OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

NOV 21 2017

The Honorable William M. "Mac" Thornberry
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The enclosed report is in response to section 728 of the Carl Levin and Howard P. "Buck" McKeon National Defense Authorization Act for Fiscal Year 2015 (Public Law 113–291), which requires the Secretary of Defense to submit a report setting forth an evaluation of specific tools, processes, and best practices to improve the Armed Forces' identification and treatment of mental health conditions and traumatic brain injury (TBI) among Service members. The Department of Defense (DoD) submitted interim reports responding to subsections (b)(5), (b)(9), and (b)(10) in January 2016, and subsections (b)(2), (b)(3), (b)(6), and (b)(8) in December 2016. This final report responds to (b)(1), (b)(4), and (b)(7).

The DoD's effort to examine the effectiveness of mental health and TBI programs is comprehensive, and assists programs to better incorporate routine evaluations within program design and daily operations. Improving a program's evaluation capabilities informs policy and program decisions; identifies and allows remediation of gaps and redundancies; enables the endorsement, adoption, and application of best practices moving forward; and helps achieve better program performance, competence, and accountability.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families. A similar letter is being sent to the Chairman of the Senate Armed Services Committee.

A. M. Kurta
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

NOV 21 2017

The Honorable John McCain
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

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A. M. Kurta
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

Report on Section 728 of the Carl Levin and Howard P. "Buck" McKeon National Defense Authorization Act for Fiscal Year 2015 (Public Law 113-291): Report on Improvements in the Identification and Treatment of Mental Health Conditions and Traumatic Brain Injury Among Members of the Armed Forces

October 2017

The estimated cost of this report or study for the Department of Defense (DoD) is approximately $12,000.00 for the 2017 Fiscal Year. This includes $0.00 in expenses and $12,000.00 in DoD labor.
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Introduction

The Department of Defense (DoD) submits this report in response to section 728(a) of the Carl Levin and Howard P. "Buck" McKeon National Defense Authorization Act for Fiscal Year (FY) 2015 (Public Law 113–291), which requires the Secretary of Defense to provide an evaluation of specific tools, processes, and best practices to improve the Armed Forces' identification and treatment of mental health conditions and traumatic brain injury (TBI) among Service members. Specifically, this report responds to the following subsections:

- (b)(1): An evaluation of existing peer-to-peer identification and intervention programs in each of the Armed Forces
  - **Finding:** By leveraging shared experiences, effective peer-to-peer programs foster a supportive and trusting environment, decrease stigma, and promote help-seeking behaviors through either one-on-one peer interaction or through group activities benefiting the larger military community.
- (b)(4): An evaluation of programs and services provided by the Armed Forces that assist members of the Armed Forces and family members affected by suicides among members of the Armed Forces
  - **Finding:** The DoD dedicates significant resources to suicide-related programming; however, further evaluation of short-and long-term outcomes is needed to determine effectiveness.
- (b)(7): Recommendations for improving, consolidating, expanding, and standardizing the programs, services, tools, processes, and efforts that improve the Armed Forces' identification and treatment of mental health conditions and TBI
  - **Finding:** Programmatic considerations include establishing outcome metrics, using external and internal evaluation efforts to ensure participants' needs are met, grounding services and trainings in evidence-based practices, standardizing programs across the Services, commands, and installations to encourage collaboration, and basing funding decisions on positive program outcomes.

The DoD submitted interim reports that responded to subsections (b)(5), (b)(9), and (b)(10) in January 2016, and subsections (b)(2), (b)(3), (b)(6), and (b)(8) in December 2016.

In FY 2013, the DoD began a 5-year initiative to evaluate the effectiveness of approximately 200 DoD-funded behavioral health and suicide prevention programs, 44 of which are addressed in this response. This report discusses findings from an analysis conducted using an evidence-based rapid evaluation protocol, which includes site visits to programs, structured interviews with program staff, and an analysis of key areas indicative of program effectiveness; these areas address established program performance measures outlined in program evaluation data, and public health literature. The evaluation methodology and key questions were derived from multiple sources including DoD behavioral health and suicide prevention policies. This method provides information regarding program efficacy and verifies that the services and programs provided are robust, non-duplicative, and salient to the continued mission readiness of our military forces. The Health Resources and Services Administration, the Centers for Medicare and Medicaid Services, the Department of Veterans Affairs, the United States Agency for International Development, and the RAND Corporation have used similar rapid evaluation approaches to assess large service systems that contain widely varying programming. Potential

outcomes from current DoD programs include enabling the endorsement and application of best practices, eliminating redundant services, closing service gaps, educating key stakeholders on programmatic and policy decisions, improving program performance, and increasing competence and accountability in the evaluation of program effectiveness.

Subsection (b)(1) – Peer-to-Peer Programs

> *An evaluation of existing peer-to-peer identification and intervention programs in each of the Armed Forces.*

Summary Response

Peer support programs seek to benefit not only the individual participant but also the larger military community by creating a culture of openness and inclusion that enhances both individual readiness and unit cohesion.

DoD has established multiple interventions that leverage peer-to-peer methods to promote health and wellness of individual Service members as well as unit cohesion and engagement. Thirty psychological health programs were evaluated to examine the state of peer-to-peer identification and intervention programs within the Armed Forces. DoD peer-to-peer efforts encompass a broad range of modalities, including outreach and engagement centers, deployment and operational support events, or individualized counseling/mentoring relationships. Peer-to-peer interventions feature varying degrees of relationship building, information sharing, and interpersonal/life skill improvement from the supporting peer to the supported peer. This evaluation defined peer-to-peer programs as those programs using peer support as the primary method of prevention or treatment for both healthy and recently distressed individuals. Peer support falls into two broad categories: direct interaction and assistance provided by a trained peer who shares similar traits or circumstances to a Service member and treatment, education, and outreach provided by mental health providers in a group setting to Service members.

The DoD established policy both for psychological health in military operations, and also for peer-to-peer programs, training, leadership development, and tools that assist with adjustment to various contexts. Specifically, health promotion programs enhance mission readiness, unit performance, and health and wellness for Service members, beneficiaries, and DoD-civilian employees.

Peer-to-peer programs differ across the DoD, but they can be broadly categorized as follows. See Appendix A for a complete list of peer-to-peer programs.

- **Train-the-Trainer Programs (T3):** These programs train peer instructors in best practices to deliver assistance to fellow Service members. In turn, these Service members are able to identify peers who need psychological health assistance, provide resources, and improve their peers' coping abilities.
- **Retreat Programs:** These programs place fellow Service members in a new environment—outside of military installations—where they participate in intensive workshops that focus on multiple dimensions of their wellness.

- **Health Promotion Programs:** These programs provide services within a group setting that encourage and support physical and psychological health and wellness by addressing topics such as recreational drug and alcohol use, diet and exercise, injury and violence, reproductive and sexual health, and mental and emotional well-being.
- **Yellow Ribbon Reintegration Programs:** These programs provide services within a group setting that support the wellness of the targeted population through the four phases of the deployment cycle (i.e., pre-deployment, deployment, demobilization, and post-deployment).
- **Special Operations Resiliency Programs:** These programs, through a holistic system of health care and support services (e.g., psychological counseling, fitness, injury prevention and recovery), focus on developing resiliency to the physical, psychological, and emotional stress inherent in the jobs of members of the Special Operations Command.
- **Additional Peer Support Programs:** These programs provide services ranging from support for military children and telecounseling and referral via call center hotlines connecting Service members with their peers to high-adrenaline activities among peer groups.

The DoD identified two predominant themes during the analysis of peer-to-peer program information. First, peer-to-peer programs within the military community typically focus on primary prevention, resiliency, and education. Although peer-to-peer programs may differ in activities and service provision, they all address the barriers of stigma and social isolation that often affect the psychological health of Service members and their families. Second, T3 programs currently require further evaluation to determine effectiveness. Many programs rely on the T3 model; however, the effectiveness of the large majority of each program's train-the-trainer model depends on the quality of both the instructors' training and also the transfer of skills to meet the needs of the target population.

Subsection (b)(4) – Suicide Prevention Programs

> *An evaluation of programs and services provided by the Armed Forces that assist members of the Armed Forces and family members affected by suicides among members of the Armed Forces.*

Summary Response

Suicide prevention and response programs train Service members to identify suicide risks and to foster a climate of support for their peers.

The DoD evaluated 17 programs to examine the state of suicide programs within the Armed Forces. This report provides an overview of suicide prevention policy and headquarters level efforts to evaluate suicide trends across the Services. Additionally, findings are provided at the implementation level for both suicide prevention programs that promote and enhance prevention practices and suicide response (postvention) programs that provide support following suicides or traumatic events. See Appendix A for a list of these programs.

Overview of Suicide Prevention in the Military

DoD is responsible for supporting and protecting those who defend our country, and so it is imperative we do everything possible to prevent suicide in the military community (in accordance with the Total Force Members and Military Family Members as authorized by Public Law and Policy). Consistent with civilian health authorities (e.g., World Health Organization and Centers for Disease Control and Prevention), DoD conceptualizes suicide in the military as a public health problem in which suicide-related behaviors result from the complex interplay of multiple risk factors. In December 2015, the DoD issued the DoD Strategy for Suicide Prevention (DSSP), which laid out a comprehensive plan to serve as the foundation and strategic point of reference for suicide prevention efforts within the DoD. The DSSP taps into all available assets the DoD has to prevent suicides and reduce suicide risk including unit leaders, peers and family members, military healthcare providers, chaplains, and crisis hotline staff.

DoD is in its second year of implementing the DSSP goals and objectives although several suicide prevention efforts have been developed and implemented prior to the DSSP and therefore alignment to all DSSP goals and objectives will take time. See Appendix D for DoD's logic model for suicide prevention that represents the path in which DoD can develop new or modify existing programs and services in accordance with the DSSP. The logic model also outlines short-term outcomes related to DSSP goals and objectives that make achievement of long-term outcomes (e.g., reduction in suicide rates and suicide-related behaviors) more likely to occur. See Appendix B for a comprehensive list of the data sources that the DoD uses to assess Department-wide progress on short- and long-term outcomes.

Understanding the effectiveness of suicide prevention initiatives, interventions, and activities is challenging because of the low number of suicides relative to the larger military population and the amount of implementation time required in order to assess whether prevention efforts lead to desired changes in suicide rates. Based on the available data sources, DoD proposes that, over time, desired change in one of the short-term metrics will lead to a reduction in suicide rates and suicide-related behaviors. See Appendix C for an overview of Department-wide and Service-specific progress and trends.

Suicide Prevention Programs

DoD policy requires the Services to foster a climate that encourages help-seeking behavior and builds resilience; provide robust training standards on suicide prevention; increase awareness about behavioral health and reduce stigma for personnel who seek behavioral health care; take steps to identify members at risk for suicide; and provide continuous access to quality behavioral health care and other supportive services.

Programs in suicide prevention emphasize training in identification and referral and encourage help-seeking behaviors. They provide evidence-based annual mandatory training to all Service members—especially junior leaders, first-line supervisors, and military police—and to helping professionals (i.e., physicians, nurses, psychologists, social workers, counselors, and chaplains) on how to recognize and intervene with potentially suicidal Service members. These programs also conduct stigma reduction campaigns and other initiatives to create a culture that destigmatizes help-seeking and promotes peer-to-peer psychological health awareness and support.

The DoD's analysis indicated that suicide prevention programs aligned with policy guidance met training objective and reviewed suicide incidents comprehensively. Programs had the structural elements required for suicide prevention initiatives, demonstrated clear understanding of and alignment with their policy guidance, and used processes consistent with the objectives for providing training to increase awareness of risk factors and suicide prevention practices. Programs across the Services collect data on suicides, which is collated and detailed annually in a Services-wide report (i.e., DoD Suicide Event Report). Each year, the DoD reviews suicide incidents to identify trends through a post-hoc analysis of risk factors associated with each suicide. The DoD then addresses any trends through modifications in training and programming.

The DoD's analysis also highlighted that programs experience consistent challenges in collecting outcomes. While many programs collected output data (e.g., the number of trainings conducted and number of attendees), few programs collected data on changes in the participants' knowledge as a result of program activities. Some programs indicated they tracked suicide rates over time, but it is difficult to attribute changes in suicide rates to specific program activities. Not all programs collected systematic, long-term outcome data, and most lacked short-term measures of training effectiveness, such as demonstrating changes in knowledge, attitudes, and behaviors concerning help-seeking or peer assistance.

Suicide Response (Postvention) Programs

Postvention is the term public health experts use to describe efforts intending to help friends, family members, and acquaintances, also known as loss survivors, overcome the trauma and/or grief individuals experience when someone they know has died by or attempted suicide. The term postvention is used because many loss survivors suffer alone and experience long-lasting psychological and emotional problems adjusting to life after a suicide, which, in turn elevates suicide risk for loss survivors. The public health literature has documented instances of suicide clusters in which exposure to suicide of one individual leads to a cluster of suicides and suicide attempts amongst others in that individual's family and social network. As a result, the DoD established DSSP Goal 10 to "provide support and quality services for those in the Military Community affected by suicide deaths and attempts and implement community-wide postvention strategies to help prevent subsequent suicides."

To meet the needs of loss survivors, DoD developed several practice guidelines (e.g., DoD Leader Guide and Postvention checklist), a memorandum of understanding with the Tragedy Assistance Program for Survivors, and the Suicide Prevention Training Competency Framework. In addition, DoD has established support groups and trained healthcare providers, chaplains, first responders, and unit leaders on suicide-related bereavement and referral procedures in the event bereavement experiences of survivors who have experienced a loss lead to behavioral health problems requiring clinical care (e.g., post-traumatic stress disorder, complicated grief, major depression). DoD recently completed a bereavement needs assessment of loss survivors in the military community. The surveys identified gaps between current and best practices and recommendations for how leaders, first responders, investigators, and healthcare providers can communicate the death and offer support to loss survivors in ways that promote post-traumatic growth, resiliency, and psychological health.

In addition to the policy and practice guidelines that the DoD has established to meet the needs of survivors, the DoD has also stood up suicide response programs whose main objective is to provide short-term support for those exposed to a traumatic event or in need of

psychological health assistance following such an event (e.g., after suicides or mass casualty events). By providing education, psychological health care and stabilization, and resource referral services, these programs foster resiliency and restore unit cohesiveness.

The DoD's analysis of programs indicated that programs track output metrics such as participant counts, demographics, survey results, and feedback. Additionally, programs are committed to providing suicide response activities despite not having dedicated resources for them. However, programs experience challenges with tracking outcomes systematically (i.e., changes in behavior or knowledge gained because of the program's activities before or after a crisis), as well as the ability to maintain a formalized budget or track expenses for responses to suicide.

Subsection (b)(7) – Recommendations

> *Detailed recommendations for improving, consolidating, expanding, and standardizing the programs, services, tools, processes, and efforts that improve the identification and treatment by the Armed Forces of mental health conditions and TBI.*

Summary Response

Programs would benefit from systematic evaluation of program outcomes, continued emphasis on use of evidence-based practices, standardization of metrics and training, and consolidation of efforts to increase efficiency where appropriate.

The DoD reviewed intervention, prevention, training, education, and support programs in the broad categories of peer-to-peer identification and intervention, mental health promotion, and suicide prevention and response. It also examined provider specialty certifications and the ability of diagnostic tools to differentiate between mental health conditions arising from TBI versus those caused by other factors.

Overall, the DoD's analysis highlighted six specific areas to improve service provision to members of the Armed Forces:

Emphasize program effectiveness outcomes: Maintaining a wide variety of effective psychological health and TBI services to meet the needs of Service members and their families is a significant focus of the DoD. Programs were tracking output data (e.g., number and demographics of participants served or trained), which serves as the foundation for assessing program effectiveness. However, many of the 44 programs included in this report's analysis demonstrated difficulty producing validated outcomes. Very few programs track outcomes that address how effective their activities are in changing participants' knowledge or changing behavior (e.g., assessing post-training provider skills and competence).

Standardize metrics: Measuring program impact is critical, and many programs have identified and implemented ways to do so. However, without standardized metrics and outcomes (especially among similar programs), it is difficult to establish individual program effectiveness or determine which programs are the most cost effective. Identifying and mandating appropriate program metrics would enable the DoD to compare, identify, and disseminate effective practices.

Consolidate programming: After more than 10 years of programming growth, the DoD is committed to eliminating program redundancies in order to increase service efficiency and

reduce costs. Although limited reliable outcome data makes it difficult to determine the effectiveness of current psychological health and TBI programming, completing a more focused evaluation of intra-and inter-Service program redundancies would highlight appropriate adjustments to be made.

Incorporate evidence-based practices: The DoD has generally developed programs and trainings to reflect civilian evidence-based practices. However, such practices are not universally employed across the Military Health System, particularly for programs offering novel approaches to address conditions for which limited evidence exists. These programs in particular must identify current best practices and conduct effectiveness evaluations linking program activities to intended outcomes. Continued emphasis on incorporating evidence-based practices into program design and execution is critical in translating findings to the military health care community.

Continue to encourage inter-Service collaboration: Tri-Service working groups identify best practices within military communities and enhance efficiencies in both service provision and trainings. (The TBI Advisory Council, for example, is an inter-Service working group addressing standardization of training content and activities to improve access to resources.) Continued dissemination of lessons learned and collaboration between and within the Services will sustain a high quality of care for Service members.

Support specialty certifications and DoD-specific training for providers: To ensure the highest level of health care for the Armed Forces, it is important to support staff pursuit of specialty certification in mental health and TBI care and to be certain that civilians working with Service members have adequate military-cultural competency. Establishing a central organization responsible for investigating, developing, validating, and monitoring military-specific training content and competencies for providers will increase efficiencies and standardize provider excellence.

Conclusion:

The DoD's comprehensive effort to examine the effectiveness of mental health and TBI programs includes assisting programs with quality improvement activities designed to advance service provision for Service members; ensuring consistency in similar programs across disparate locations; and helping programs incorporate evaluation within their design and daily operations. These efforts both ensure that programs are serving the needs of their target population and also provide data necessary for adjustments. Of critical importance to such efforts are leveraging technological advances, capitalizing on military cultural competency for providers, and supporting inter-Service collaboration to establish standardized metrics for outcomes. These steps will help improve programs' evaluation capabilities, which will, in turn, inform policy and program decisions; identify and allow remediation of gaps and redundancies; enable the endorsement, adoption, and application of best practices moving forward; and help achieve better program performance, competence, and accountability.

Appendix A: List of Suicide Prevention & Peer to Peer Programs

Sponsoring Service	Program Name	Peer-to-Peer	Suicide Prevention and Response
Air Force	Air Force Chaplain Corps "Care for the Caregiver" Reintegration/Resiliency Training	✔	
Air Force	Air Force Chaplain Corps MarriageCare	✔	
Air Force	Air Force Special Operations Command Resiliency Program	✔	
Air Force	Air Force Suicide Prevention Program		✔
Air Force	Defender's Edge	✔	
Air Force	Deployment Transition Center	✔	
Air Force	Disaster Mental Health		✔
Air Force	Resilience Program	✔	
Air Force Reserves	Yellow Ribbon Reintegration Program (YRRP) [Air Force/Air Force Reserve Command]	✔	
Air National Guard	Air National Guard (ANG) Suicide Prevention Program		✔
Air National Guard	ANG YRRP / [YRRP (Air Force)]	✔	
Air National Guard	ANG Psychological Health Program (PHP) [ANG Directors of Psychological Health (DPH)]		✔
Army	Army Combat and Operational Stress Control (COSC)		✔
Army	Army Reserve Suicide Prevention Program		✔
Army	Comprehensive Soldier Fitness/Resilience Program / Comprehensive Soldier and Family Fitness Program	✔	
Army	Strong Bonds Program	✔	
Army	Traumatic Event Management		✔
Army	Warrior Adventure Quest	✔	
Army National Guard	Army National Guard (ARNG) PHP [ARNG DPH]		✔
Army; Army National Guard	Army Suicide Prevention Program		✔
Army; Army Reserve	Army Reserve YRRP	✔	
Army National Guard	ARNG Suicide Prevention Program / ARNG Suicide Reduction Initiative		✔

Sponsoring Service	Program Name	Peer-to-Peer	Suicide Prevention and Response
Army National Guard	ARNG YRRP	✔	
DoD-wide	Military Kids Connect - Telehealth and Technology	✔	
DoD-wide	Non-Medical Counseling Program		✔
Marine Corps	DSTRESS line	✔	
Marine Corps	High Intensity Tactical Training	✔	
Marine Corps	Marine Corps Martial Arts Program	✔	
Marine Corps	Operational Stress Control and Readiness, COSC	✔	✔
Marine Corps	Semper Fit - Are You Listening?	✔	
Marine Corps	Semper Fit - Physical Fitness Program [Aquatics Maximum Power-Intense Training]	✔	
Marine Corps	Semper Fit & Recreation - Operation Adrenaline Rush	✔	
Marine Corps	USMC Semper Fit Health Promotion	✔	
Marine Corps	YRRP (Marine Corps)	✔	
Navy	Navy Suicide Prevention Program		✔
Navy	Operational Stress Control Program - N109	✔	✔
Navy	Special Psychiatric Rapid Intervention Team- East		✔
Navy	Special Psychiatric Rapid Intervention Team - San Diego		✔
Navy / Marine Corps	CMAR CREDO (CREDO Mid-Atlantic Region); CNAR CREDO	✔	
Navy / Marine Corps	Naval Center for COSC - N3	✔	✔
Navy / Marine Corps	Naval Medical Center Portsmouth Back on Track Program	✔	
Navy / Marine Corps	Naval Special Warfare Resilience Enterprise - N93	✔	
Navy Reserve	YRRP - Navy Reserve (Navy)	✔	
Special Operations Command	USMC Special OPs Performance and Resilience Program [Special Operations Force Resilience Enterprise Program SOCOM HQ (DoD-wide)]	✔	

Appendix B: DoD Data Sources to Assess Suicide Outcomes

Data Source	Description
The Department of Defense Suicide Event Report (DoDSER)	A web-based system and summary report DoD uses to collect case-level data, within each calendar year, relevant to suicide deaths and suicide attempts reported to official DoD authorities; includes data about suicide decedents and attempters, characteristics of the suicide event, and stressors or adverse life experiences that may have contributed to the suicide or suicide attempt.
The Joint DoD and Department of Veterans Affairs Suicide Data Repository / Military Mortality Database	A consolidated repository of suicide decedents who have had a history of military Service dating back to 1979; supplements the DoDSER with historical data as well as data on military suicide decedents not on Active-duty orders at the time of death.
The Status of Forces Survey of Active-duty Members	A bi-annual population survey asking a broad range of questions including those on suicide ideation and suicide attempts (both reported and not reported to official DoD authorities) as well as the impact of financial, family, deployment, permanent change of status stressors on Service member well-being; the survey also asks about awareness and utilization of resources designed to promote psychological health, well-being, and resiliency.
The Survey on Health-related Behaviors	A bi-annual population survey asking a broad range of questions including those on suicide ideation and suicide attempts (both reported and not reported to official DoD authorities) as well as the prevalence of problematic behaviors such as substance abuse and post-traumatic stress and access to/utilization of medical and psychological health services.
The Defense Equal Opportunity Institute's Organizational Climate Survey (DEOCS)	A continuous survey which unit leaders administer within 90 days of assuming command and one year later; the DEOCS includes a broad range of questions including thoughts of hopelessness, burden, social isolation, exposure to a suicide event, and unit cohesion.

Appendix C: Overview of Suicide Prevention Progress and Trends

Metric	Goal from DoD Strategy for Suicide Prevention	Data Source	Current Trend
DoD-wide Proximal Metrics			
Serious mental illness	Promote and implement effective clinical suicide prevention practices in military healthcare (Goal 9)	Department of Defense Suicide Event Report (DoDSER)	25% of Service members who died by suicide had a serious mental illness (2012-2015)
Access to behavioral health services	Promote suicide prevention in military healthcare (Goal 8); Develop, implement, and monitor effective programs that promote resilience, and prevent suicide and related behaviors (Goal 5)	DoDSER	30% of Service members who died by suicide accessed behavioral health services prior to death (2012-2015)
Stigma (barriers to care)	Educate the Military Community on the protective factors against suicide (Goal 3); Goal 5	Status of Forces Survey for Active-duty (SOFS-A)	Majority of Service members would not seek help because of perception of being broken or feeling inadequate (2016)
Suicide ideation	Goal 3; Goal 5	SOFS-A	14% of Service members have had lifetime ideation; 43% did not seek help for ideation (2016)
Lethality of means of suicide	Goal 6 – Promote efforts within to reduce access to lethal means of suicide among individuals with identified suicide risk	Armed Forces Medical Examiner System	70% of Service members who die by suicide use most lethal means of suicide; 95% die from self-inflicted gunshot wound (2014)
Feeling like a burden to others	Implement research-informed communications that prevent suicide by changing knowledge, attitudes, and behaviors (Goal 2); Goal 5	Defense Equal Opportunity climate Survey[1] (DEOCS)	15% feel like others would be better off without them (2016)
Hopelessness	Goal 2; Goal 5	DEOCS[1]	20% of Service members report feeling hopeless (2016)
Coping skills (relationship, financial, and adjustment issues)	Goal 5	DoDSER	43 % of Service member who died by suicide had a failed relationship prior to death (2015); 25% had an adjustment disorder
Resource or person who majority of Service members want help from if stressed out	Goal 3; Goal 5	SOFS-A; DEOCS	Majority of Service members want help from a friend, a fellow member of family member want help from if stressed out
Economic concerns	Goal 5		

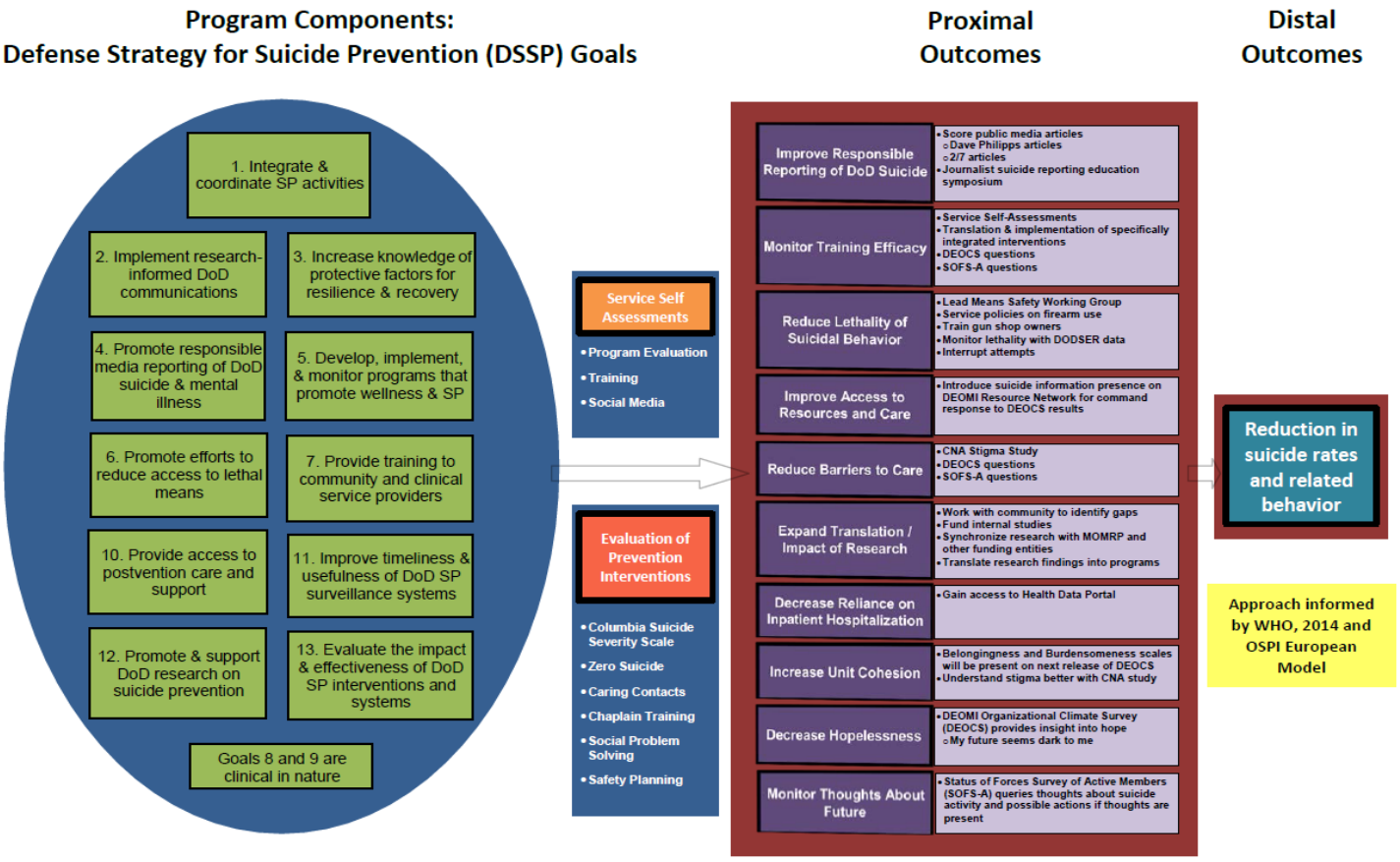
[1] Defense Equal Opportunity Management Institute conducted a confirmatory factor analysis to demonstrate the construct validity of a Unit Connectedness subscale.

Metric	Goal from DoD Strategy for Suicide Prevention	Data Source	Current Trend
		Military and Family Life Survey	60% of Service members are very concerned about their pay and benefits
Safety of media reporting on suicide	Encourage responsible media reporting and portrayals of Military Community suicide and mental illnesses (Goal 4)	DSPO scoring of news media articles for military suicide [2]	30% of articles are unsafe and have at least 4 errors
Crisis line contacts	Goal 5	SOFS-A	Only 5% of the force would call the MCL if they were in crisis
Service-Level Proximal Metrics			
Evaluation of Marine Intercept Program	Outreach caring contacts, risk assessments to Marine who have ideation or attempted (Goal 7)	Implementation pilot	Interim data expected by end of FY 2017
By-Stander Suicide Prevention Training (All Services)	Integrate and coordinate suicide prevention activities across the Department of Defense (Goal 1)	Service training logs and post-course surveys	At least 95% received and reported gains in knowledge and intent to use training
Chaplain Training (Navy, Marine Corps, National Guard)	Goal 7	Implementation pilot	Interim data expected by end of FY 2017
Gatekeeper training in ASSIST (All Services)	Goal 1	Service training logs and post-course surveys	At least 95% received and reported gains in knowledge and intent to use training
Tele-health Counseling (Navy, Marine Corps)	Goal 8	Implementation pilot	Interim data expected by end of FY 2017
Social Problem Solving (Air Force)	Goal 3	Implementation pilot	Interim data expected by end of FY 2017
Army Study to Assess Risk and Resilience Among Service Members (STARRS)	Increase the timeliness and usefulness of national surveillance systems, and improve the ability to collect, analyze, and use this information for action (Goal 11); Goal 1	Multiple Army data sources	Multiple publications available on the Army STARRS web site
Evaluate gatekeeper use of the Columbia Suicide Severity Rating Scale (USAF/USMC)	Goal 9	Program evaluation	Interim data expected by end of FY 2017
Emotion Regulation Training (Marine Corps)	Goal 7	Implementation pilot	Interim data expected by end of FY 2017
DoD-wide Distal Metrics			

[2] Scoring guidelines based World Health Organization Safe Messaging Criteria

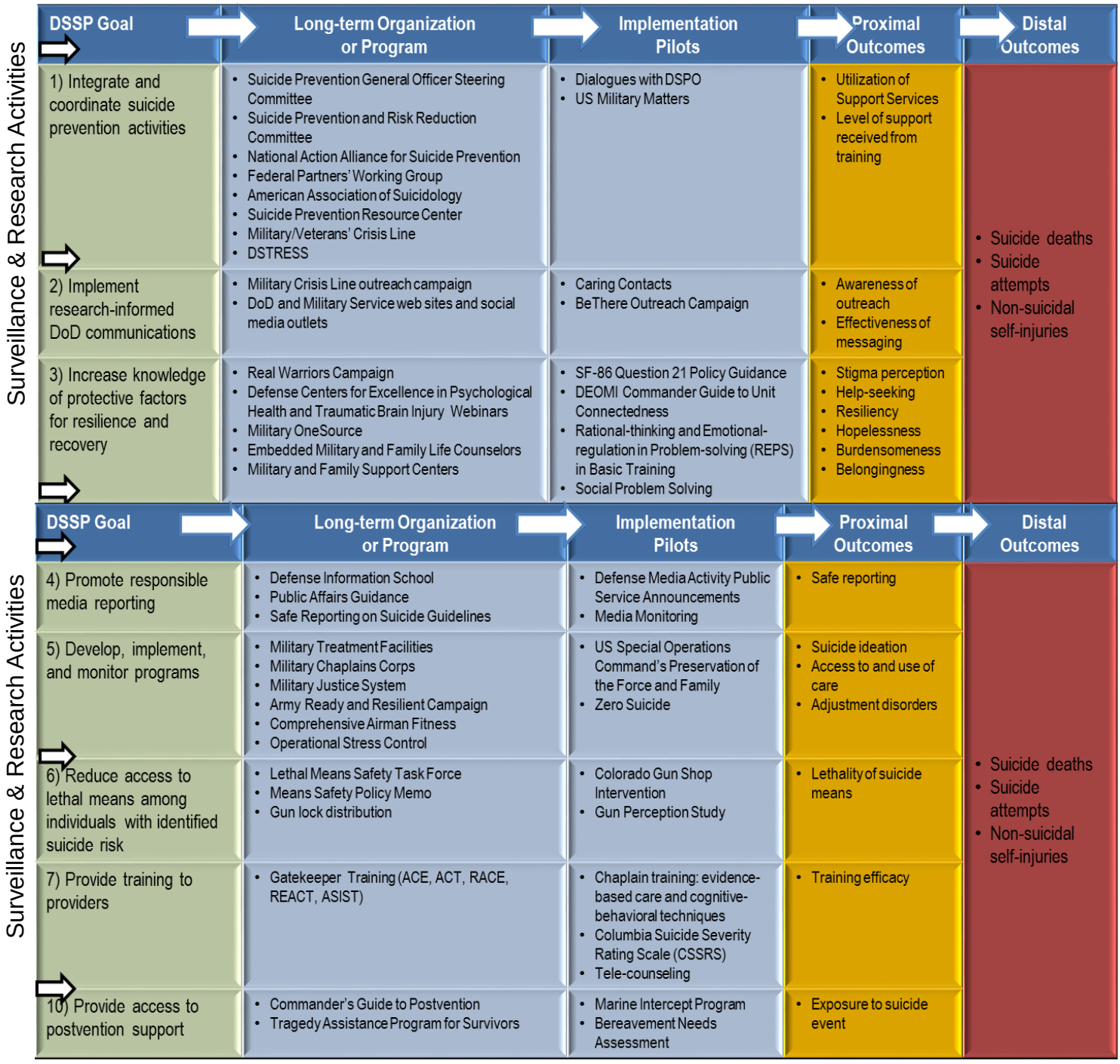
Metric	Goal from DoD Strategy for Suicide Prevention	Data Source	Current Trend
Suicide deaths	All Goals	DoDSER	Current trends documented in CY 2015 DoDSER Annual Report
Suicide attempts	All Goals	DoDSER	Current trends documented in CY 2015 DoDSER Annual Report
Non-suicidal self-injuries	All Goals	Force Risk and Reduction Database	Pending additional consultation with Personnel Risk Reduction and Resilience

Appendix D: Logic and Measurement Models



Measurement Models

This more detailed logic model links DSSP community-oriented goals with long-term organizations/programs, newer implementation pilots, proximal outcomes, and distal outcomes. Surveillance and research informs other goals.



In FY 2017, the DoD will explore ways to link certain implementation pilots to enterprise-wide proximal outcomes. The below table maps the implementation pilot to the proximal metric.

Implementation Pilot	Goal 3	Goal 5	Goal 7	Goal 10
REPS	Help Seeking*, Resiliency*			
Social Problem Solving	Help Seeking*, Resiliency*			
Zero Suicide		Suicide Ideation*, Access to and Use of Care*, Adjustment Disorders*		
Chaplain Training		Access to and Use of Care	Training Efficacy*	
CSSRS		Access to and Use of Care	Training Efficacy*	
Tele-counseling		Access to and Use of Care	Training Efficacy*	
Marine Intercept Program	Resiliency	Access to and Use of Care		Attitudes After Exposure to Suicide Event*

* - Indicates the primary proximal metric for the intervention from DSPO's program evaluation perspective