suicidal Veterans after receiving the training. In addition, participants were more likely to indicate that their job was to help a suicidal Veteran after completing the training. Dr. Kemp concluded by reporting that training was effective for both clinical and non-clinical employees although these two groups differed in some survey responses.

Homecoming: Warrior to Citizen
1545-1715
Presented by: LTC Cynthia Rasmussen, MSN, Minneapolis VA Medical Center

LTC Rasmussen provided background information about Reservists, highlighting that 90% are civilians who were raised mainly in corporate America and had limited military experience and skills. LTC Rasmussen stated that National Guard Reserve members typically do not ask for help until it is too late, indicating that their support systems often do not understand the military culture. She pointed out the many difficulties that service members face when transitioning from a warrior back to a citizen, noting that reintegration back into society after theater is an extremely complicated and complex task. LTC Rasmussen discussed the difference between "war zone skills" and "home skills," remarking that Soldiers struggle with safety, trust, anger, and several other emotions upon returning home. In terms of readjustment, there is no definite time period, as it can take an individual weeks or months depending on length of separation, experiences, and resources. LTC Rasmussen concluded by focusing on the need to combat the stigma of mental illness and increase available health care resources for National Guard Reserve Members during and after their transition home. There is a continued need to follow up with Service members and families even after discharge from the military, and recognize that “no one comes back unchanged."

DAY 4- WEDNESDAY, 13 JANUARY

Developing Tomorrow’s Leaders Today: Changing the Culture and Stigma of Seeking Help through Education and Outreach
1000-1130
Presented by: CDR Brice Goodwin, PhD, ABPP, Director, Midshipmen Development Center, and LT J. Porter Evans, PsyD, ABPP, Staff Psychologist, Midshipmen Development Center

CDR Goodwin and LT Evans presented suicide prevention at the United States Naval Academy (USNA), noting that suicide continues to be a critical challenge in the military. A joint military and civilian task force concluded that current mental health care efforts within DoD and VA fall significantly short of adequately serving military members and their families. They explained that the genesis of the USNA's approach was to integrate the needs of a college age population with the demands of the military culture. Additionally, a suicide prevention program must adapt to variables that military leaders can understand and accept. As a result of these needs, they have developed a suicide prevention program for midshipmen at USNA with the goal, over the course of four years at the Naval Academy, to enact significant change in the attitudes and beliefs of midshipmen that will serve in the fleet over the years. Senior midshipmen in the role of company training officers were trained and provided the necessary resources to conduct suicide prevention training. They explained that the trainers were expected to be aware of social modeling, ask questions as they arise, and provide honest feedback to the counseling center staff. The feedback that was collected from both participants and trainers was primarily positive. Moving forward

it is important that the program continues to refine the training methods, increase personalization, increase training marketing, and integrate the training into curriculums.

Peer Support Programs
1415-1530
Presented by: Dr. Cindy Claassen, Chief Interventions and Health Services Core, VISN 2 Center of Excellence for Suicide Prevention

Dr. Claassen described peer providers as individuals with a serious mental illness who are trained to use their experiences to provide recovery-oriented services and support to others with serious a mental illness. Peer providers can have a variety of helping roles, including assisting clients, providing support services, providing liaison services, dispelling possible stigma or bias toward clients, and augmenting overburdened mental health systems. Dr. Claassen explained the three levels of the peer support system to prevent suicide, which include (1) gatekeeping (identifies those at risk), (2) Vet-to-Vet programs (provides a support system for those at risk), and (3) peer support programs (provides role models). She explained that peer support is an important strategy for making mental health care more recovery-oriented, with peers serving as role models to others with similar problems. These peer providers serve as a source of motivation, and are able to promote their own recovery while helping others. Dr. Claassen concluded by stressing the importance of monitoring and preventing suicide contagion, highlighting the need to ensure that suicide does not become a part of the identity of the Veteran.

Improvements in Suicide Surveillance: the DoD Suicide Event Report (DoDSER)
1545-1715
Presented by: Dr. Gregory A. Gahm, T2, and Dr. Mark A. Reger, T2

Dr. Gahm began by discussing the increase in Active Duty Military suicide rates since 2001 before providing an overview the DoDSER. They explained that the Services' Suicide Prevention Program Managers meet monthly as part of the SPARRC. In one of their meetings they discussed an interest in standardizing idiosyncratic Service-level surveillance systems. In response, T2 took the lead in collaborating with the Services to develop the DoDSER, by employing detailed software requirements developed with Suicide Prevention Managers across the Services. The initial data collection-only website was developed and launched January 1, 2008 before undergoing a major software revision in August 2009. Dr. Gahm and Dr. Reger described the DoDSER content as objective, subjective, detailed, and standardized information, which accounted for comprehensive event data and extensive risk factor data. They discovered that demographic groups at highest risk for suicide were similar to findings in civilian research, and that there is an opportunity to intervene in some cases. Research also indicated that significant stressors were common prior to suicide, and that the majority of suicides did not occur during deployment. However, 13% of DoD suicide cases had a history of multiple deployments to Iraq or Afghanistan. They concluded the presentation by stressing this is the first year that the DoDSER has been released and there are plans to release a report every year.

Use of a VA Root Cause Analysis Database to Reduce Suicide among Recently Returned Veterans
1545-1715
Presented by: Dr. Peter Mills, Director, VA National Center for Patient Safety Field Office, Adjunct Associate Professor of Psychiatry, Dartmouth Medical School, and Pamela Copeland, JD, Armed Forces of Pathology

Dr. Mills explained that the focus of root cause analysis is to identify systemic and organizational factors that may have led to an adverse event, including environmental factors, breakdowns in the communication of critical information from one clinician to another, non-standardized processes for assessing or treating patients, training, and fatigue. Within the VA, the root cause analysis is conducted by staff at hospitals where events occurred in an attempt to assist the facility in making improvements and preventing future events. The root cause analysis includes a detailed narrative report of what happened, why it happened, and how to prevent the event from happening again. They stated that previous root cause analyses have indicated that inpatient suicide on VA psychiatry units continues to be an extremely rare event, accounting for approximately 2.3 completed suicides for every 100,000 admissions. Suicide by means of hanging oneself continues to be the most common method for inpatient suicide, and sheets and bedding continue to be the most common type of lanyard used for hanging. Dr. Mills and Ms. Copeland concluded the presentation by highlighting that root cause analysis reports can identify organizational vulnerabilities detected at the local level that may be applicable system wide. In

addition, special attention needs to be directed towards improving suicide assessments, coordinating care and providing timely care, as these areas may have a significant impact on reducing suicide among OEF/OIF Veterans.

8.0 TRACK 5: ARMY RESERVE SUMMARY

DAY 4- WEDNESDAY, 13 JANUARY

United States Army Reserve National Guard (USARNG)
1415-1700

- ***Army National Guard Overview***

Presented by: MSG Marshall Bradshaw, USARNG

MSG Bradshaw with the USARNG opened the session by describing the most important objective of the day as connecting with other state representatives to identify best practices that may be implemented in other states. MSG Bradshaw also painted the current operating picture by describing the most common stressors as relationship failure, job problems, legal problems and financial problems. In addition, MSG Bradshaw stated that in 2009 there were 66 suicides in the Army National Guard with 16 still pending investigation. One of the larger issues this year was that 28 Soldiers committed suicide without having been deployed. This significant fact indicated that Soldiers are entering the Army National Guard with problems and are killing themselves prior to deployment, due to issues they are experiencing at home. MSG Bradshaw encouraged everyone to ensure that recruiters are properly screening for mental health issues. MSG Bradshaw highlighted the following as other issues the Army National Guard is facing: E-trans process losing records for Soldiers; geographically dispersed populations create issues with Soldiers spreading out without support of nearby units; limited mental health and chaplain resources; recruiting of high risk Soldiers. Although there are challenges, MSG Bradshaw discussed success through the home front interactive video, state initiatives and the passion and drive of the Suicide Prevention Program Managers, task forces and support personnel. In conclusion, MSG Bradshaw stated the way ahead included collaboration across services, components, national agencies, states, counties and local communities and standardized and funded policies.

- ***United States Army National Guard (USANG Overview)***

Presented by: CAPT Martin, USANG

CAPT Martin opened the session by providing an overview of improved resources available through the various services. The Computer Based Training (CBT) program through the Air Force website where members and leaders can review best practices was discussed. CAPT Martin noted that the Army website has a peer program, awareness program, and train the trainer programs while the Marine Corps site has tools for the Marine and family, programs for children on how to deal with suicide, in addition to programs for leaders and MH professionals and chaplains. Lastly, the Air Guard programs are primarily online trainings but due to an increase in suicide numbers, all are encouraged to complete more than the required CBT trainings. It is recommended that the Directors of Psychological Health have face to face trainings but there are restrictions and the Guard side keeps to CBT at a minimum. CAPT Martin said there is an analysis being conducted on the cost-benefit ratio of bringing in new resources to expand beyond CBT trainings. CAPT Martin concluded by saying that in the Army National Guard there are no investigations being done on suicides which is a major problem, but is currently being addressed.

- ***Pilot (NE, IA, VA, NC, MA)—Virtual Reality Exposure Training—Raydon Corporation***

Presented by: Don Ariel, Deborah Quackenbush

Mr. Ariel and Ms. Quackenbush explained that Raydon is the integrator for the National Guard for ground combat training courses, using video technology to begin to tear down some of the stigma associated with TBI and PTSD. Through training, Raydon is constantly recording information about each Soldier and actively teaching cognitive motor skills. Relating to PTSD, Raydon is able to review and discuss psychological impacts of combat training after a simulation has taken place. The Army National Guard has invested $200 million in virtual reality training infrastructure. Additional funding would allow the Army National Guard to propose a series

of pilot programs for individual states that could provide passive baseline data during Soldier training. Through the virtual combat training, Soldiers will complete training, unaware that it is suicide prevention training.

- ***Nebraska—Fellowship Groups, Peer-to-Peer***

Presented by: CH (CAPT) Scott Ehler

CAPT Ehler spoke about Nebraska's National Guard peer to peer program. The peer to peer program provides personnel to support Soldiers in need until professional help can be provided in geographically dispersed areas throughout the state. Peer to peer personnel undergo 16 hours of courses over one weekend with a 10 hour refresher training each year. CAPT Ehler also spoke about the Unit Ministry Teams (UMT) which provides available and ready Pastoral resources in support of deploying units. The UMT's alleviate the Command Staffs preoccupation with potential problems and serve as a point of contact with families back home. During deployment, the Nebraska NG conducts emotional support groups (ESGs) to create a casual, non-threatening place to meet with other family members of deployed Warriors. ESGs provide families with the opportunity to get information and check up on their Soldier. The Nebraska National Guard provides education for Warriors and their families on best practices for communication and relationship enhancement as it pertains to reintegration after a long separation. They also educate Warriors and their families on how to recognize behavioral warning signs and the available resources for help.

- ***Kentucky State Partnerships***

Presented by: CH (CAPT) Philip Majcher, Kentucky Suicide Prevention Program Manager

CAPT Majcher opened by stating, suicide is the second leading cause of death in Kentucky. CAPT Majcher reviewed various initiatives for suicide prevention in the state of Kentucky. CAPT Majcher stated Kentucky's primary goal is to train every state resident in Question, Persuade, Refer (QPR) as a means of suicide intervention. For children, Kentucky has piloted a drama program and made an agreement with St. Louis fine arts to create a drama team that takes the stories of young girls who attempted suicide (similar to theater of war) into schools and asks what could have been done differently. This program forces youth to detect warning signs and think about what actions could have been taken to prevent suicide. In conclusion, CAPT Majcher stated that Kentucky took programs that were already in place in other states and applied them toward the common goal of reducing suicides in Kentucky.

- ***Indiana—Crisis Intervention Teams***

Presented by: CAPT Elizabeth Williams

CAPT Williams discussed crisis intervention teams (CIT) which include substance abuse specialists. Indiana has found it useful to include these specialists because substance abuse is often related to suicidal behaviors. In Indiana the National Guard has assigned a CIT to each command. They have been trained to teach intervention techniques to support knowledge sharing at the unit level.

- ***OHIOCARES/Community Relationships***

Presented by: CH (CAPT) Nicholas Chou, Dr. Jeremy Kaufman

CAPT Chou and Dr. Kaufman explained the mission of OHIOCARES is to enhance the "safety net" of behavioral health services available for service members and their families. OHIOCARES is a collaboration of state and local agencies supporting this effort. Although the VA is the primary source of services for Veterans, this partnership also identifies community based resources such as county alcohol, drug and mental health boards, public agencies, and private providers for all Service members and their families. OHIOCARES activities involve training and educating primary care and medical professionals with training on the basics of diagnosing TBI and PTSD and medications to use for symptoms.

- ***Michigan—Buddy to Buddy***

Presented by: Dr. Elizabeth Perkins, The Buddy to Buddy Program

Dr. Perkins described The Buddy to Buddy program, which is similar to Vet-to-Vet but is a partnership between the Army National Guard, University of Michigan and Michigan State University. The program is in pilot phase

going on one year and has formally trained two units from Iraq. There are two components to the program. Buddy 1 is the line on the ground within the unit. If the Soldier calls identifying a concern, they can call the Director of Psychological Health, suicide hotline, or chaplain. They also have the option to call a Buddy 2 whose role is to partner with the service member to motivate them to seek out treatment.

- ***California—Embedded Health, Peer-to-peer***

Presented by: Lt Col Roger Duke, California National Guard

Lt Col Duke stated that the California National Guard provides ongoing referral/resources through the California Guard website, a quarterly article, The Grizzly, and through crisis intervention. The Embed program is a pilot program that provides mental health consultation working at many levels, has 27 providers within the units and a large scale of identified needs.

9.0 TRACK 6: NATIONAL GUARD SUMMARY

DAY 4 - WEDNESDAY, 13 JANUARY

Army Reserve Breakout
1415-1700

Presented by: COL Nicole M Keesee, Deputy Surgeon for Behavior Health, Army Reserve,

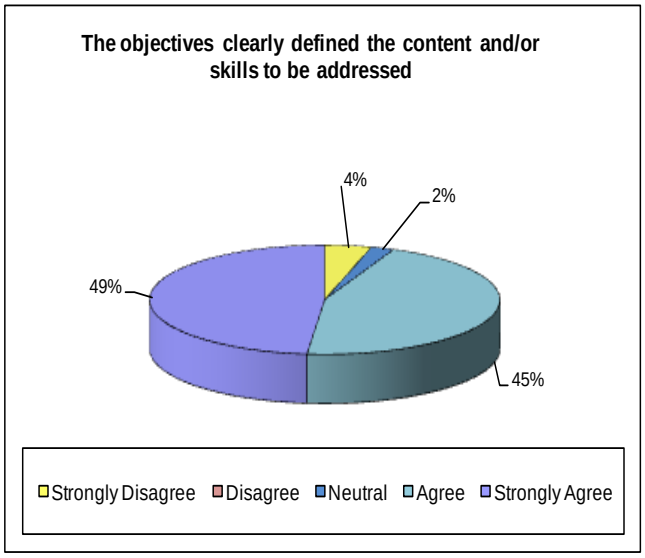
COL Keesee provided an update on the Chief of the Army's suicide prevention council. She stated that for the first time ever, the Army National Guard has direct access to the Vice Chief of the Army. She also highlighted a number of initiatives coming to fruition in the Army Reserve. The Reserve is getting approximately 15 federal recovery care coordinators for the seriously wounded and there is an additional requirement to have a suicide prevention program manager. The concept under consideration calls for 38 suicide prevention program managers, 40 family advocacy, 8 substance abuse counselors, 4 Directors of Psychological Health, and 91 Department of the Army civilian clinical positions. Furthermore, COL Keesee stated that there is currently a checklist for the Army Reserve commanders on how to establish a suicide prevention program, noting that the Vice Chief wants all the programs in the Army identified for suicide prevention. COL Keesee noted there were 42 programs and 38 IT systems for suicide prevention. COL Keesee also received a lot of questions regarding the Yellow Ribbon Panel and concluded by saying that improvements are being made to connect Soldiers to the right resources and events, but it is critical to get commanders informed and appropriately trained. She encouraged everyone to review the Yellow Ribbon website.

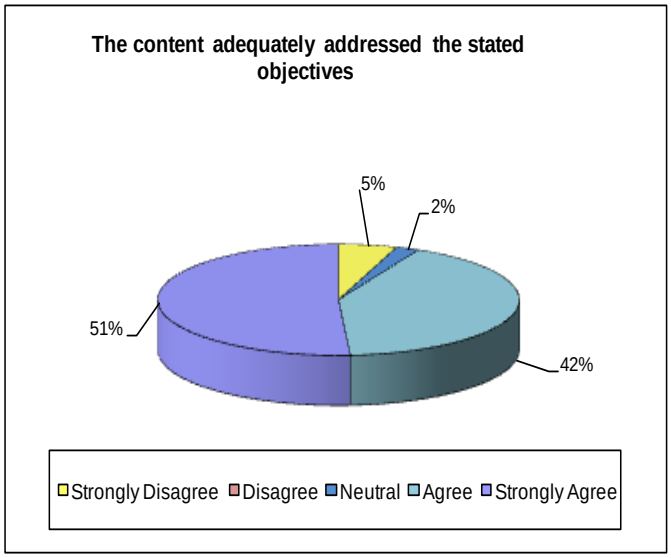
10.0 Evaluation Feedback

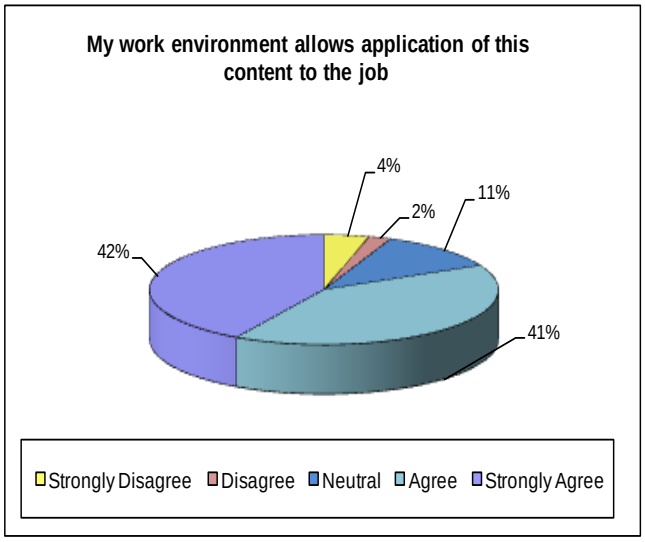
Preconference Evaluation Feedback, 10 January

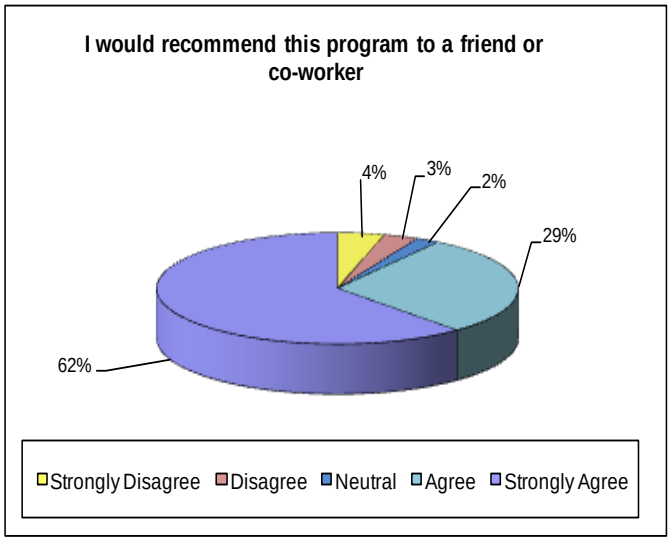
Preconference participants were asked to complete an online evaluation form to gather feedback, address any content gaps, highlight if the conference met stated objectives, and discuss areas needing improvement or areas of success. Among the participants, 11% completed the evaluation form with many individuals providing comments. A full summary of submitted comments are listed in Appendix D.

Below are four graphs that provide an overview of the participant's satisfaction with this year's preconference:









Below is a summary of the common themes found in the responses to key questions in the preconference evaluation form:

I plan to change at least one thing in my work as a result of this educational activity. List those changes in the space provided:

- Utilize and integrate Chaplains in suicide prevention and mental health treatment teams
- Increase use of safety plans
- Try different methods and approaches with Veterans
- Change risk assessment tool to include new factors
- Promote reduction of stigma

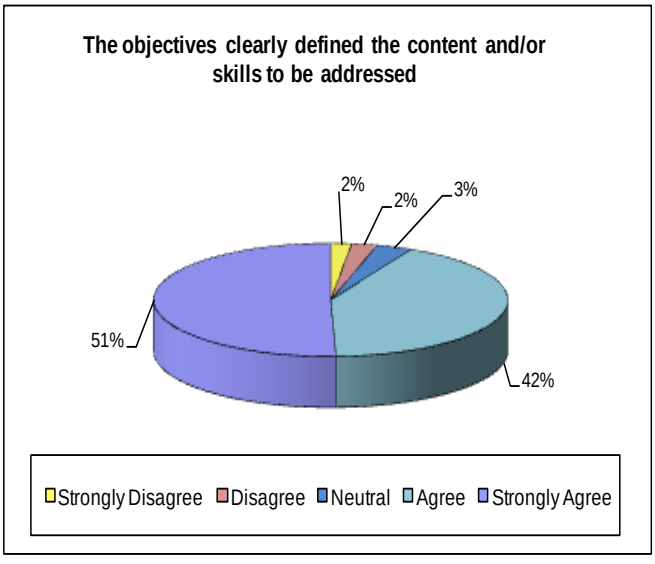
Preconference Workshop Comments:

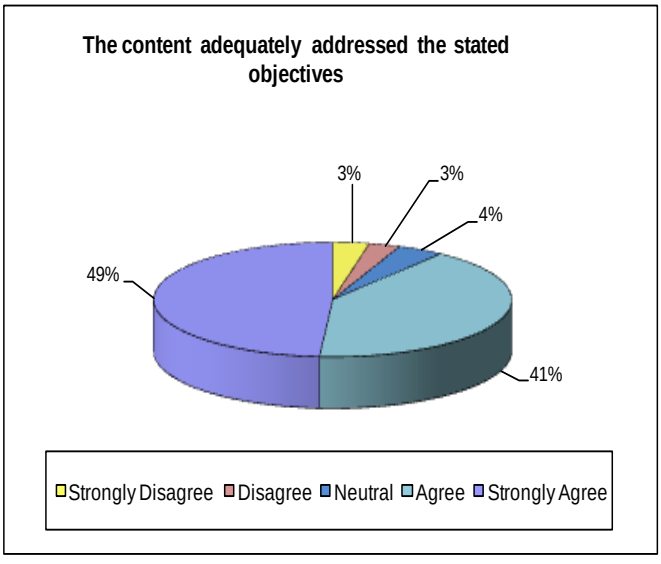
- Conference offered quality content
- Conference provided best practices and research based information
- Conference was informative and increased sensitivity
- Handouts of presentations should be made available for participants to follow along and take notes
- Impressed with the professionalism, commitment, and knowledge base possessed by each of the speakers and panel members presenting and participating at this conference
- Overall, great program

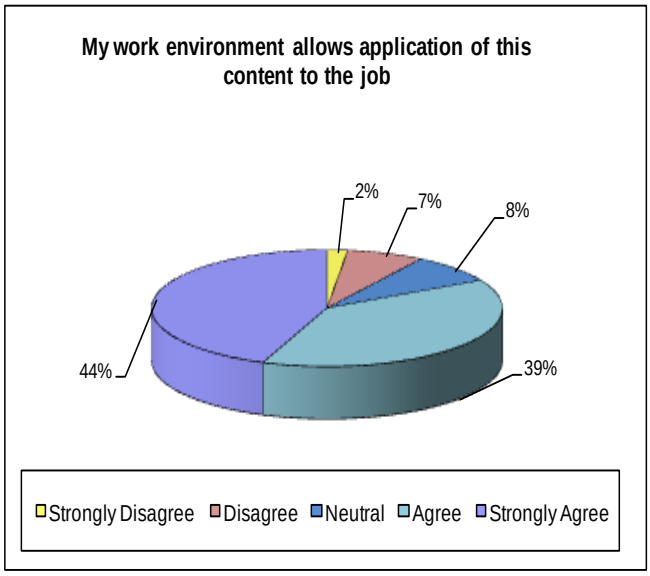
CONFERENCE EVALUATION FEEDBACK, 11-14 JANUARY

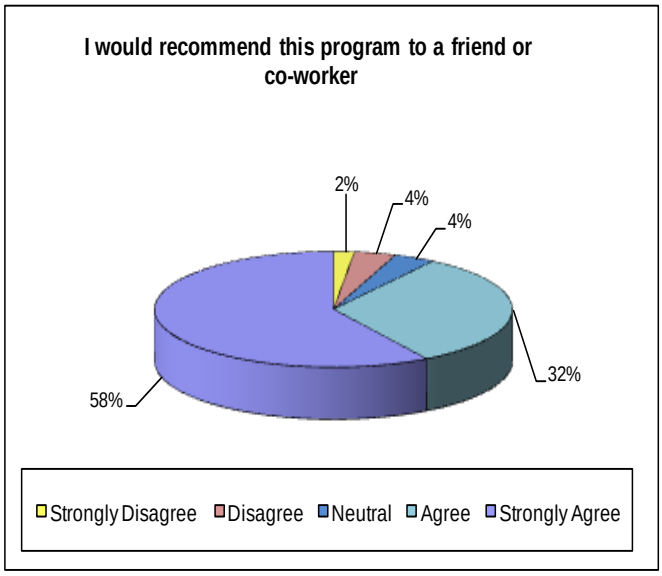
Conference participants were asked to complete an online evaluation form to gather feedback, address any content gaps, highlight if the conference met stated objectives, and discuss areas needing improvement or areas of success. Among the participants, 24% completed the evaluation form, with many individuals providing comments. A full summary of submitted comments are listed in Appendix D.

Below are four graphs that provide an overview of the participant's satisfaction with this year's conference:









Below is a summary of the common themes found in the responses to key questions in the evaluation form:

I plan to change at least one thing in my work as a result of this educational activity. List those changes in the space provided:

- Safety planning, community outreach
- Focus on peer to peer programs
- Safety planning groups with inpatient Veterans. Explore use of the CAMS tools to DBT/mindfulness techniques with Veterans
- Provide educational resources for Suicide Prevention to Veterans and families
- Collaborate more with other services
- Provide more resources about suicide, and provide other leaders with resources and training

Conference Comments:

- It was an outstanding program
- Fantastic collaboration between DoD and VA
- Provide presentation summaries to increase awareness about session topics
- Provide participants with PowerPoint slides prior to the sessions for note taking
- This was a stellar conference
- One of the most interesting and prevalent conferences

11.0 Conclusion and Overall Conference Recommendations

Key Discussion Points and Takeaways

The following is a summary of key discussion topics and takeaway messages from the conference.

- Reducing Stigma
  - Importance of seeking help, support and treatment, particularly as it relates to building resilience was emphasized by those who experience depression and survivors of those who have attempted suicide
  - Continued focus on encouraging help-seeking behaviors, particularly though leaders' actions
- Family Outreach
  - Support and commitment on the issue of suicides from the Chairman of the Joint Chiefs of Staff, Admiral Mullen, which include finding ways to reach out to families and children in an anonymous setting
  - Additional educational resources and training for families of those living with a mental health disorder
  - Additional training for family members on how to recognize signs and risk of suicide and resources for seeking help
  - Additional educational resources to help military families build resilience
- National Guard and Reserve Component Outreach
  - Continued expansion of support systems for members of the National Guard and Reserve Component to ensure they receive support and care
  - Additional efforts to determine innovative approaches to reach the National Guard and Reserve Component population, including utilizing social media
- Tools and Programs
  - Currently available tools and processes, such as the DoDSER and the VA Suicide Behavior Report (SBR) provide a standard platform to track suicide events at the DoD and VA leadership levels and provide statistics to analyze potential risk and protective factors
  - Practical applications, such as the VA Suicide Prevention Hotline, are aimed at outreach efforts to prevent suicide
  - Other applications, such as the Real Warriors Campaign (www.realwarriors.net), focus on reducing stigma and encouraging help-seeking behaviors to prevent suicide
  - Additional efforts to disseminate usable information about current innovations and best practices in suicide risk assessment, intervention and follow-up for utilization at the local and system level

Way Forward

Conference attendees collaborated to generate ways to address some of the issues and roadblocks that were identified during discussions, including innovative ways to reduce stigma, improve outreach and tackle the overarching issue of suicide prevention. Suggestions included:

- Ensure availability of resources and free educational programs for family members at outreach centers
- Institute more face-to-face sessions for suicide prevention training. Computer-based training seems to have become more prevalent, but must be evaluated to determine its effectiveness
- Conduct post-deployment evaluations with an eye for clues to suicidal ideation. Ensure individuals reviewing the evaluations have been thoroughly trained to look for signs of suicide ideation
- Monitor service members' public communication on social media websites and provide assistance when concerns arise
- Develop tools for training and outreach in rural areas, particularly as it pertains to the National Guard, Reserves and Veterans. It is important for service members to feel community support. A Suicide

Prevention Toolkit for Rural Primary Care could be a beneficial tool. Explore the use of resources developed specifically for rural health care providers

- Increase communication between professions, such as mental health providers and chaplains, in an attempt to provider better care to the service members and families and Veterans in need
- Promote outreach programs currently available, such as Vet Centers, the DCoE Outreach Center and Military OneSource, while continually working to diminish visible barriers
- Focus on families as a first line of defense in recognizing the signs and symptoms of suicide risk

DCoE and its partners on the SPARRC, including the VA will continue to collaborate to address some of the most pressing issues related to suicide prevention as highlighted during the conference. These action items include the following:

- Continue to promote resources such as the Real Warriors Campaign across the services to reduce stigma
- Launch the SPARRC website, which will include informational resources and practical tools for service members, Veterans, families and clinicians related to suicide prevention in order to further educate and provide training
- Form a family subcommittee to determine the needs of families and how to best address those needs
- Form a Senior Enlisted subcommittee to engage with line leaders on to address suicide prevention.
- Disseminate RAND Corporation suicide prevention recommendations to inform program development
- Work collaboratively with the Army and DoD Suicide Prevention Task Forces as well as the VA Suicide Prevention Office
- Examine Dr. Thomas Joiner's model for potential ways to inform prevention and treatment in the military
- Promote state of the art interventions and therapies
- Enhance the number and use of postvention programs for survivors

RECOMMENDATIONS

In order to gain additional attendee feedback, an increase in the amount of free response questions in next year's conference evaluation is recommended. Suggested questions include:

- What recommendations do you have for future conference presentation topics?
- Please provide up to three measureable practice changes you are contemplating as a result of participating in this conference?
- What new collaborations or networking would be useful to you?
- Will you attend next year's conference, why or why not?
- What other additional information needs, unanswered questions, suggestions, or comments do you have for the faculty and conference planners?

APPENDIX A: ACRONYM LIST

Acronym	Name
ACCME	Accreditation Council for Continuing Medical Education
ACT	Ask, Care, Treat
AFSP	American Foundation for Suicide Prevention
AFSPP	Air Force Suicide Prevention Program
BH	Behavioral Health
BP	Blister Pack
CAMS	Collaborative Assessment and Management of Suicidality
CAMS-BI	Collaborative Assessment and Management of Suicidality Brief Index
CBOC	Community-Based Outpatient Clinic
CBT	Computer Based Training
CDC	US Center for Disease Control
CH	Chaplain
CIT	Crisis Intervention Team
CJCS	Chairman of the Joint Chiefs of Staff
CO	Commissioned Officer
COE	Center of Excellence
CUA	Catholic University of America
DAU	Dispense As Usual
DBT	Dialectical Behavioral Therapy
DCoE	Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
DoD	Department of Defense
DoDI	Department of Defense Instruction
DoDSER	Department of Defense Suicide Event Report
ESG	Emotional Support Group
HHS	Department of Health and Human Services
IDS	Integrated Delivery System
IPTS	Interpersonal-Psychological Theory of Suicide
ISP	Interactive Screening Program
MH	Mental Health
MIRECC	Mental Illness Research, Education, and Clinical Center
MMFT	Mindfulness-based Mind Fitness Training
NCO	Noncommissioned Officer
NIMH	National Institute of Mental Health
NKO	Navy Knowledge Online
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
PDHA	Post Deployment Health Assessment
PDHRA	Post Deployment Health ReAssessment
POPPA	Police Organization Provides Peer Assistance
PTSD	Post Traumatic Stress Disorder
QPR	Question, Persuade, Refer
RAND	Research ANd Development
SAMHSA	Substance Abuse and Mental Health Services Administration
SBR	Suicide Behavior Report
SDV	Self-Directed Violence
SP	Suicide Prevention
SPARRC	Suicide Prevention and Risk Reduction Committee
SPPM	Suicide Prevention Program Manager
STARRS	Study To Assess Risk and Resilience in Service members
T2	National Center for Telehealth and Technology
TAPS	Tragedy Assistance Program for Survivors

TBI	Traumatic Brain Injury
TIP	Treatment Intervention Protocol
TMH	Telemental Health
UMT	Unit Ministry Team
USA	United States Army
USAF	United States Air Force
USANG	United Stated Army National Guard
USARNG	United States Army Reserve National Guard
USCG	United States Coast Guard
USMC	United States Marine Corps
USN	United States Navy
USNA	United States Naval Academy
USNG	United States National Guard
USPHS	United States Public Health Service
USUHS	Uniformed Services University of the Health Sciences
VA	Department of Veterans Affairs

APPENDIX B: SPONSORING ORGANIZATIONS

DEFENSE CENTERS OF EXCELLENCE FOR PH/TBI (DCOE)

In November 2007, Deputy Secretary of Defense, the Honorable Gordon England, announced the opening of the DCoE. The DCoE leads a collaborative effort toward optimizing psychological health and traumatic brain injury treatment for the Department of Defense (DoD). Partnering with the VA and an extensive network of collaborators, the DCoE supports a holistic approach committed to the establishment of best practices and quality standards for leadership intervention; comprehensive outreach (service member, family, unit and community); education and training; resilience and prevention; clinical care; telehealth connectivity; program excellence; and relevant research. It is responsible for leading and orchestrating a national collaborative network of military, federal, family, and community leaders, advocacy groups, clinical experts, and academic institutions to best serve the urgent and enduring needs of Warriors and their families with psychological health and/or traumatic brain injury concerns.

DEPARTMENT OF VETERANS AFFAIRS (VA)

VA was established on March 15, 1989, succeeding the Veterans Administration. It is responsible for providing federal benefits to Veterans and their families. VA is the second largest of the 15 Cabinet departments and operates nationwide programs for health care, financial assistance, and burial benefits. About a quarter of the nation's population, approximately 74.5 million people, are potentially eligible for VA benefits and services because they are Veterans, family members, or survivors of Veterans. VA's fiscal year 2007 spending is projected to be over $80 billion, including $34.9 billion for health care and $41.5 billion for benefits.

Perhaps the most visible of all VA benefits and services is health care. From 54 hospitals in 1930, VA’s health care system now includes 155 medical centers, with at least one in each state, Puerto Rico, and the District of Columbia. VA operates more than 1,400 sites of care, including 872 ambulatory care and community-based outpatient clinics, 135 nursing homes, 45 residential rehabilitation treatment programs, 209 Veterans Centers, and 108 comprehensive home-care programs. Providing a broad spectrum of medical, surgical, and rehabilitative care, VA has experienced unprecedented growth in the medical system workload. Over the past few years, the number of patients treated increased by 29 percent from 4.2 million in 2001 to nearly 5.5 million in 2007.

VA also manages the largest medical education and health professions training program in the United States, training about 90,000 health professional each year, with affiliations with 107 medical schools, 55 dental schools, and more than 1,200 other schools across the country. The VA Research and Development program—an intramural program located within the VA health care system—has served as the foundation for advancements in Veterans' health care for over 60 years.

VA research currently supports more than 3,000 active investigators and support staff at more than 100 sites across the nation, and its career development program is helping to train America's next generation of health researchers.

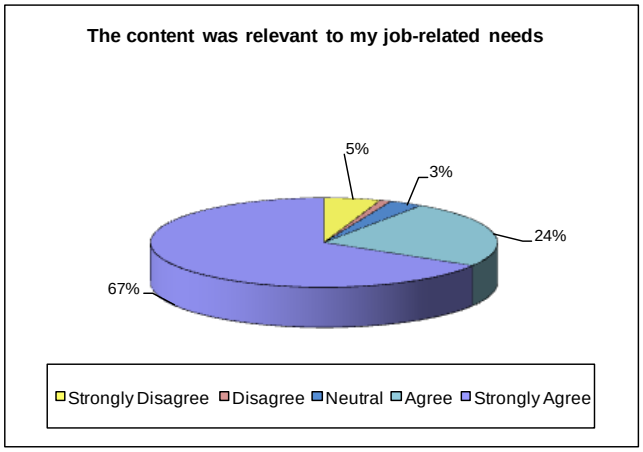
APPENDIX C: CONFERENCE GUIDEBOOK

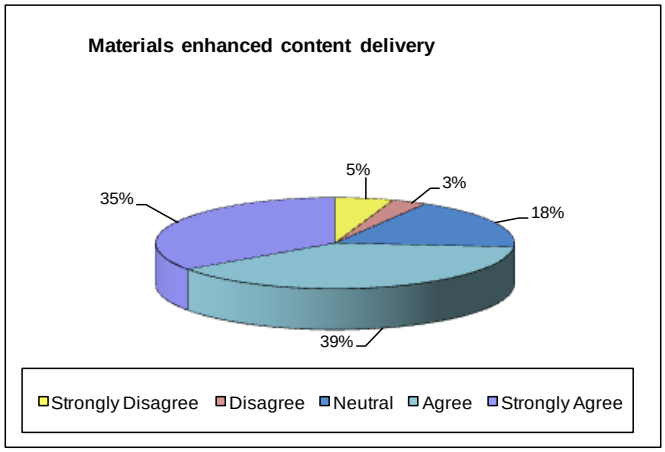
DCoE_SPC_2010_Conference_FINAL.pdf

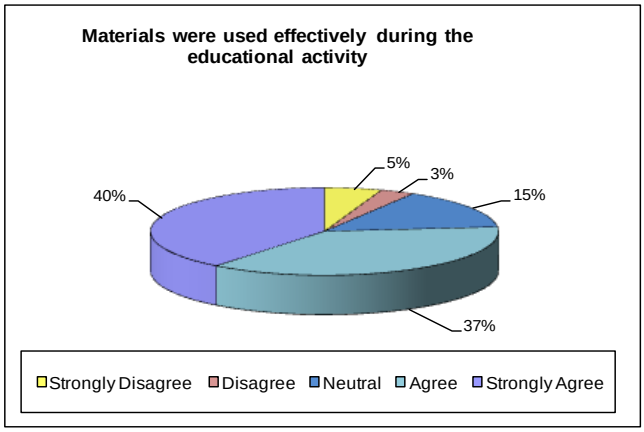
APPENDIX D: CONFERENCE EVALUATION SUMMARIES

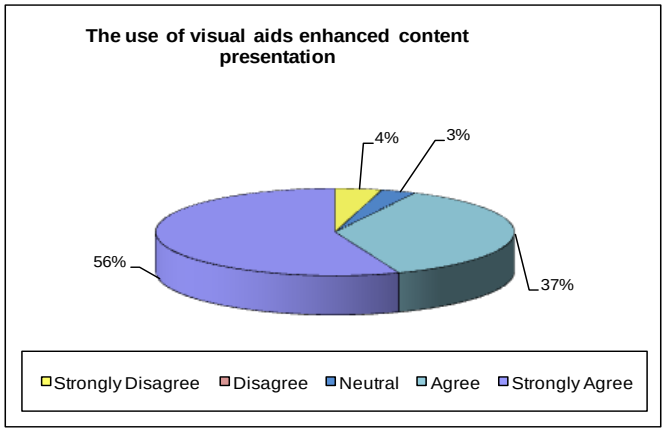
PRECONFERENCE EVALUATION SUMMARIES

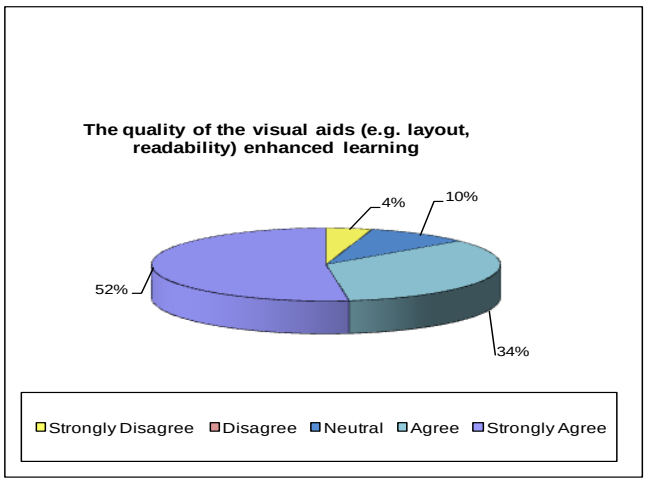
Participants were asked to complete an evaluation of the preconference. The figures below illustrate a summary of the responses received. Comments in this section represent 109 responses.

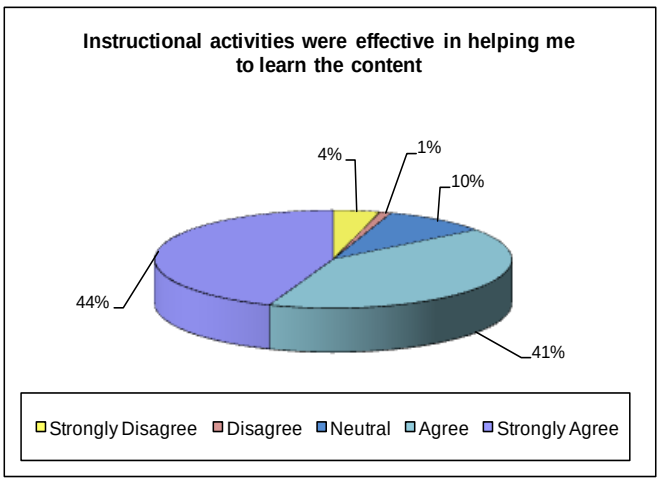




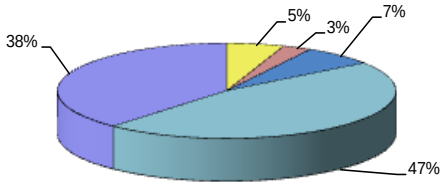






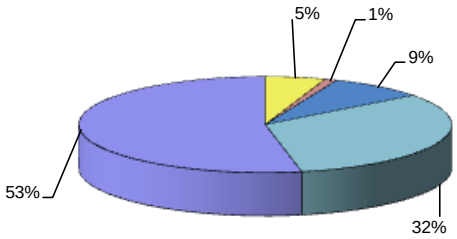


The length of the educational activity was sufficient for me to understand the content



Strongly Disagree Disagree Neutral Agree Strongly Agree

The training was environment was conducive to learning



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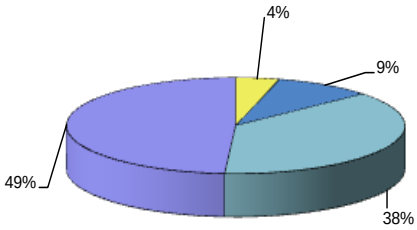
Logistics regarding the educational activity were clear



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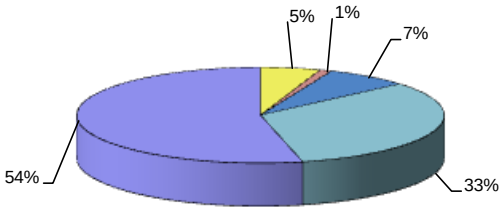
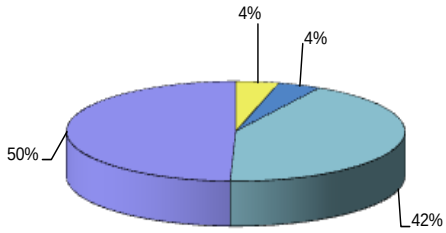
I gained new knowledge or skills are a result of my participation in this educational activity



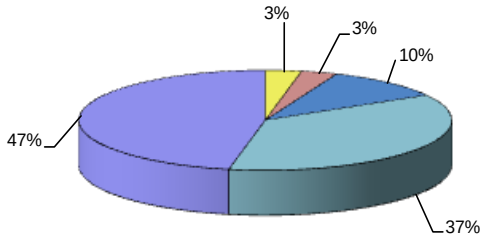
Strongly Disagree Disagree Neutral Agree Strongly Agree

I have learned the content required to attain the objectives of the educational activity



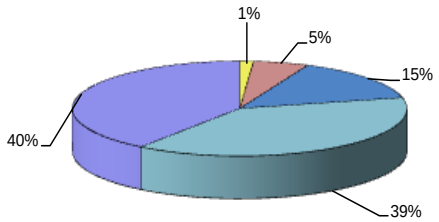
Strongly Disagree Disagree Neutral Agree Strongly Agree

I plan to change at least one thing in my work as a result of this educational activity



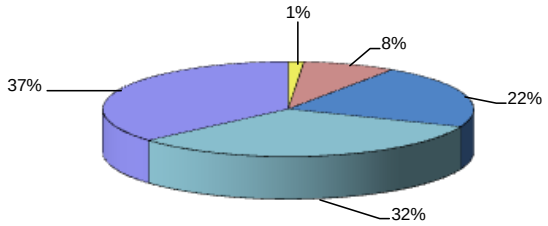
Strongly Disagree Disagree Neutral Agree Strongly Agree

Acquire knowledge of current innocations and best practices in suicide risk assessment



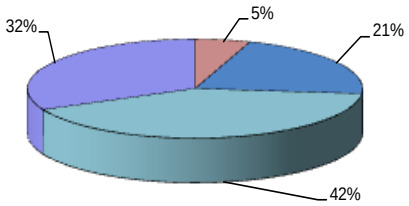
Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

Acquire knowledge of intervention and follow-up skills for suicide



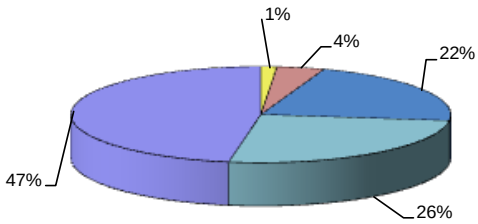
Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

Implement one or more intervention and/or follow-up skills at the local and system levels in order to improve care



Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

Employ one or more techniques that may reduce suicidal behaviors among Veterans and Active Duty Personnel



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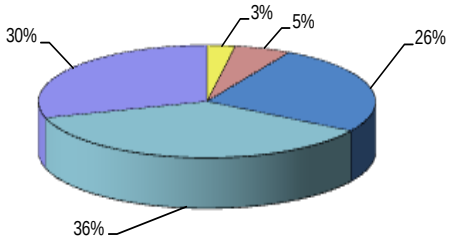
Acquire knowledge of two or more tools grounded in public health, multi-disciplinary and/or strength-based approaches that may be implemented at a local or system level to reduce suicidal behaviors



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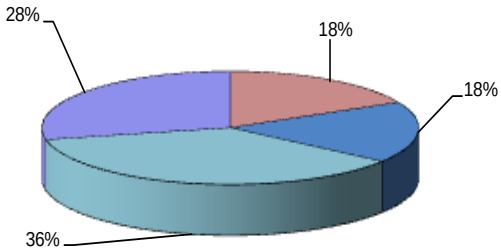
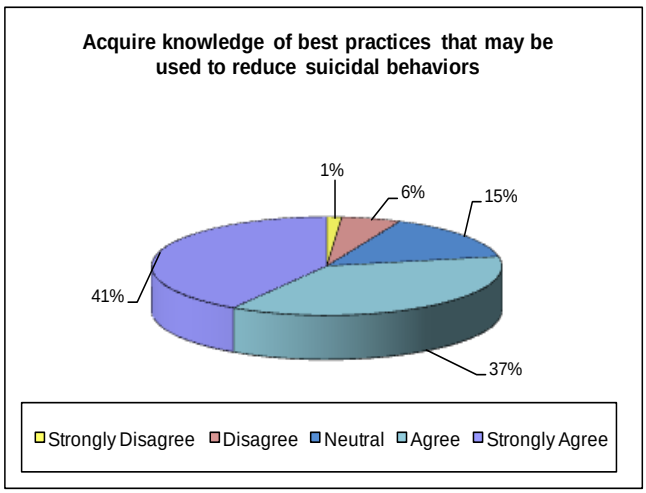
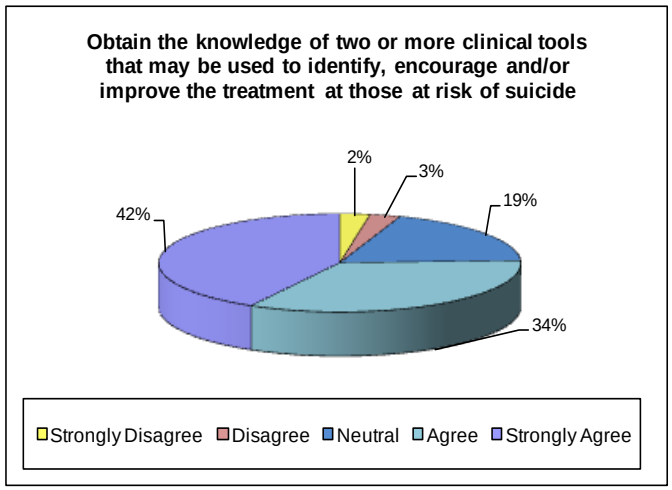
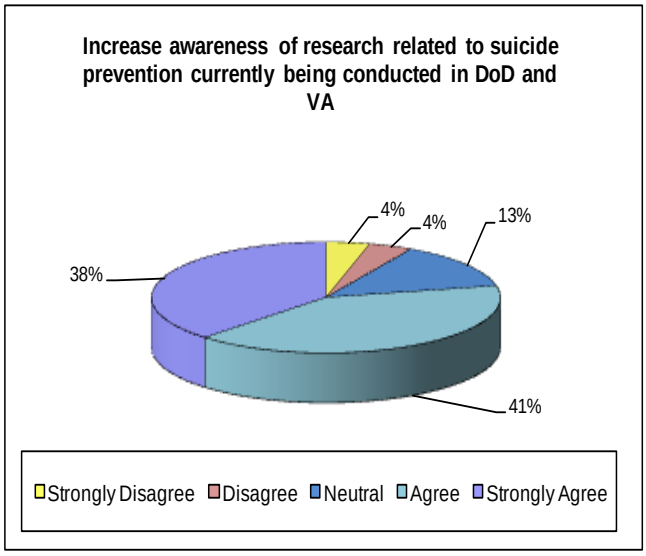
Acquire knowledge of community resources that may be used at a local or system level to reduce suicidal behaviors

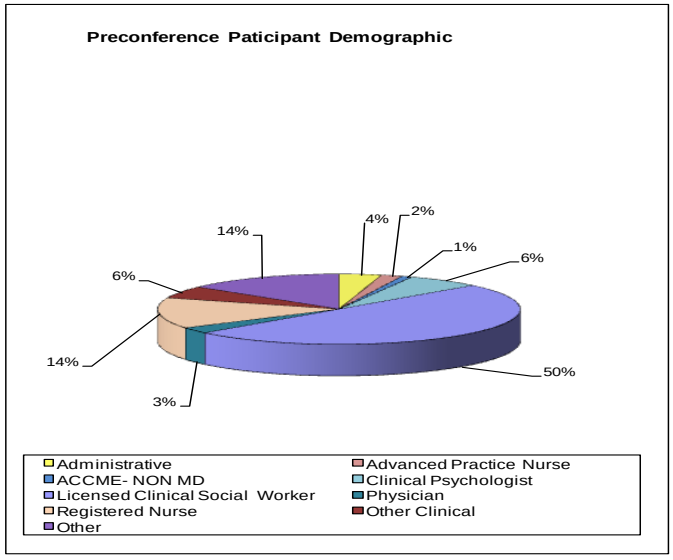


Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree









The preconference participant demographic by organizational affiliation was as follows:

Organizational Affiliation	Number of Conference Attendees
Administrative	4
Advanced Practice Nurse	2
ACCME - NON MD	1
Clinical Psychologist	7
Licensed Clinical Social Worker	53
Physician	3
Registered Nurse	15
Other Clinical	6
Other	15

Participants were asked to answer several qualitative questions regarding the preconference. The following table captures the answers to the open ended questions posed.

I plan to change at least one thing in my work as a result of this educational activity. List those changes in the space provided
▪ The management of RCA tasks ▪ Update my Suicide Prevention training. Become involved in various organizations ▪ New resources - improved assessment tools ▪ Mindfulness ▪ Listen more carefully! ▪ Incorporate materials into our protocols ▪ Promoting reduction of stigma ▪ Improved trainings, develop new programs ▪ Will enlist new skills and strategies presented to meet the unique needs of Reservists/National Guard members behavioral health issues ▪ Important stress control training ▪ More thorough suicide assessment ▪ May use the safety of plan discussed. Try different methods and approaches with Veterans ▪ Safety plan ▪ Presentation of suicide prevention to Active duty Marines ▪ Increase my staff training in Risk Assessment ▪ Enhanced use of motivational interviewing and cams ▪ Integrate Chaplains more into treatment teams ▪ Utilize Chaplaincy more effectively in SP and MH. Connect with CIT in community. Refer to TAPS as needed ▪ USE TAPS as referral ▪ Do more educational workshops on suicide awareness ▪ Safety planning process ▪ I went to recognizing and responding to suicide risk in primary are and from that I am going to get our PCMS trained ▪ Teach others about the warning signs of suicide and post information on how to get help ▪ Change how I assess suicide and implement treatment ▪ New information on suicide risk assessment ▪ Include spirituality in treatment please ▪ May use the safety plan discussed. Try different methods and approaches with Veterans ▪ Utilize information in administration of the BH TRICARE benefit ▪ Surveillance of data ▪ Review results of RAND study to apply to peer review activities ▪ Focus on postvention training ▪ I am changing my position where I sit ▪ Suicide Family Prevention ▪ Change risk assessment tool to include new risk factors ▪ Taking care of the care takers, mind fitness training, reducing risk and promoting health ▪ Will implement more clearly defined process for deployment activities ▪ Various treatment options ▪ More cognizant of the literature and nature of the field ▪ I gained increased awareness of types of issues that affect reservists, families, in addition to active duty. There is increased sensitivity ▪ Increase use of safety plans ▪ Work more closely with the faith community and my chaplains ▪ Assessment tools ▪ Prevention efforts
If commercial products were discussed, I found the information presented in this program to be fair, objective, and balanced in relations to discussions regarding commercial products
▪ I found it distracted from the message in the future, refraining from discussing commercial products

would be helpful for the audience to find the audience to find the content credible and unbiased, especially given the seriousness of the situation

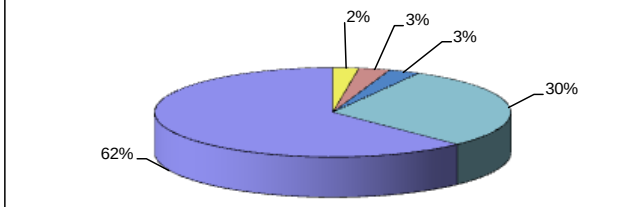
Preconference Workshop Comments

- More detailed descriptions of what the breakout sessions cover
- I was impressed with the professionalism, commitment, and knowledge base possessed by each of the speakers and panel members presenting and participating at this conference. I think that having Soldiers and families present to contribute and tell their stories was a real asset for learning. The entire conference was motivational
- The course was excellent! I don't think we had enough time the last day for the breakout session for the different branches of the military
- Have handouts of presentations available at the time of presentation to follow along and take notes on
- I would highly recommend building into the program mandatory breakout sessions that pair up DoD and VA attendees, per State of Region, to ensure good networking occurs during the conference. Thank you!
- Excellent
- Please provide coffee in the AM!!
- Great conference
- Conference offered quality content. Found shared best practices and research based information, informative and deepened my sensitivity
- Opportunities for meetings with people in geographical areas. It would have been wonderful to meet people from VA in my part of the country
- Very well organized conference
- Tell all presenters to be aware of their statements. The person on compassion fatigue asserting the Ft. Hood shooting was related to compassion fatigue came across as (uninformed), even if she isn't in real life
- VA Focus on more provider involvement
- Excellent conference. Learned a lot of practical information to use in teaching nursing students, and also in my own practice
- Enjoyed the conference. Please provide an attendee list to facilitate networking. Include TRICARE in program. West Region has had a very effective crisis line in operation for 13 years
- Training environment poor, hotel not very helpful
- The conference planners deserve applause for organizing the conference presentations into the four distinct categories. A great help in deciding which trainings to attend. Well done.
- Overall, great program

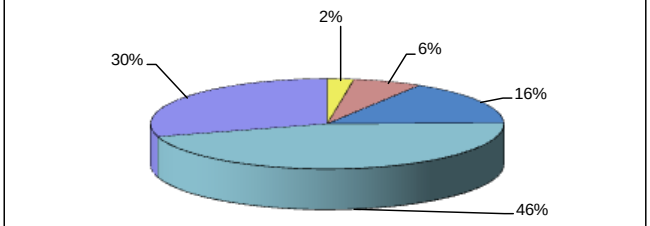
CONFERENCE EVALUATION SUMMARIES

Participants were asked to complete an evaluation of the conference. The below figures illustrate a summary of the responses received. Comments in this section represent 232 responses.

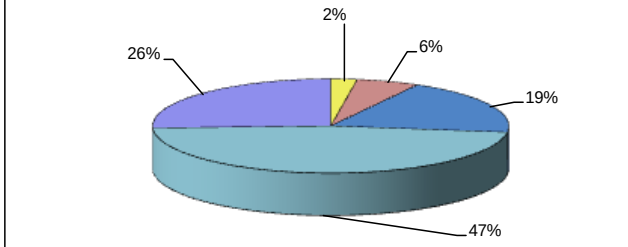
The content was relevant to my job-realted needs



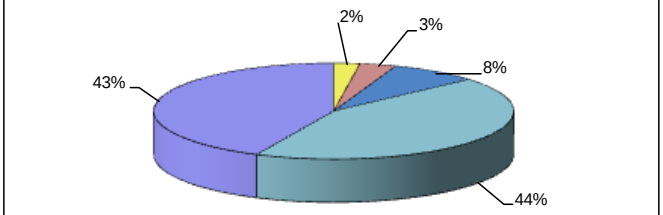
Materials enhanced content delivery



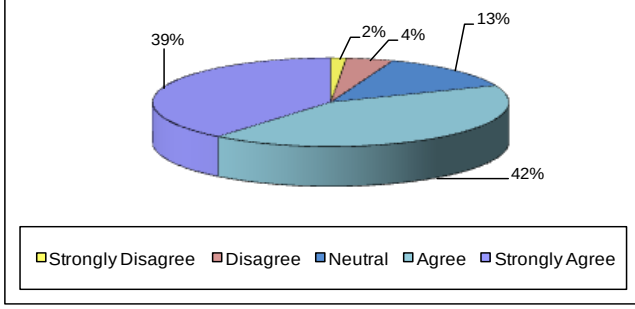
Materials were used effectively during the educational activity



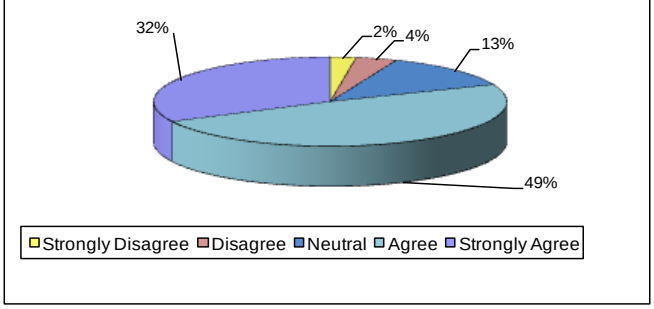
The use of visual aids enhanced content presentation



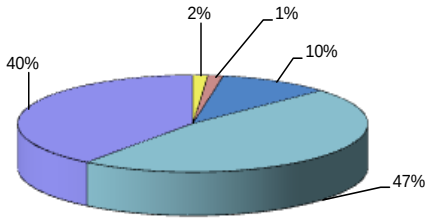
The quality of visual aids (e.g., layout, readability) enhanced learning



Instructional activities were effective in helping me learn the content

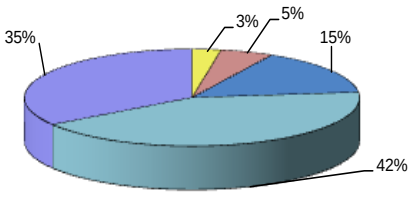


The length of the educational activity was sufficent for me to understand the content



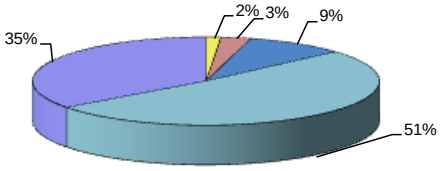
Strongly Disagree Disagree Neutral Agree Strongly Agree

The training environment was conducive to learning



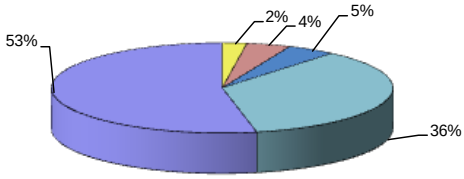
Strongly Disagree Disagree Neutral Agree Strongly Agree

Logistics regarding the educational activity were clear



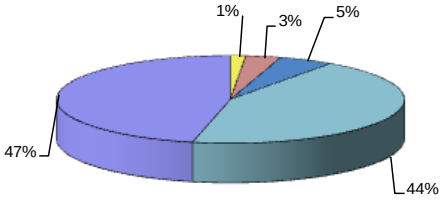
Strongly Disagree Disagree Neutral Agree Strongly Agree

I gained new knowledge or skills as a result of my participation in this educational activity



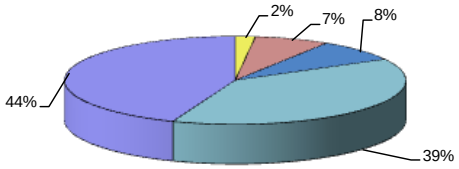
Strongly Disagree Disagree Neutral Agree Strongly Agree

I have learned the content required to attain the objectives of the educational activity



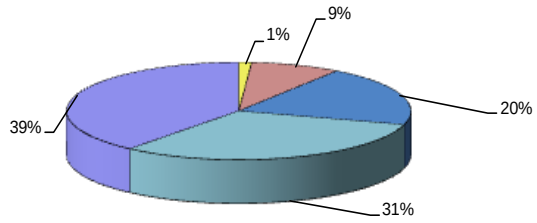
Strongly Disagree Disagree Neutral Agree Strongly Agree

I plan to change at least one thing in my work as a result of this educational activity



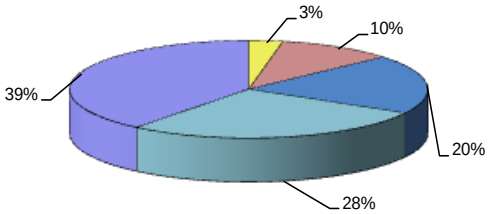
Strongly Disagree Disagree Neutral Agree Strongly Agree

Acquire knowledge of current innovations and best practices in suicide risk assessment



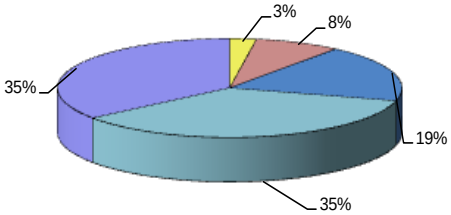
Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

Acquire knowledge of intervention and follow-up skills for suicide prevention



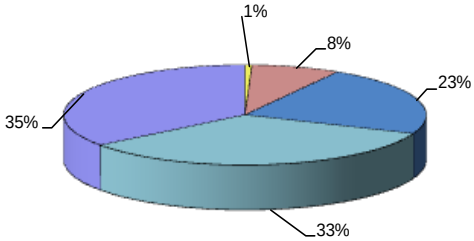
Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

Implement one or more intervention and/or follow-up skills at the local and system levels in order to improve care



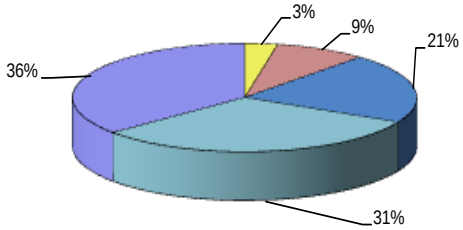
Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

Employ one or more techniques that may reduce suicidal behaviors among Veterans and Active Duty personnel



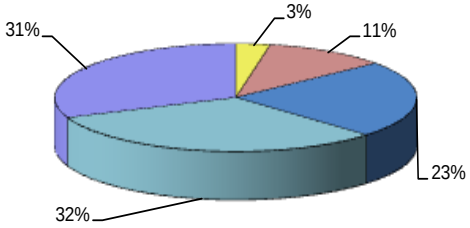
Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

Acquire knowledge of two or more tools grounded in public health, multi-disciplinary and/or strength-based approaches that may be implemented at a local or system level to reduce suicidal behaviors

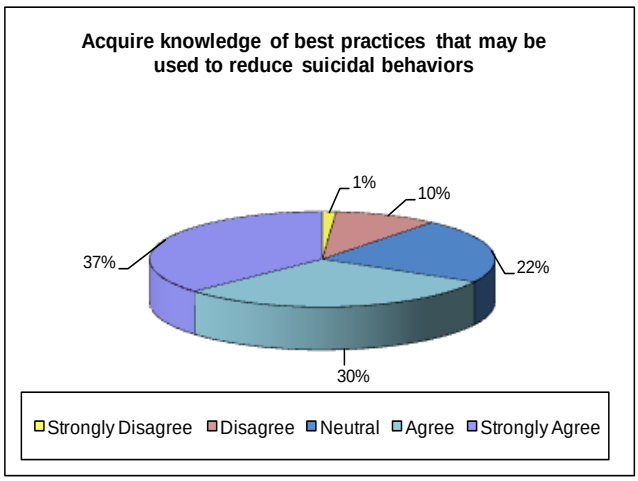


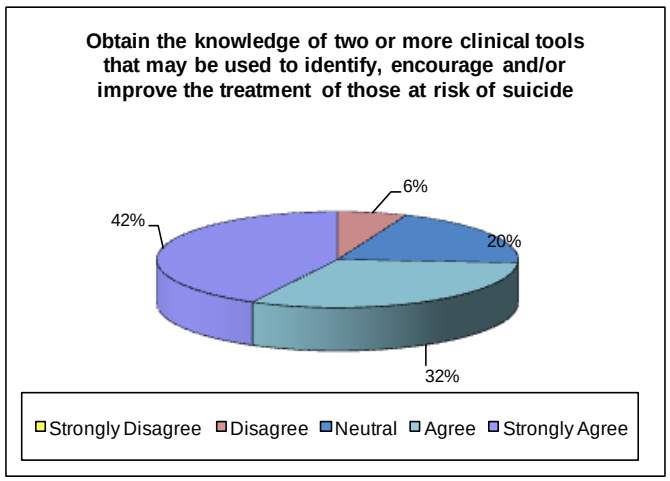
Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

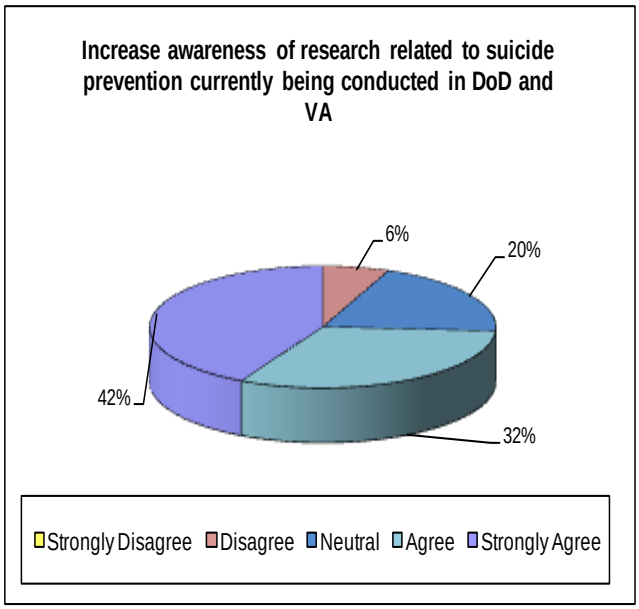
Acquire knowledge of community resources that may be used at local or system

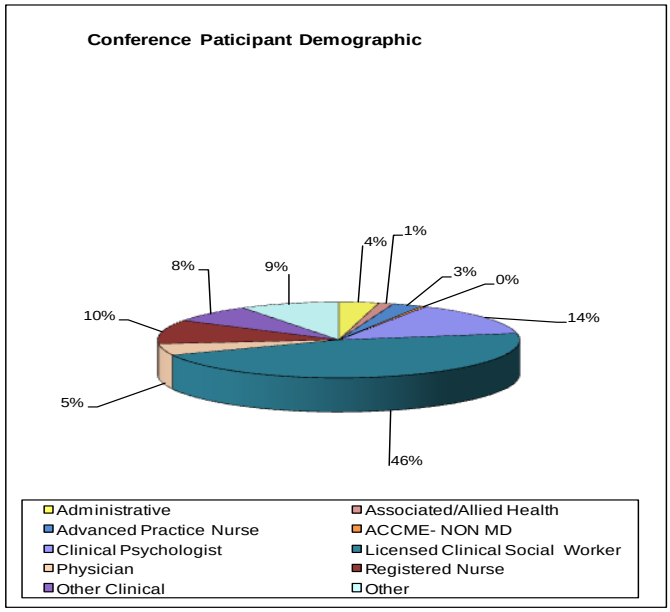


Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree









The conference participant demographic by organizational affiliation was as follows:

Organizational Affiliation	Number of Conference Attendees
Administrative	8
Associated/Allied Health	3
Advanced Practice Nurse	6
ACCME - NON MD	1
Clinical Psychologist	32
Licensed Clinical Social Worker	104
Pharmacy Tech	1
Physician	11
Registered Nurse	23
Other Clinical	17
Other	20

Participants were asked to answer several qualitative questions regarding the conference. The following table captures the answers to the open ended questions posed.

I plan to change at least one thing in my work as a result of this educational activity. List those changes in the space provided.
▪ Will utilize new assessment skills ▪ More proactive ▪ More contact with family community ▪ I will make sure the people I teach in a class will either have Power Point note takers or know at the beginning of the training/class that the Power Point slide presentation will be available later ▪ Concentrate more on family members, we tend to overlook them ▪ More outreach ▪ I plan to brief the CO's on base on the navy's new suicide prevention instruction ▪ Staff training and raising constituent awareness ▪ Specific risk assessment questions ▪ Incorporate new prevention materials presented ▪ Adding treatment graphs for suicide prevention modifying tracking system ▪ Safety Planning ▪ Safety planning, community outreach ▪ Supplement NKO ▪ Increase screenings for SI at intake ▪ I will possess a greater appreciate for depth of commitment of VA/DoD to prevent suicide ▪ Identified additional training I can provide to (or bring in for) facility mental health providers ▪ Consult with staff regarding possibility of "pill box" clinics ▪ More detailed/through suicide assessment ▪ Have presentations/handouts pre-printed online for attendees ▪ Will use one suicide intervention/prevention technique/method ▪ To sit with client, side by side, to develop plan together. To make sure there is a suicide prevention plan in client's charts if client has suicidal I/I ▪ Relationship in regards to medications pre and post pregnancy for female vets ▪ Be more aware in noticing behavioral changes amongst co-workers and friends ▪ Implement a crisis response plan program ▪ Utilize data and statistics more carefully ▪ Add crisis safety plan. Educate colleagues and enhance suicide risk assessment protocol. Encourage strength based approach ▪ Collaborate more with other services ▪ More attention to opportunities for research ▪ Focus efforts on peer to peer programs ▪ Teaching method, content ▪ Safety planning groups with inpatient Veterans. Explore use of the CAMS tools to DBT/mindfulness techniques with Veterans ▪ Increase technology utilization ▪ I will use the suicide risk assessment form presented ▪ Try to bring Theater of War to Arizona. Look more at the spiritual side of suicide prevention. Use more research information in my outreach presentations ▪ Develop peer support for Veterans and families. Distribute TAPS resources ▪ Develop outreach mechanism for detached duty personnel ▪ Become more aware of all programs on Suicide Prevention by DoD/VA ▪ CAMS, TAPS, Rural SP Toolkit, SP focused CBT ▪ Very much value concept of asking Veterans what they thought of suicide, elicits fear versus comfort ▪ More in-service trainings ▪ Become more sensitive to risk factors for suicide in my patients ▪ Establishment of safety plans ▪ Be more attentive to content of our screening measures ▪ Provide educational resources for Suicide Prevention

- Education, teaching Veterans and families
- Utilizing the three pronounced variables for suicide based risk, reared fearlessness of death, belonging or lacking and purpose in life
- Alertness
- Improvement of my risk assessment. Use of various websites/resources for clients
- Renew compassion skills, use of mindfulness technique, Improve education teaching
- They way I do Safety Contract
- Add social networking to our program
- Extensive safety plan, and more aware of habitation
- More in-depth briefings
- Pass on concepts learned or enhanced
- Become more aware of all the programs on suicide prevention by DoD/VA
- Use other agencies as needed
- Incorporate peer support
- Education provided to new employees, VA Veterans and community members
- The use of CAMS
- Provided new information to read, investigate and apply, as well as outside resources to utilize in certain circumstances
- Provide more literature/awareness
- Suicide assessment mindfulness
- Will begin using Suicide Status Form with CAMS approach, Identify postvention needs, change safety plan
- Increase collaboration and "objectivity" in therapy sessions with suicidal individuals (i.e. follow CAMS approach)
- How the "monitoring list" at our facility is managed
- Widen the scope of Suicide Prevention Training for the Incorporate newly found programs like Real Warriors and TAPS
- Learned valuable skills in process of suicide risk assessment
- Suicide assessment mindfulness
- Provide Inpatient support group. High risk review process
- Use SPI instead of contracting for safety
- Additional outreach training to local law enforcement
- Ask more questions pertaining to suicidal thoughts
- Increase evidence based practice
- Provide more resources about suicide, and provide other leaders with resources and training
- Implement changes to trainings to include new information. Bring information back to CBOCS and Primary Care
- Enhance educational training to other staff at my facility
- Incorporating Dr. Joiner's theory, mindfulness
- Provide additional resources, 1-800-273-TALK
- Asking a Veteran, "does the thought of suicide comfort you or frighten you?"

If commercial products were discussed, I found the information presented in this program to be fair, objective, and balanced in relations to discussions regarding commercial products

- One presenter over-sold his book, but he was a very good speaker
- Will implement a peer support program
- A few books mentioned, all excellent and written by the best, Jobes, Rudd, Joiner, and Viner
- Yes

Conference Feedback Summaries

- Unclear why more SAMHSA-based grantee information was not included
- More detailed description of breakout session content
- This was an exceptional program... It would have been nice to buy a box lunch for lunch
- For future DoD/VA Suicide Prevention conferences, please assure that leadership (conference leadership) is present at the survivor/family panel!
- Classes seemed a bit long at times. More breaks, perhaps 10 minutes every hour
- It was an outstanding program. I applaud cooperation between DoD/VA
- This percentage increase in perceived ability to attain program objective in an awkward approach to

determining the efficacy of the conference, and difficult to gauge

- Class summaries would have been helpful as many of the classes I attended were not what I thought they would be (i.e. Suicide risk Reduction - Building Skills Toward Prevention was all about PET scans and medicine effects on the brain while discussing a suicide assessment, tool for psychiatrists
- Excellent. Would like more survivors at plenary sessions
- Outstanding conference
- It would be helpful to have handouts for slides
- I learned a lot about the resources available
- Recommend that refreshments start earlier
- Have handouts or power point presentations, or list of contact information to request same
- Great networking with DoD folk, and other SPCs. More practical techniques given with new research would be helpful
- It would be nice if the presenters could provide some hard copy of their presentation materials
- Excellent. Would like more survivors at plenary sessions
- Good topics
- More combined input with DoD staff. Seems that we separated a great deal instead of mingling together
- I enjoyed the different tracks available, and was able to attend at least one session in each track. Very impressive to have 1,000 participants from DoD/VA together. Everything appeared to go very smoothly. Thank you for all the hard work that went into this conference
- The conference was paramount in addressing the suicide dilemma among all branches of the Armed Forces
- Really appreciated speaker Ken Norton's prepared handout. Have shared with staff at my VA facility, great reviews
- Asking for an evaluation for each presenter a week after the conference with several presenters is not accurate as they tend to run together
- Conference was educational and inspiring
- Impressive number of attendees. Possibly put monitors halfway back in audience for plenary sessions to make it easier for those in back to see power point presentations
- The conference contained good information, but nothing that I can use in my daily work. Also, was difficult to write down all the information
- You chose outstanding speakers, and the Theater of War was awesome
- Learned a great deal. Great location
- Excellent conference, well worth my time and expense
- Great conference! Breakout sessions were excellent, especially Navy meeting!
- Chairs need to be spaced a little farther apart so people can focus better on content
- David Jobes, PhD, is a real asset to this workshop. Knowledgeable, passionate and engaging
- I feel the conference was relevant. I hope it's in Washington DC again, but can it be moved to a warmer time of year?
- It would be nice to see breakout sessions offer actual useable tools rather than pilot or research based tools
- Smaller workshops/breakout sessions to allow more dialogue, more skill/clinical building sessions focusing on specific treatments, not just discussing research findings
- Refreshments as do appreciated, but I do not eat pastry. Not a big deal, but healthy choices like vegetables, fruit. Etc., even popcorn is better than cookies, etc
- The breakout sessions on the last day were the most beneficial to me, as I found out specifically what I need to do and how all of this applies to me and my service. Recommend more breakout sessions that are service-specific
- Seemed more "report" oriented as opposed to training oriented. I may have been a mismatch for this conference. I live in the operational (even tactical) world. The conference was at the strategic level
- Most informative conference I have attended. Speakers were very knowledgeable. Have gained invaluable information through my attendance
- It was an outstanding program, I applaud the cooperation between the DoD and VA
- Include formula to obtain ROI as a handout that was used on 8/22
- Excellent conference. Good information
- For each workshop/breakout there should be at least one page executive summary about the topic
- Excellent conference. It has made it easier to talk about suicide

- Have the slides available for all presentations, or have them present at the sessions. Overall, great, well put together conference
- While the Theater of War is great, it is becoming rather redundant at these conferences, and I am not sure it is teaching us anything other than the issues we are facing aren't new
- Power point handouts to participants
- This was a stellar conference. Probably the most interesting and useful one I've ever attended