

ARMY

Health Promotion Risk Reduction Suicide Prevention

REPORT 2010





VCSA Sends

Leaders,

This report is a leader's story—a story about Soldiers. Read, study and act on this report. It represents over a year's worth of work to research, plan and implement health promotion, risk reduction and suicide prevention. It requires your immediate attention.

Last year I visited six installations with a team for the sole purpose of looking at suicide prevention efforts in the force. The result of that eye-opening experience prompted an Army campaign to rebalance health promotion, risk reduction and suicide prevention programs and services. What we witnessed firsthand were real indicators of stress on the force and an increasing propensity for Soldiers to engage in high risk behavior. This report validates a central conclusion of that trip: risk in the force cannot be mitigated by suicide prevention alone. Army leaders must take a holistic, multidisciplinary approach to address this risk. This report examines our policies, structure, processes and programs to reduce suicides, risk-related deaths, and other negative outcomes of high risk behavior. It confirms the need for a coordinated effort across the Army to promote the good order, discipline and health of the force.

I have immense faith in our phenomenal military and Civilian leaders who continue to tackle the significant challenges associated with the Army's high operational tempo. What we focus on gets done. Over the past year, our commitment to health promotion, risk reduction and suicide prevention has changed Army policy, structure, and processes. We have initiated Comprehensive Soldier Fitness as an essential element of Army wellness, realigned garrison programs, increased care provider services, refocused deployment and redeployment integration, enhanced treatment of Post Traumatic Stress Disorder (PTSD) and mild traumatic brain injury (mTBI), and promoted tele-behavioral medicine. Our success notwithstanding, we still have much more to do. We face an Army-wide problem that can only be solved by the coordinated efforts of our commanders, leaders, program managers and service providers.

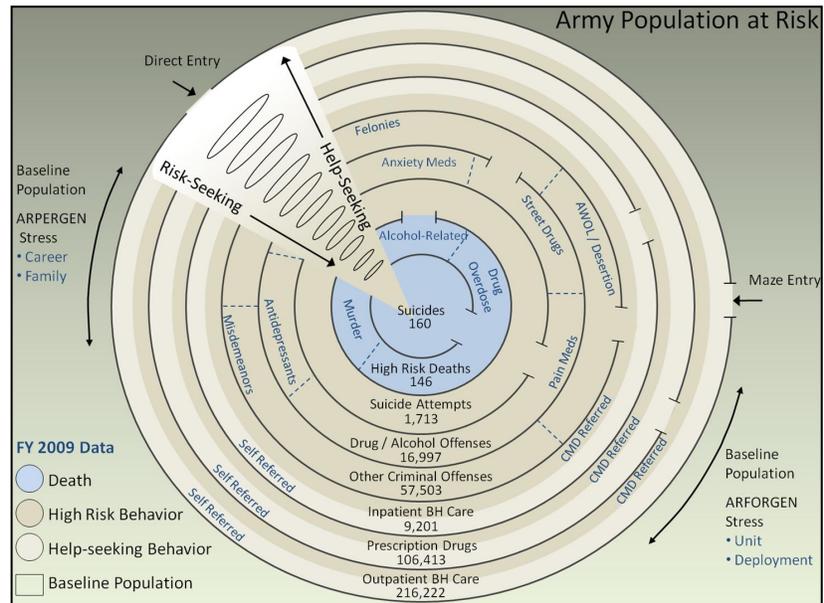
In Fiscal Year (FY) 2009 we had 160 active duty suicide deaths, with 239 across the total Army (including Reserve Component). Additionally, there were 146 active duty deaths related to high risk behavior including 74 drug overdoses. This is tragic! Perhaps even more worrying is the fact we had 1,713 known attempted suicides in the same period. The difference between these suicide attempts and another Soldier death often was measured only by the timeliness of life-saving leader/buddy and medical interventions. Some form of high risk behavior (self-harm, illicit drug use, binge drinking, criminal activity, etc.) was a factor in most of these deaths. When we examined the circumstances behind these deaths, we discovered a direct link to increased life stressors and increased risk behavior. For some, the rigors of service, repeated deployments, injuries and separations from Family resulted in a sense of isolation, hopelessness and life fatigue. For others, a permissive unit environment, promoted by an out of balance Army with a BOG:Dwell of less than 1:2, failed to hold Soldiers accountable for their actions and allowed for risk-taking behavior – sometimes with fatal consequences.

These are not just statistics; they are our Soldiers. They are Soldiers who may be stressed, feel isolated, become dependent on drugs or just need more time to recover. The good news is that Soldiers are seeking behavioral health care in record numbers with over 225,000 behavioral health contacts, indicating that our efforts to emphasize the importance of behavioral health are working. They are working because Soldiers recognize the importance of individual help-seeking behavior and commanders realize the importance of intervention.

Unfortunately, we have identified a troubling subset of our population who increasingly place themselves at risk. This cohort includes Soldiers who refuse help, use/distribute illicit drugs, and commit crimes. The amalgamation of these factors creates an Army population that increasingly takes risk due to an escalation of stressors. For some, this risky behavior results in seriously dangerous outcomes.

Now more than ever, our Soldiers need firm, fair and consistent leadership. Latest accounts estimate that approximately 106,000 Soldiers are prescribed some form of pain, depression or anxiety medications. The potential for abuse is obvious. Criminal offenses are also on the rise. There were 74,646 criminal offenses including 16,997 drug and alcohol related offenses in FY 2009 alone. These numbers do not account for disciplinary infractions handled by commanders through AR 15-6 investigations. Make no mistake – these are leader concerns.

We have a tremendous influence on increasing help-seeking behavior, reducing high risk behavior and, ultimately, on reducing our unacceptable casualty rates. Each of us can make an immediate and positive impact on reducing Soldier risk.



This model (see page 39), based on FY 2009 data analyses, demonstrates a population of Soldiers who may be at-risk. It depicts Soldier data in concentric rings that represent increasing severity for potential outcomes as it approaches the center. The model demonstrates an overlap of two populations—Soldiers, in the lighter shade, who need and are seeking help and, those in the darker shade, who exhibit high risk behavior with dangerous consequences. The center, in blue, represents suicides and high risk deaths in FY 2009. The model is analogous to a maze; each subsequent passage adding complexity and increasing potential severity of behavioral consequences. Escape from the maze will generally require help-seeking behavior and/or leader intervention to arrest the spiral toward the center. Note the following:

- Populations in this chart are not mutually exclusive; Soldiers may appear in more than one ring
- A Soldier may enter at any point/ring of the maze
- Outpatient behavioral healthcare (BH) represents unique Soldier BH contacts (ranging from screening to therapy)
- Crimes are felony and misdemeanor representing unique Soldier cases; drug offenses are included in “other criminal offenses”

Figure 1 – An At-Risk Army Population

We must identify our Soldiers who are at-risk, mitigate their stress and, if necessary, personally intervene to assist them. By working together we can provide holistic care for help-seeking Soldiers, while acting firmly to reduce the high risk population. We must increase health care access, reduce the stigma associated with help-seeking behavior and implement the Army's Pain Management Plan to increase the health of the Force.

The overarching goal of this concerted effort is to increase resiliency in our Soldiers and Families who continue to serve under a high operational tempo. The Comprehensive Soldier Fitness program is leading our effort in changing the way we address cumulative stress on the force. It promotes a positive and proactive approach to developing a population that is resilient, capable of coping and instinctively help seeking. This will ensure that we shift our focus from intervention to prevention; from illness to wellness.

We must also recognize that on occasion we need to do the right thing for both the Soldier and the Army through firm enforcement of discipline, retention and separation policies. I've heard the argument that by separating Soldiers from the service who cannot adapt, we are passing on a problem to the civilian sector. This is simply not true. We must ensure that Soldiers who cannot adapt to the rigors and stress of this profession find sanctuary elsewhere for their own wellbeing and for that of the force. This will require compassionate, fair but firm leaders who understand when to mentor Soldiers and when to accept that they will not meet Army standards. These high risk individuals pose an unacceptable level of risk to themselves and the Army. By reducing the high risk population we can shift the focus of *Health Promotion, Risk Reduction and Suicide Prevention* policy, process and resources from avoiding risk to promoting wellness.

We all recognize the effects of working under an unprecedented operational tempo for almost a decade. The challenges of serving in today's Army have tried our leaders, tested our Soldiers and exhausted our Families. On one hand we have successfully transformed the Army, simultaneously prosecuted contingency operations in two theaters, implemented BRAC, mobilized the Reserve Component in historic numbers and responded to natural disasters. On the other hand, we now must face the unintended consequences of leading an expeditionary Army that included involuntary enlistment extensions, accelerated promotions, extended deployment rotations, reduced dwell time and potentially diverted focus from leading and caring for Soldiers in the post, camp and station environment. While most have remained resilient through these challenges, others have been pushed to their breaking point. It is up to us to recognize the effects of stress in our ranks. I call on each of you to thoroughly study this report and work together with me to promote health, reduce risk-taking behavior and impose good order and discipline in the force.

Leaders, this is a hard-hitting and transparent report based on what we know and what you have helped us identify. This is our report and not Army policy. It is designed to inform and educate, spark discussion, hone compliance on existing policy and provide an azimuth for the way ahead. It presents findings and recommendations that may be implemented or modified, but only after we have all had an opportunity to read, study and participate in meaningful dialogue.



General Peter W. Chiarelli

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Next: Introduction to HP/RR/SP

I – Introduction to Health Promotion, Risk Reduction and Suicide Prevention (HP/RR/SP)

1. Introduction | “Why you should read this report...”

This report reflects a year’s worth of work at the direction of the Army’s Senior Leadership to provide a “directed telescope” on the alarming rate of suicides in the Army. It represents both initial findings of the Army Suicide Prevention Task Force and informs the future of Suicide Prevention within the Army. Suicide is a devastating event. What was once considered a private affair or family matter now threatens our Army’s readiness. Equally alarming to the rising rate of suicide in the Army is an increasing number of Soldiers who engage in high risk behavior. Equivocal deaths,¹ deaths by drug toxicity, accidental deaths, attempted suicides, and drug overdoses are reducing the ranks and negatively effecting the Army’s ability to engage in contingency operations in Iraq and Afghanistan. These deaths further strain efforts to sustain institutional operations. No one could have foreseen the impact of nine years of war on our leaders and Soldiers. As a result of the protracted and intense operational tempo, the Army has lost its former situational awareness and understanding of good order and discipline within its ranks.

This report’s comprehensive review exposes gaps in how we see, identify, engage and mitigate high risk Soldiers. These gaps exist in our systems and processes due in part to Army Transformation and nearly a decade of war. Policy, process, structure and programs have not kept pace with the expanding needs of our strained Army. While leadership schools emphasize battlefield skills, leaders are not as adept at negotiating the art of leadership in a garrison environment as they were prior to OEF and OIF. Failure to execute policies designed to ensure good order and discipline in garrison sends a message of permissive complacency. Failure to refer a Soldier with a drug positive urinalysis to the Army Substance Abuse Program (ASAP); initiate administrative separation for positive urinalysis; administratively separate Soldiers committing multiple instances of misconduct; and report unlawful activity all contribute to a breakdown in good order and discipline. This, in turn, has led to an increasing population of high risk Soldiers whose transmittable behavior can erode Army values and unit readiness.

Additionally, our units, Soldiers and Families are feeling the strain and stress of nine years of conflict. The cumulative effect of transitions borne of institutional requirements (professional military education, PCS moves, promotions) coupled with family expectations/obligations (marriage, child birth, aging parents) and compounded by deployments is, on one hand, building a resilient force while on the other, pushing some units, Soldiers and Families to the brink.

¹ Equivocal deaths are cases in which the available facts and circumstances do not clearly distinguish the manner of death (natural, accident, suicide, homicide or undetermined).

² At 24 years of age, a Soldier, on average, has moved from home, family and friends and has resided in two other states; has

“The Army is committed to providing the best resources for suicide awareness, intervention, prevention, and follow-up care – all of which are critical in helping Soldiers and Family members prevent unnecessary loss of life.”

– GEN George W. Casey, Chief of Staff, Army
NIMH, 23 October 2008

Quote 1 – GEN George Casey, 23 Oct 08

In just six years, Soldiers experience the equivalent of a lifetime when compared to their civilian counterparts.² (See *Composite Life Cycle Model*, beginning on page 89). Soldiers, however, do not live the equivalent life of their civilian peers. They endure sacrifices inherent to the profession of arms. These are remarkable individuals and this Nation demands a great deal of them. Our senior leadership adheres to the belief that many, if not most, suicides and equivocal deaths can be prevented. For that reason, the Army Suicide Prevention Task Force was formed and this report published.

This report offers a thorough and candid assessment along with the means to immediately address high risk behavior in the Army. It introduces new terms such as “ARPERGEN” (Army Personnel Generation), which is a concept to address Soldier and Family readiness in coordination with ARFORGEN.³ It provides models to frame concepts with application; it calls for adherence to established policies; it provides conclusions and recommendations; and, finally, it firmly demonstrates the Army Senior Leadership’s commitment to health promotion, risk reduction, and suicide prevention (HP/RR/SP). It also shows that the Army can, when faced with a problem, investigate itself and use those results to fix what is broken. In total, this report —

- Provides an in-depth discussion on the reality and complexity of suicide (pages 11-34);
- Stresses the importance of Comprehensive Soldier Fitness (CSF) and Master Resiliency Trainers.
- Underscores the necessity of commanders at all levels to enforce good order and discipline, while promoting health and managing risk-taking behavior of their Soldiers (pages 35-88);
- Introduces the concept of the Composite Life Cycle Model and explains how HP/RR/SP must be viewed as a composite of units, Soldiers and Families (pages 89-109);
- Provides honest dialogue with leaders on our role to work together as a corporate body to mitigate suicides (pages 111-130);
- Introduces a notional Governance Model (with background tutorial) to realign HP/RR/SP policy, structure and process across the proposed Army enterprise-based business transformation model (page 131);
- Highlights the need for an enduring council dedicated and responsive to Senior Army Leadership that will provide an independent review of HP/RR/SP activities (page 132);
- Highlights the importance of exportable elements of HP/RR/SP programs to all COMPOs and ASCCs (pages 157-158);

² At 24 years of age, a Soldier, on average, has moved from home, family and friends and has resided in two other states; has traveled the world (deployed); been promoted four times; bought a car and wrecked it; married and had children; has had relationship and financial problems; seen death; is responsible for dozens of Soldiers; maintains millions of dollars worth of equipment; and gets paid less than \$40,000 a year.

³ ARPERGEN (Army Personnel Generation) is proposed as a term to describe and accommodate Soldier/Civilian and Family life cycle transitions that should be considered in relationship and as a counterbalance to the ARFORGEN. ARFORGEN generates operationally ready units through a structured progression of training and mission preparation. ARPERGEN is the individual Soldier/Civilian and Family equivalent of operationally ready unit members through identification and recognition of life and Family events.

- Introduces a *HP/RR/SP Portfolio Management Model* (with background tutorial) to develop and manage a balanced *HP/RR/SP Program Portfolio*, equally applicable to other Army-wide program portfolios (pages 161-182);
- Realigns investigations and reporting to improve accuracy and timeliness of findings and data (pages 183-200);
- Provides Health, Law Enforcement and Risk Reduction reporting and data management recommendations to develop net-centric solutions, enhance leadership situational awareness, inform policy and programming requirements and seed future research (pages 201-216);
- Establishes HP/RR/SP Research Governance through new research policy, structure and process with information and recommendations on current and ongoing research (pages 217-234);
- Strengthens the bonds between unit leaders and garrison support; and
- Clearly indicates there is a confluence of stressors that cause suicides but no single panacea to prevent them.

2. Organization | “What you will find in the report ...”

This report is presented in ten sections, followed by annexes, which can be read in sequence or separately by topic, section or annex. Each section, described below, can be viewed as a stand-alone yet becomes more relevant and valuable in the context of the entire report. The report’s annexes collate information found throughout the text used to explain, amplify, or simplify the report’s topics, concepts, or discussions. An added feature of this report is that it has an interactive version with internal references (documentary and electronic) designed to appeal to diverse audiences; from HQDA proponents to field commanders; ASCCs, the Reserve Component (RC), Garrisons and program and service providers at every level.

The report was written with varying audiences in mind—HQDA (Secretariat and Staff Principals, ARSTAF), Senior Commanders (flag level) and staff, Operational Commanders (brigade through company) and staff, Program/Service Providers, Leaders, Soldiers, Civilians, Family members and the public at large. Each section summary below suggests its principal audience, but everyone is encouraged to read the report in its entirety.

a. Reality of Suicide

[*Principal Audience: All*] Over the past year, the Army Suicide Prevention Task Force examined the complexity of suicide, taking into account national suicide trends, individual Soldier risk factors and the Army’s institutional approach to suicide prevention. The Task Force identified risk factors and indicators that help illuminate potential correlations to high risk and suicidal behavior in the Army. This section describes the complexity of suicide from a medical/behavioral health perspective and further identifies the contribution of the cultural, operational, geographical and social environments that are unique to Soldiers and Families. It is further recognized that suicide is typically the result of cumulative stressors that may result in a planned or impulsive act but there is not always a single identifiable catalyst. Admittedly, suicide within the Army is a complex phenomenon. It will require continued and focused attention to develop a more comprehensive understanding that will guide effective mitigation efforts. Army leadership is firmly convinced health promotion and risk reduction programs and services that promote resiliency (e.g., CSF) are key to decreasing suicidal and high risk behavior and to ensuring personnel readiness.

b. Lost Art of Leadership in Garrison

[Principal Audience: All] The Army's institutional policies, processes, and programs have not kept pace with changes resulting from nearly a decade at war and the simultaneous efforts of Army Transformation. Institutional education and experiential knowledge of good order and discipline processes in a garrison environment have atrophied among leaders who have operated only in an Army at war. Leaders are consciously and admittedly taking risk by not enforcing good order and discipline. Systems established to ensure a healthy force are not being used to their full extent. Illicit drug use, alcohol abuse, disciplinary infractions, misdemeanors and felony crimes are on the rise. There is a clear link between high risk behavior and suicides. Data collected since 2005 consistently show that approximately 29% of suicides included either drug or alcohol use. In addition, 25% had some form of closed or pending misdemeanor or felony investigation. From a larger perspective, these risk factors speak to the need for better Health Promotion and Risk Reduction in order to affect Suicide Prevention. Anecdotal information suggests that the force is becoming more and more dependent on both legal and illegal drugs and that these issues lead to a high risk population. This section examines these assumptions from both a medical and legal perspective and identifies several disconcerting trends affecting the force. These data used for this report to capture these trends were not easy to collect or analyze. It comes from several disparate databases, given to the Task Force through only a small number of individuals who control and release these data. Consequently, it is difficult to get visibility of the problems at HQDA level to enforce standards and accountability. When taken as a whole, all of these institutional risk factors point to a few central themes: the loss of Army-wide visibility, Soldier accountability and policy/process compliance (i.e., the art of leadership in garrison).

c. Composite Life-Cycle

[Principal Audience: All] This section introduces two tools for immediate application—the *Composite Life Cycle Model* and the ARPERGEN Forum. Units have a recognized and relatively predictable life-cycle known as ARFORGEN. Soldiers and Families adjust their respective “life cycles” to meet the demands of current OPTEMPO-driven ARFORGEN. It is the juxtaposition and concurrence of these less predictable “life cycles” with the rigors and demands of the ARFORGEN life cycle that can result in the accumulation of stress-inducing events. We refer to these accumulative events as stress windows, which act as potential accelerants for risk-taking behavior. This section introduces the *Composite Life Cycle Model* that graphically depicts how acute, recurring, and cumulative stressors associated with the demands of the unit, career, and home burden Soldiers and Families. It also introduces the concept of ARPERGEN and suggests Army leadership consider policy and program adjustments to address the synchronization of ARFORGEN and ARPERGEN.

d. Army Suicide Prevention Campaign

[Principal Audience: All] The SecArmy and CSA appointed the Army's Vice Chief of Staff (VCSA), in late February 2009 to lead the Army's efforts to focus urgent attention on the alarming rate of suicides in the Army. The VCSA ordered the immediate activation of a Suicide Prevention Task Force in March 2009 to dedicate focused energies and resources to tackle the complexity of suicide. The Army Suicide Prevention Task Force immediately developed the Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention as a vehicle to deliver change. The Campaign Plan allowed for rapid policy and programmatic adjustments by providing immediate guidance to commanders in the field and provided strategic oversight by creating a multi-disciplinary Army Suicide Prevention Council to operate

as an expedited change agent at the HQDA level. Although the Campaign Plan set the foundation for rapid and immediate action, the Army recognized the complexity of suicide requires a long march toward resiliency. While this campaign has only existed for one year, this report will set the stage and ensure continued effort in the future.

e. Program Governance for HP/RR/SP

[*Principal Audience: HQDA, Senior Commanders and staff*] This section rolls out a proposed *HP/RR/SP Program Governance Model* which parallels the proposed Army enterprise-based business transformation model and management relating to HP/RR/SP from strategic policy, structure and process to program execution at field and garrison levels.⁴ The Army is contemplating transforming its governance to an enterprise-based framework to define business rules and align policy, structure, people, process and technology to enable business transformation and achieve its strategic goals. Proposed HP/RR/SP program governance requires managed change at all levels of the Army. The proposed *HP/RR/SP Program Governance Model* leverages the Event Cycle and Care Continuum, explained below, to develop seamless, end to end management of the Soldier and Family through an efficient and effective institutional response along all phases of the Care Continuum.⁵ The model aligns strategic and operational management with the execution of the *HP/RR/SP Program Portfolio* to achieve the overall goal of Army wellness. Change starts with decisive action. The proposed *HP/RR/SP Program Governance Model* recommends the migration of eight Army HP/RR/SP programs to other HQDA proponents to ensure better top to bottom integration oversight.

f. Managing the HP/RR/SP Program Portfolio

[*Principal Audience: HQDA, Senior Commanders and staff, Program/Service Providers*] This section introduces a method and model to create and manage a balanced program portfolio that meets Soldier and Family HP/RR/SP needs across the Care Continuum. A primary goal of transforming HP/RR/SP governance using enterprise precepts is to achieve an efficient and effective portfolio of programs and services. The *HP/RR/SP Portfolio Management Model* creates an integrated and holistic system that utilizes business tools such as common program measurement, performance and risk analysis, and continuous process improvement. This management model creates a balanced *HP/RR/SP Program Portfolio* that provides comprehensive coverage and care for its customers – commanders, Soldiers and Families. By managing HP/RR/SP programs and services as a portfolio, the Army will both exercise responsible stewardship of its resources (through elimination of gaps, redundancies and inefficiencies) and ensure that program customers receive the highest quality services (through performance analysis). The *HP/RR/SP Program Portfolio* is a powerful management process that will focus the Army's institutional attention where it belongs - on maximizing the readiness of the force by providing comprehensive care and support to commanders, Soldiers and Families.

⁴ HP/RR/SP is the collection of programs and services throughout the Army to promote health/wellness, mitigate risk seeking behavior and prevent suicide behavior.

⁵ This report uses “Care Continuum” to refer to the Army’s institutional response by commanders, leaders, and program/service providers to Soldier, Civilian, and Family HP/RR/SP requirements across the pre-event, inter-event, and post-event stages of the Event Cycle (i.e., status of Soldier/Family with respect to their placement within a specific stage based on demonstrated indicators).

g. Investigations and Reporting

[*Principal Audience: All*] The Army's current policies and processes for investigating and reporting criminal behavior do not provide the information needed for commanders to properly manage their high risk population. There is no central repository for the three types of investigations – commanders' inquiries, military police reports and CID investigations – that can be accessed so data can be analyzed and reviewed by commanders and law enforcement. One of the effects of this disjointed system is evident in the processes used to notify the Families of fallen Soldiers. Lack of coordination between agencies has resulted in conflicting and contradictory information, causing confusion where there should be clarity. This report recommends synchronized investigative and reporting efforts and the creation and maintenance of a single investigative database.

h. Information Sharing and Retrieval

[*Principal Audience: HQDA, Senior Commanders and staff, Program/Service Providers*] This section exposes the sheer magnitude of data and the challenges associated with data sharing and retrieval. It introduces data solutions to provide leaders with situational awareness of HP/RR/SP requirements to inform their decisions regarding unit good order and discipline and Soldier and Family care. Currently, leaders and care providers at every level cannot effectively access, see or share data regarding the health of the force. Data are not reliable let alone integrated or responsive. Effective HP/RR/SP programs require a composite view that accounts for the many risks and stressors confronting units, Soldiers, Families and Army Civilians in an era of persistent conflict. This section provides strategies and solutions to mitigate the difficulties in data sharing and retrieval. It demonstrates the limitations of current information governance and sharing initiatives and discusses the need to establish portals for HP/RR/SP information as a bridge to transition from information silos to a net-centric environment. It further provides recommendations for rapid information sharing to address HP/RR/SP information gaps while simultaneously supporting DoD and Army net-centric data strategy goals.

i. HP/RR/SP Research Governance and Current/Future Research

[*Principal Audience: HQDA, Senior Commanders and staff*] This section discusses the current efforts that effect HP/RR/SP research. It provides recommended changes to the way Army research is governed. During the development of this report, the Report Team found that while there are research efforts that effect HP/RR/SP, there is no governing portfolio that is specifically designed to inform research efforts. Many research organizations carry out programs that could inform some aspect of HP/RR/SP but they are not integrated across the force. Just as the Care Continuum defines the Army *HP/RR/SP Program Portfolio*, it should also be used to inform a balanced *HP/RR/SP Research Portfolio* with transparency of efforts as the main goal. These recommended changes are intended to better integrate Army-wide (in this case HP/RR/SP research) to reduce duplication of effort and more importantly to ensure research that is carried out leads to meaningful and executable programs that affect the lives of Soldiers and Families.

j. Annexes

[*Principal Audience: All*] These annexes serve as quick references to material already included in the body of the report. Caution: information taken directly from the annexes could lack the context and relevance of how they were applied or used in the report and should be reviewed as amplification of the report’s message.

3. Navigation | “How you should read this report...”

This is a complex report covering a complex subject. In order to help navigate this document, we’ve developed conventions, tools and hyperlinks to assist in reading, using and referencing this report. Internal report references are hyperlinked to navigate from any point to sequential discussions of that same point across all sections (e.g., while reading about mTBI under the section titled, “*The Reality of Suicide,*” you can touch the hyperlink to continue that thread in vignettes or under the section titled “*HP/RR/SP Research Governance and Current/Future Research*”).

The use of acronyms in this report is unavoidable but an acronym list is included at Annex A. However, to preclude overreliance on acronyms or disrupt the reader’s flow, we’ve employed the following naming conventions:

- Health Promotion, Risk Reduction and Suicide Prevention = HP/RR/SP.
- The team responsible for authoring this report (The Army HP/RR/SP Report) = the Report Team.
- Army Suicide Prevention Task Force = the Task Force.
- The Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention = the Campaign Plan.
- The Army Suicide Prevention Council or the later renamed Army Health Promotion Council = the Council.
- All programs, services and initiatives associated with health promotion, risk reduction and suicide prevention = HP/RR/SP programs and services.

Report sections, conclusions and recommended actions, vignettes, quotes, figures, tables and tutorials are all uniquely and consistently identified by distinct conventions as demonstrated below:

Sections

This report has nine major sections following this Introduction to HP/RR/SP: *The Reality of Suicide, The Lost Art of Leadership in Garrison, The Composite Life Cycle, The Army Suicide Prevention Campaign, Program Governance for HP/RR/SP, Managing the HP/RR/SP Program Portfolio, Investigations and Reporting, Information Sharing and Retrieval, and HP/RR/SP Research Governance and Current/Future Research*. Whether read separately or in sequence, the major sections are distinct reports by their very nature but also inform and complement other sections. Each section is introduced by its title in large, black font. Major subsection headers appear in a large dark red font and are underlined. Secondary headings also appear in red font, tertiary headers are light red and indented, and quaternary headings are bold, red, italic and smaller font.

Each major report section ends with a transition indicator to signal the next section. The indicator appears near the bottom right corner of the page as shown in Figure 2.

Next: Upcoming Section Title

Figure 2 – Example of Section Transition Marker

Conclusions and Recommended Actions

The conclusions in this report are derived from our experiential knowledge of Army HP/RR/SP programs/services, research and knowledge of Army governance, policy, infrastructure and process. Implementation of the associated recommended actions offers the means to improve Army HP/RR/SP efforts. Conclusions and recommended actions will be incorporated into the Army Health Promotion Council Sync Matrix for staffing/implementation by HQDA proponents, proposed enterprise based forums and associated commands.

Foundation Conclusions and Recommended Actions (marked by a “★”) appear in tables identified by a black margin bar on the left and star bullets. These appear throughout the body of the report at critical points within a section. They are also listed in Annex B. Supporting Conclusions and Recommended Actions (marked by a “●”) complement the foundation set and appear only in Annex B:

CONCLUSIONS

- ★ Conclusions which appear in more than one section show the corresponding pages in parentheses. (10, 17, 48)
- Supporting conclusions and recommended actions use standard bullets and appear only in Annex B.

RECOMMENDED ACTIONS

- ★ [*HQDA*] The specific audience for each recommended action is italicized and shown in brackets following the star.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 1 – Example of Conclusions & Recommended Actions

Foundation conclusions are the distillation of the discussion in each section. Conclusions correlate to either recommended actions or recommendations for future research and apply to all levels of the Army from HQDA to field and garrison organizations.

Vignettes

There are many real-world stories (vignettes) that substantiate the findings in this report. Vignettes are used to provide an example or help explain a situation or concept. They are boxed with a light green background and black band header. Vignettes are only included to demonstrate the consequences of gaps in health promotion, risk reduction and suicide prevention.

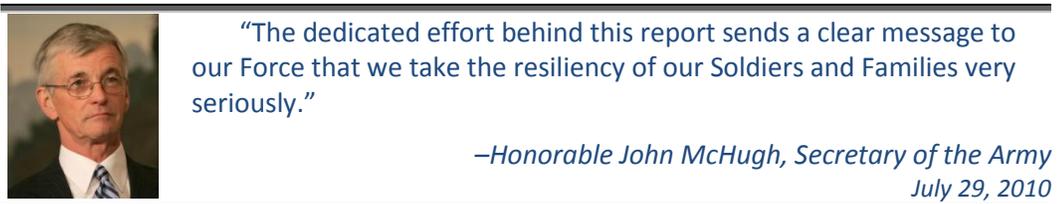
EXAMPLE VIGNETTE

Vignettes identified by a light green shaded box are used throughout this report and serve to reinforce the Task Force’s findings. While the vignettes are intended to be illustrative of a concept, they can be bypassed without losing the context of the section or the report.

Vignette 1 – Example of a Vignette Box

Quotes

Our Army leaders are actively engaged in promoting health and wellness, combating suicide and reducing the risk-taking behavior that affects the health and readiness of our Army. Their strategic communications help inform the public and shape Army efforts. Their quotes are included throughout the report and represent our senior leaders’ commitment, passion and concern regarding the Army’s suicide problem. Throughout the report, these quotes are used to reinforce a key theme or emphasize a point. Quotes appear in dark blue text bracketed between black bars.



Quote 2 – Example Quotation: SA John McHugh, 29 Jul 10

Figures

Figures are used throughout the document and provide a visual explanation of models, tables, or statistics. Models were developed to clearly explain and illustrate some of the more complex concepts. A purposefully developed feature of some of the more complicated models is the gradual build (Figure 3) with corresponding text to assist the reader in understanding the concept. Tables are also introduced and referenced to convey the complexity of suicide.



Figure 3 – Sample Illustration of Model Build

Tutorials

Tutorials are included in some sections to provide background information on a complex or esoteric subject (e.g., a description of separation authorities for enlisted personnel) that is prerequisite to a comprehensive understanding of this report. The intent is to assist readers who may not be familiar with the subject or may benefit from a refresher. This text is clearly marked with green left and right borders. Readers already familiar with the topic may bypass the tutorial without losing the context of the report section.



Next: The Reality of Suicide

II – The Reality of Suicide



“Every Suicide is as different and as unique as the people themselves. And, the reality is there is no one reason a person decides to commit suicide. That decision reflects a complex combination of factors and events”

– General Pete Chiarelli, Vice Chief of Staff, Army
Testimony before the House Armed Services Committee, 29 July 2009

Quote 3 – GEN Pete Chiarelli, 29 Jul 09

Historically, the Army suicide rate has been significantly lower than the civilian rate (the civilian demographically adjusted rate typically is about 19.2 per 100,000). However, suicide and accidental death rates began trending upward in 2004, and in 2008, the Army suicide rate crested above the national average and reached a record of 20.2 per 100,000.

In Fiscal Year (FY) 2009, 160 active duty Soldiers took their lives, making suicide the third leading cause of death among the Army population. If we include accidental death, which frequently is the result of high risk behavior (drinking and driving, drug overdose, etc.), we find that less young men and women die in combat than die by their own actions. Simply stated, we are often more dangerous to ourselves than the enemy.

To understand why the Task Force examined specific issues and why this report includes certain sections and recommendations one must first appreciate the complexity of the suicide problem. The events leading up to a suicide may include a devastating family tragedy or appear to be related to something as innocuous as a trip to the movies. Only after all the factors are examined does a complete and holistic picture of the final event come into focus. Once this retrospective examination is done, it is easier to realize just how far the individual had traveled through a maze of stressors. Perhaps the individual started as a resilient Soldier who, after experiencing a series of life events, moved along a continuum past intervention and treatment until it was too late.

SUICIDE CASE STUDY

A Staff Sergeant had a hard childhood. His father was in and out of jail and both parents used illegal drugs. When he joined the Army, he thought he had finally escaped his background. He was promoted through the ranks and was well respected by his leadership. He helped to emancipate his sister and was paying for her college. Following a very violent improvised explosive device (IED) attack, he started having difficulty sleeping and was waking up with nightmares. Shortly after deploying, his parents stole his identity and incurred a large debt in his name. One night, after arguing with his family, he took his life. His action took his leadership by surprise. He was viewed as one of the most resilient Soldiers in his company.

- Indicators visible to unit leadership may not identify stressors in personal or Family life.

Vignette 2 – Suicide Case Study

Each of us exists somewhere along a spectrum of wellness, moving at different times in our lives along a continuum. Sometimes people are healthy and vibrant. At other times they need to rely on Family, friends or seek specialty care to cope with major life stresses. This report refers to this spectrum of wellness as the Care Continuum (“Care Continuum” often refers to the continuum of health care services, but is used in a broader context in this report to include recruiting thresholds, good order and discipline, post event inquiry, etc.). To understand the complexity of suicide, this report will examine this continuum and how the risk-seeking or suicidal individual travels from resiliency to isolation or despair and finally to crisis or death (See Figure 49, page 144, Event Cycle and Care Continuum). At any point along this continuum there is an opportunity for the individual, Family, friends or leaders to intervene, but for that to happen, each should understand the nature of suicide and the relationship between resiliency, assessment, intervention, treatment and risky behavior which often leads to catastrophic outcomes including suicide and accidental [risk related] death.

CONCLUSIONS

- ★ In FY 2009, more Soldiers died as a result of high risk behavior than died in combat. (page 11)
- ★ At any point along the Care Continuum there is an opportunity for the individual, Family, friends or leaders to intervene. Intervention requires an understanding of the high risk behavior often associated with suicide and equivocal deaths. (page 12)

RECOMMENDED ACTIONS

- ★ [ALL] All leaders and program/service providers should review this report to better understand the nature of high risk behavior associated with suicide and equivocal deaths.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 2 – Introduction to the Reality of Suicide

1. Suicide as an Epidemic

a. National Statistics

Recent news coverage has highlighted an increase in suicides at a national level. The Las Vegas Sun reported that the suicide rate “in Clark County [Nevada] jumped by 10 percent from 2007 to 2008.” The Idaho Mountain Express reported that the suicide rate had “tripled in Blaine County [Idaho] during the past six months.” In March 2010, The New York Times covered Cornell University’s “suicide cluster.” Before that, in November 2009, MSNBC reported the increase in suicide deaths in Elkhart, Indiana. It is possible to speculate, based on these and other news reports, that the national rate is increasing – but limitations in available data prevent definitive conclusions.

The Centers for Disease Control and Prevention (CDC) is responsible for collecting, analyzing and publishing fatality statistics in the United States using the National Vital Statistics System. Very few local governments use this automated reporting system. As a result, much of the CDC data are obtained from manually inputting data from individual death certificates. The CDC typically takes 18-24 months to compile, verify and prepare these data for release to the public. This means that while the Army and military data have shown an increase in suicide over the last four years, it is unknown how the national suicide data are trending over the same period. This is specifically pertinent due to the recent economic turmoil, which may have affected suicide rates across the country.

When the economy declines, there is an increased risk for suicide. Unemployment, decreasing value of investments and declining housing markets all have an impact on the nation's suicide rate. In January 2009, CNN reported on the relationship between the unemployment rate and the nation's suicide rate. Simply stated, as unemployment rates increased, suicide rates increased. This trend is also supported by data from the National Suicide Prevention Lifeline, which demonstrated a dramatic increase in calls between 2007 and 2009. General Lifeline calls increased from 381,316 in 2007 to 501,562 in 2009, while the Veterans Hotline increased from 20,853 to 125,625 during the same period.⁶

Further complicating national suicide reporting is the lack of standardization for determining the manner of death across the United States. In 2006, the number one cause of death for both 15-24 and 25-34 age groups was unintentional injury. It is widely believed that some suicide deaths are categorized as unintentional injuries due to the stigma of suicide (e.g., loss of life insurance benefits, religious beliefs, etc.) and the equivocal nature of unintentional injuries (e.g., single vehicle accidents, accidental overdose, etc.). Despite these classification issues, suicide was still the third leading cause of death nation-wide for the 15-24 and the second leading cause of death for 25-34 age groups in 2006 (these groups represent the vast majority of the Army's recruiting population).⁷

In addition, there are differences in how death investigations are conducted and how the "manner of death" is determined across the nation. Law enforcement investigators work with medical examiners to determine the manner of death as homicide, suicide, natural, accidental or undetermined. Although final determination of the manner of death is based on the totality of the evidence, discerning the victim's intent (e.g., witness testimony, notes or other communication) can be challenging. With the absence of intent, the manner of death from drug overdoses, traffic fatalities and other risk related deaths are routinely classified as accidental and undetermined. A 2006 report on the validity of suicide comparisons noted that "(s)tudies of suicide determinations demonstrate (that) the magnitude of misclassification is substantial, with 20-30% of suicides inaccurately assigned as accidental or undetermined."⁸ Misclassifications have also been documented in military death records.⁹ Additionally, the disparity in protocols among law enforcement agencies and medical examiners nationwide, which makes reporting deaths of RC Soldiers not on active duty difficult, further degrades data reliability.

There are also basic differences in economic stressors, access to healthcare and access to behavioral healthcare across the country. As an illustration, the American Foundation for Suicide Prevention displays the variability between state suicide rates on their *2010 Fact and Figures on Suicide* factsheet demonstrating that even states adjacent to each other often have very different suicide rates (Figure 4).

⁶ National Suicide Prevention Lifeline, www.suicidepreventionlifeline.org.

⁷ Centers for Disease Control and Prevention, Office of Statistics and Programming, National Center for Injury Prevention and Control, *20 Leading Causes of Death, United States, 2006, All Races, Both Sexes*, www.cdc.gov.

⁸ Eaton et al., "Strengthening The Validity of Population-Based Suicide Rate Comparisons: An Illustration Using U.S. Military and Civilian Data, *Suicide and Life Threatening Behavior*, The American Society of Suicidology, 36(2), April 2006, p. 183.

⁹ Ibid. Also Carr, Joel R., DO, MPH, et. al., "Suicide Surveillance in the U.S. Military – Reporting and Classification Biases in Rate Calculations," *Suicide and Life-Threatening Behavior*, American Association of Suicidology, 34(3), Autumn 2004.

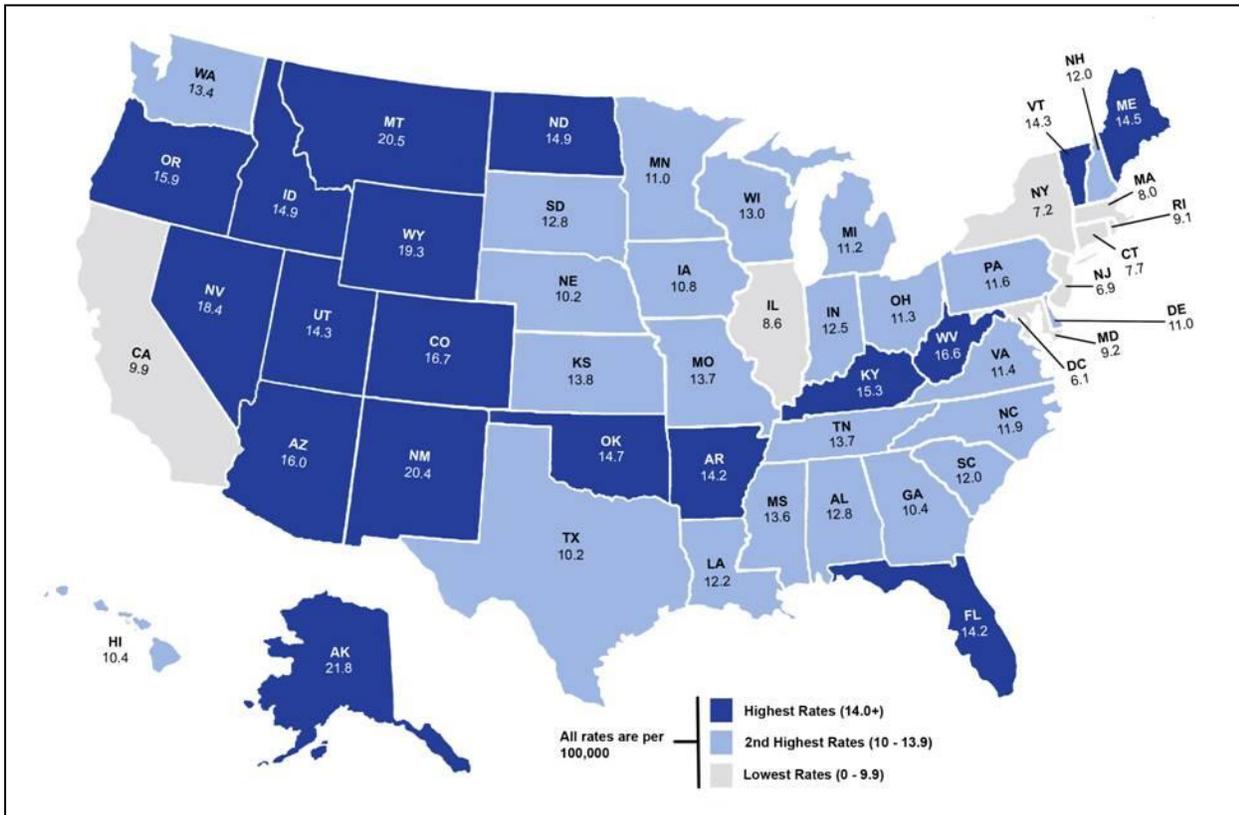


Figure 4 – Suicide Rates by State, 2007 (Darker is Higher)

b. Army Statistics Compared with the Nation

Historically, the suicide rate has been significantly lower in the military than among the U.S. civilian population. Beginning in 2004 that pattern changed, and in 2008 the suicide rate in the Army exceeded the age-adjusted rate in the civilian population (20.2 out of 100,000 vs. 19.2).¹⁰ Because the CDC’s suicide data lag the Army’s data by several years, calendar year 2006 CDC data were used to compare with 2008 Army data. Although this lag has made it somewhat difficult to accurately compare and contrast the Army to the civilian population, newly released National figures from 2007 show little appreciable change compared with 2006.

In terms of generating data, the Army has more defined procedures with stricter timelines for reporting and determining the manner of death. The Army has a single law enforcement agency with unified protocols for investigating and reporting suicides or equivocal deaths. The Army is typically able to identify suspected suicide deaths within a few days for the active duty and within two months for non-active duty Soldiers (Army National Guard (ARNG) or U.S. Army Reserve (USAR)). For active duty Soldiers, the Armed Forces Medical Examiner (AFME) is typically able to determine manner of death within four to six months (although there are some complex cases that can take 12 to 18 months). As a result, the Army is able to identify emerging trends for active duty Soldiers faster than the CDC. For

¹⁰ The 2008 Army suicide rate is being compared to the 2006 CDC suicide data.

non-active duty Soldiers, the Army relies on local medical examiners to determine the manner of death, which can result in greater variability in the death investigations and reporting.

The majority of active duty military autopsies are conducted or validated by the AFME, which ensures a consistent application for determining the manner of death. There are some challenges with the timing of the final determination of manner of death (which is often determined before a full investigation is concluded). In 2008, AFME reported that accidents and suicides accounted for almost 50% of all fatalities in DoD, with suicides outnumbering combat deaths for the first time since 2003.¹¹ The Army had 126 accidental and undetermined deaths in FY 2009.¹² High risk behavior, such as illegal drug abuse, driving while intoxicated and suicidal behavior, appears to be the leading cause of death in both the civilian and military populations for those under the age of 50.

It is difficult, if not impossible, to compare the Army’s suicide rate directly to the general population. It is possible that young adults who are willing to join the Army at a time of war may have a higher level of risk-taking tolerance than that of their civilian counterparts. Also, the nature of the Army career is very different when compared to a civilian career. Many Soldiers experience a lifetime of transitions (moving, new career, Family separation, etc.) in their first few years in the military that most civilians never experience. These times of transition can lead to instability and compound stress.

In lieu of current CDC data, there are surveys that can help illuminate the similarities between military and civilian populations. In 2008, the Substance Abuse and Mental Health Services Administration (SAMHSA) added questions on suicide thoughts, plans and attempts to their *National Survey on Drug Use and Health* questionnaire. Based on the 2008 findings, an estimated 8.3 million adults had serious thoughts of suicide, 2.3 million made a suicide plan, and 1.1 million attempted suicide. The rate of suicide thoughts, plans and attempts was found to be highest in younger age groups (see Figure 5). These findings are similar to the 2008 *Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel*. The DoD survey findings estimate that 4.9% of the Army seriously considered suicide in the past year, and 2.0% of the Army attempted suicide in the past year. While these two surveys have similar findings, the difference in the research methodologies prevents a direct comparison of the resulting percentages.

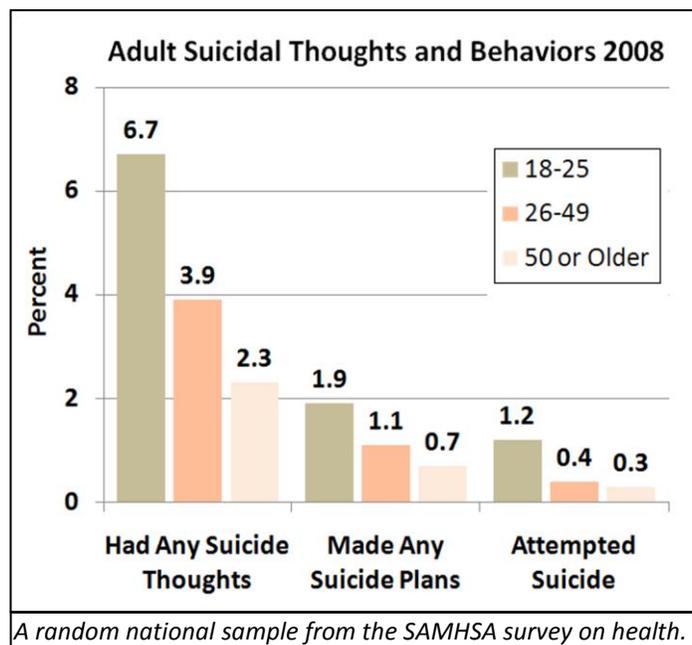


Figure 5 – Adult Suicidal Thoughts and Behaviors, 2008

¹¹ Medical Surveillance Monthly Report, May 2009.

¹² Army Criminal Investigation data, May 2010.

c. Army Statistics Compared with Other Services

It is perhaps more useful to compare the Army's suicide rate with that of the other services (Figure 6).¹³ While the civilian rate has remained relatively stable between 2001 and 2007 (purple line), both the Army and Marine Corps rate has increased steadily. The Navy and Air Force rates have shown a very slight increase, and it is not yet known if this is the beginning of a significant trend. The Army and Marine Corps, which have borne the majority of ground combat operations, have had the greatest increase.

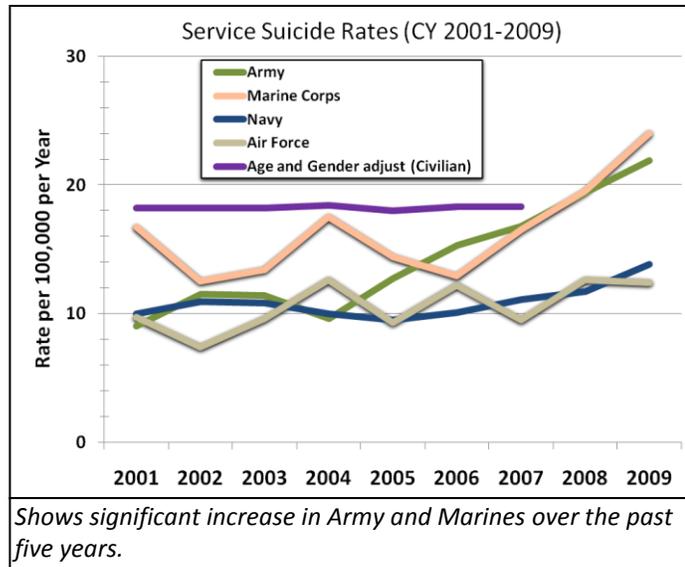


Figure 6 – Service Suicide Rates since CY 2001

CONCLUSIONS

- ★ It is difficult to directly compare and contrast the Army's suicide rate to the general (national) population due to differences in: reporting timelines and procedures, investigative protocols, manner of death determination, economic stressors, access to healthcare and access to behavioral healthcare. (pages 12-15)
- ★ High risk behavior (e.g., drug abuse, alcohol related incidents and suicidal behavior) is the leading cause of death for both the civilian and military populations for those under the age of 50. (page 15)
- ★ The self-selection bias of young adults who are willing to join the Army at a time of war may indicate a higher level of risk tolerance than their civilian counterparts. (page 15)
- ★ While the civilian suicide rate has remained relatively stable through 2007 (with 2008 and 2009 unknown), the Army rate has increased steadily through FY 2009 (see Figure 6). (page 16)
- ★ The greatest increase in military suicides have occurred in the Army and Marine Corps which have borne the greatest burden of ground combat in a protracted war. (page 16)

RECOMMENDED ACTIONS

- ★ [CDRs] Leaders should recognize that a potential self-selection bias indicating high risk tolerance, combined with service related transitions may result in high risk behavior – especially among first term Soldiers.
- ★ [HQDA] Charter research to test the hypothesis that Soldiers who voluntarily enlist [self-select] during a time of war may be more willing to engage in high risk behavior.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 3 – Suicide Statistics

¹³ Armed Forces Medical Examiner System, Mortality Surveillance Division, 19 March 2010.

d. Economic Factors and Suicide

Economic difficulties are potentially magnified for members of the Armed Forces. As individual Soldiers return from deployment and move to their next assignment (whether back to civilian life or to the next duty station), there is a degree of economic stress associated with transitions. Can I sell my

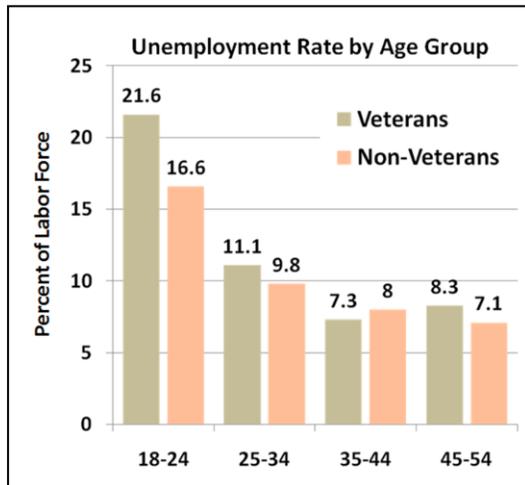


Figure 7 – Unemployment Rate, 2009

house in the current housing market? Will my job still be waiting for me once I return? Will I miss a critical opportunity for advancement? These questions and others are common among members of the armed services.

However, job-related stress may be more acute among ARNG and USAR members. There has been an increase in the number of ARNG and USAR members who have reported employment difficulties following deployment. In March 2010, the Department of Labor published a report on the “*Employment Situation of Veterans – 2009*” showing that young veterans are more likely to be unemployed than non-veterans of the same age (see Figure 7).

The Employer Support of the Guard and Reserve Office, part of the Office of the Assistant Secretary of Defense for Reserve Affairs, is responsible for assisting in conflict resolution arising from an employee's military commitment. Conflicts can range from the need to take time off from a civilian job for military training to employment discrimination following active duty service. This office has recently reported an increasing number of requests for support from ARNG and USAR Soldiers. In FY 2007 they received 19,400 requests for assistance; in FY 2008 they received 28,000; and in FY 2009 they received 31,500 requests.¹⁴ This indicates ARNG and USAR Soldiers are facing increasing employment challenges that contribute to overall economic stress.

e. Active Duty Suicide Demographics

Only one in four young Americans is eligible to enlist into the military. Preexisting conditions – including obesity, medical and behavioral health conditions, criminal history or other administrative disqualifiers – limit the number of eligible recruits.¹⁵ While military entrance standards help to ensure a healthy force (and likely explains the lower suicide rate in prior years), the recent prolonged conflict may be creating undue stress on the existing force as well as unintentionally shifting the Army demographic towards a larger risk-seeking population. Data from Accessions Command indicate that since 2004, some 20% of the new recruits were allowed entrance into the Army through a waiver process. These waivers granted admission to Soldiers with a variety of conditions that may have been disqualifying in previous years (for more information on waivers see page 68).

¹⁴ *Employer Support of the Guard and Reserve, Annual Report, 2009*, www.esgr.org.

¹⁵ *Ready, Willing and Unable to Serve*, www.missionreadiness.org.

Suicide is a concern of the Total Army including both the Active Component (AC) and the Reserve Component (RC). In FY 2009, 160 Soldiers committed suicide while on active duty (137 AC plus 23 mobilized RC). In order to get a complete picture of the stress on all components, the Army also keeps limited statistics on those who are not serving on active duty. Of those, there were 79 suicide deaths of RC Soldiers who took their lives while not on active duty (see Table 1).¹⁶ This means that in FY 2009, a total of 239 Soldiers died by suicide.

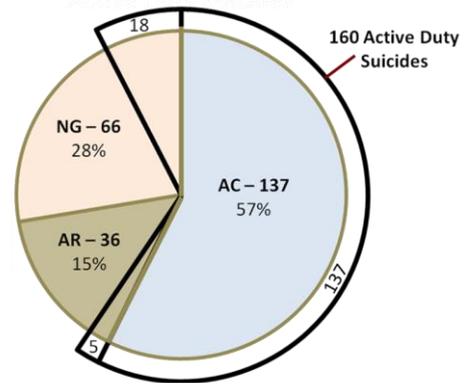


Figure 8 – FY09 Suicides by COMPO and Duty Status

In 2009, AC Soldiers committed suicide at a disproportionate rate compared to the other components (see Figure 8).¹⁷ The AC accounted for 57% of the total suicide deaths yet constituted only 49% of the Total Army. Both the National Guard and Army Reserve accounted for less than their representative populations within the Total Army. As of the publication of this report, this trend has reversed itself in FY 2010. Proportional differences, however, do not tell the whole story and should not detract from the fact that suicide rates have risen in all three components over time.¹⁸

	Active Component	Reserve Component	Total
Active Duty	137	23	160
Not On Active Duty	–	79	79
2009 Totals:	137	102	239

Table 1 – FY09 Army Suicide Deaths by Component & Duty Status

If we further examine the composition of the “typical” suicide victim within the Army, we find an Active Component, 23 year old, caucasian, junior-enlisted male Soldier. These facts are documented in detail in Table 2. For example, 86.6% of the Army population is male, while 96.9% of the suicide deaths in 2009 were male. Although 62.7% of the Army population is caucasian, 76.7% of the suicide deaths were caucasian victims.¹⁹ Interestingly, marriage or one or more deployments appears to decrease risk. However, analysis of prior deployments can be confounded by higher attrition from service following deployment resulting in a self-selection process whereby those who remain in service after deployment tend to be a relatively healthy segment of the population.²⁰

¹⁶ Army Suicide Prevention Task Force analysis, as of 21 May 2010.

¹⁷ FY 2009 Army Profile, DCS, G-1, Office of Army Demographics.

¹⁸ Proportional differences do not reflect population-level incidence.

¹⁹ Center for Health Promotion and Preventive Medicine (CHPPM), Epidemiological Report No. 14-HK-0BW9-10c, *Analyses of Army Suicides, 2003 – 2009*, 29 April 2010, p. 3-5.

²⁰ Hoge, C.W., Auchterlonie, J. L., Milliken, C.S., “Mental Health Problems, Use of Mental Health Services and Attrition from Military Service after Returning from Deployment to Iraq or Afghanistan.” *Journal of the American Medical Association*, March, 2006, 295[9], p. 1023-1032.

Active Duty Suicide Demographics	Active Duty Army 2009 Demographics	Active Duty Suicide Deaths 2003- 2009	Active Duty Suicide Deaths 2009	2009 Difference From Army Demographic:
Gender: Male	86.6 %	94.4%	96.9%	+10.3%
Age (Mode)	23 ²¹	21	23	0
Race: Caucasian	62.7%	74.3%	76.7%	+14%
Marital Status: Married	58.0%	52.1%	48.5%	- 9.5%
Rank: Jr. Enlisted	45.5%	57.1%	58.3%	+ 12.8%
Career Field: Infantry	13.2%	20.7%	23.9%	+ 10.7%
Component: AC	77.0%	83.3%	89.0%	+ 12%
Deployment History: One or more	70.9%	69.3%	68.7%	-2.2%

Table 2 – Active Duty Suicide Demographic Data

Of all suicides between 2005 and 2009, the “typical” suicide occurred within the United States and was committed using a firearm. It often involved the use of drugs or alcohol and may have been the result of multiple stressors including relationship issues and work/life balance. A list of major contributing individual risk factors is shown in Table 3. The primary motivation is often unknown (due to the lack of a suicide note or evidence of motivation). However, an assessment of stressors and primary motivation (that may have contributed to suicide or suicidal behaviors) may be determined by a death investigation that, ideally, is supported by a behavioral health provider who uses available evidence to make a clinical judgment (bio-psycho-social assessment).

AD Suicide Characteristics	AD Suicide 2005-2009 (2009)
Location of Suicide	<u>72.9% (80%) USA</u> 22.8% (17%) In Theater 4.3% (3%) Other
Method	<u>67.5% (62.0%) Gunshot</u> 19.8% (23.3%) Hanging 4.6% (6.2%) Overdose (Drugs & Alcohol)
Stressors (can be > 1)	<u>55.8% (55.8%) Relationship</u> 49.6% (57.4%) Military / Work 20.0% (23.2%) Physical Health 15.8% (16.7%) Substance Abuse (n=108)
Alcohol or Drug Involvement	<u>19.8% (17.6%) Alcohol</u> 9.8% (5.7%) Drug (n=108)
Primary Motivation	<u>41.2% (47.2%) Unknown</u> 15.2% (16.7%) Emotional Relief 14.2% (11.1%) Hopelessness / Depression 7.5% (4.6%) Avoidance / Escape (n=108)

Table 3 – Individual Risk Factors for Suicides (Active Duty)

²¹ Defense Manpower and Data Center, FY 2009 Army Age Modes and Means prepared on May 12, 2010.

f. Non-Active Duty Suicide Demographics

Detailed data collection on non-active duty suicide deaths did not begin until CY 2009, when a Task Force initiative standardized the active duty protocols for death investigation and expanded their reach to include Reserve Component non-active duty deaths. Available data indicate a similar profile to those in the Active Component who commit suicide. These individuals are typically young, caucasian, male, junior enlisted Soldiers. In the case of the Reserve Component suicide victim, however, most of the individuals who take their own lives have never deployed. Highlighted data points indicate a material difference ($\geq 10\%$) between non-active duty suicide data and Army-wide data.

Non-Active Duty Suicide Demographics	Non-Active Duty Army 2009 Demographics	Non-Active Duty Suicide Deaths 2009	2009 Difference from Non-Active Duty Demographics
Gender: Male	82.5%	93.9%	+11.4%
Age (Mode)	ARNG: 21 USAR: 25	ARNG: 20, 22, & 25 USAR: 29	ARNG: 0 USAR: +4
Race: Caucasian	69.1%	84.2%	+15.1%
Marital Status: Married	45.2%	57.3%	+12.1%
Rank: Jr. Enlisted	48.2%	62.2%	+14.0%
Deployment History: One or more	52.8%	47.6%	- 5.2%

Table 4 – Non Active Duty Suicide Demographic Data

Gunshot wounds are the most frequent cause of death in cases where manner of death is ruled a suicide. However, as discussed earlier, manner of death determination may underreport a number of suicides by other means. For example, drug overdoses or vehicle fatalities are routinely labeled accidental, meaning that without other evidence (note/media communication, witness, etc.) the autopsy will generally reflect the manner of death as “accidental.” This creates an artificial distinction between suicide and other equivocal deaths, particularly among the increasing number of drug-induced deaths.

This fact was reported in 2002 by the American Institute of Pathology where it was noted that “risk-taking behavior poses challenges when classifying manner of death. More and more, people are engaging in risky sports, recreational activities, and other personal behaviors. Injury or death, when it occurs during such activities, is not entirely unexpected, prompting the argument that such deaths may not truly be accidents.” The phenomenon of the national increase in accidental overdose deaths is discussed in depth in this section of the report beginning on page 27.

Non – AD Suicide Characteristics	Non – AD Suicide 2009
Location of Suicide	100% USA
Method	67.1% Gunshot 19.5% Hanging 3.7% Overdose (Drugs & Alcohol)

Table 5 – Non Active Duty Suicide Characteristics

CONCLUSIONS

- ★ Job-related stress may be more acute among Reserve Component Soldiers. (page 17)
- ★ Manner of death determination may underreport a number of suicides by other means. This creates an artificial distinction between determination of suicide and other equivocal deaths. (page 20)
- ★ The American Institute of Pathology notes that “risk-taking behavior poses challenges when classifying manner of death... Injury or death, when it occurs during such [high risk] activities is not entirely unexpected, prompting the argument that such deaths may not truly be accidents.” (page 20)

RECOMMENDED ACTIONS

- ★ [HQDA] Fund suicide behavior surveys that span both civilian and military populations in order to make direct comparisons.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 4 – Suicide Factors and Demographics

2. Complexity of Suicide

David Émile Durkheim’s historic book *Le Suicide*, published in 1897, was a landmark social case study that identified gender, religious and occupational factors directly related to a higher risk for fatal suicidal behavior. Despite the progress made in an attempt to better understand behavioral health issues since 1897, research on suicide prevention efforts still lacks definitive answers as to why individuals take their own lives.

Suicide is complex. While a convergence of many factors may merely challenge one Soldier these same issues may be devastating to another. These differences lead to the idea that there are potentially protective factors that promote resilience and there are susceptibility factors (high stress, relationship issues, financial issues, etc.) that can lead to suicide. Increasing awareness of potential risk factors affecting Soldiers will assist leaders and program/service providers to make timely and effective interventions.

Several studies and programs have been initiated in the Army in an attempt to understand these protective or susceptibility factors. These studies inform Army leadership who in turn create programs so that leaders at all levels can be aware of potential issues. Studies indicate that one of the major barriers facing Army Soldiers is the stigma of seeking behavioral health treatment for those who need it. A better understanding of this issue by leaders will provide a real opportunity to assist Soldiers.

a. Stigma Associated with Help-Seeking Behavior

“The stigma attached to seeking mental health treatment is not just an Army problem ... this is a societal problem that we all have to wrestle with...”

– General George Casey, Chief of Staff, Army
American Forces Press Service, 10 November 2009



Quote 4 – GEN George Casey, 10 Nov 09

Stigma is typically the perception among leaders and Soldiers that help-seeking behavior will either be detrimental to their career (e.g., prejudicial to promotion or selection to leadership positions), or that it will reduce their social status among their peers. The perceived stigma associated with seeking behavioral health treatment represents a very real barrier to care for individuals who would benefit from professional treatment. This barrier is further increased within the military culture where mental toughness is seen as a sign of strength, while seeking behavioral health assistance may be a sign of weakness.

The term stigma carries significant negative connotations and includes the idea that society will judge the individual once the stigma is recognized. A Soldier who receives an annual performance evaluation that stated “SGT Jones overcame a debilitating gunshot injury and returned to lead his squad in Afghanistan” would be commended for his strength and resilience; while this same individual might not be perceived in the same light if he receives a report that stated “SGT Jones overcame PTSD following a firefight that included casualties to return to lead his squad in Afghanistan.”

Data from OEF and OIF support the fact that a large percentage of those who would benefit from behavioral health treatment often resist seeking care due to the perception of peer disapproval.²² Additionally, once Soldiers have been identified with a behavioral health issue, they may tend to internalize negative stereotypes and enforce “self-stigma.”²³ These factors contribute to the fact that those who need behavioral health care the most are typically the least likely to seek care.

While stigma associated with seeking behavioral health treatment remains a problem in the military, there is evidence that the current anti-stigma communications campaign is improving perceptions.²⁴ The Army Research Institute’s Sample Survey of Military Personnel found changes in responses from 1999 to 2009 indicate a positive trend among the general Army population, while other surveys found little or no change. While this is encouraging, 51% of both officer and enlisted Soldiers still believe that seeking behavioral health counseling would negatively affect their careers. This indicates that a majority of the active duty population still believes behavioral health counseling/care would have a negative impact on their career. Until the stigma associated with behavioral health treatment can be overcome, the Army should continue to look at alternative methods for identifying Soldiers who may be in need of such care, either by command intervention or through medical encounters. The first step toward care, however, begins with Soldiers who recognize when they need help.

²² Hoge, C.W., et al., “Combat Duty in Iraq and Afghanistan, Mental Health Problems and Barriers to Care.” *US Army Med Dep J*, 2008, p. 7-17; Langston, V., M. Gould, and N. Greenberg, “Culture: What Is Its Effect On Stress in the Military?” *Mil Med*, 2007, 172(9): p. 931-5; and Hoge, C.W., et al., “Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care.” *N Engl J Med*, 2004. 351(1): p. 13-22.

²³ Rusch, N., et al., “Implicit Self-Stigma in People with Mental Illness.” *J Nerv Ment Dis*, 2010, 198(2): p. 150-3; and Greene-Shortridge, T.M., T.W. Britt, and C.A. Castro, “The Stigma of Mental Health Problems in the Military.” *Mil Med*, 2007, 172(2): p. 157-61.

²⁴ Warner, C.H., et al., “Soldier Attitudes Toward Mental Health Screening and Seeking Care Upon Return from Combat.” *Mil Med*, 2008, 173(6): p. 563-9.

OVERCOMING STIGMA

When Staff Sergeant Megan Krause returned home from a deployment to Iraq in 2006, she thought the scariest moments of her life were over. “Boy, was I wrong,” said Krause, who later found herself waging a terrifying war with post-traumatic stress disorder. “I discovered there was no shame in admitting that I was in trouble and needed help.”

Source: *PTSD: One Soldier’s Story*, American Forces Press Service, January 14, 2010

Vignette 3 – Overcoming Stigma**CONCLUSIONS**

- ★ Despite the progress made in an attempt to better understand behavioral health issues related to suicide, research on suicide prevention still lacks definitive answers. (page 21)
- ★ The perceived stigma associated with seeking behavioral health treatment is a real barrier for those who would benefit from seeking professional care. (page 22)
- ★ Those Soldiers who need behavioral health care the most are typically the least likely to seek care. (page 22)

RECOMMENDED ACTIONS

- ★ [HQDA] Enhance research efforts for identifying at-risk Soldiers to provide effective and efficient programs/services.
- ★ [CDRs] Ensure leaders at all levels encourage help-seeking behavior and convey anti-stigma messages as a routine matter of unit operations.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 5 – Stigma**b. Increasing Awareness of Risk Factors**

There are a number of factors that may contribute to suicide. Individual relationship stressors, environmental influences, high risk behavior, medical conditions or a combination of all of these have been found to increase the likelihood of suicide. When leaders and peers begin to identify potential risk factors, tragedy can be averted, but only when action is taken.

To better understand the specific factors involved in suicidal influences, the Department of Defense Suicide Event Report (DoDSER) collects data on suicide. The DoDSER is a surveillance tool used to gather risk and protective factor information on suicides, suicide attempts, self-harm events and suicidal ideations. The overall goal of this report is to leverage lessons learned to better identify individuals at-risk. The DoDSER information includes:

- Demographics: gender, age, ethnicity, marital status, education level, religious preference, children, place of residence, etc.
- Conditions of Life: failed relationship, death of loved one, loss of property or finances, loss of job or position, legal issues, investigations or pending incarceration, access to weapons, adrenaline seeking or risk-taking behaviors, etc.
- High Risk Behavior: illicit use of drugs (illegal and prescription), substance abuse, criminal activity, gambling, infidelity, excessive spending, reckless driving, etc.

- Military Specific Information: duty status, pay grade, duty station, length of time in unit, deployment history, exposure to death or violence, etc.
- Medical Information: behavioral health diagnosis, PTSD, mTBI, physical pain, substance dependence or abuse, loss of limb, prescriptions, family history of suicide, etc.
- Circumstances surrounding the Suicide Event: a note or other communication, method used, use of alcohol or drugs, prior attempts, environment or place of event, etc.

Information gathered from the DoDSER indicates there are several individual Soldier risk factors and stressors associated with suicidal behavior, particularly high risk behaviors and medical conditions. A detailed discussion of the DoDSER can be found in this report starting at page 186.

MASKING STRESSORS TO AVOID STIGMA

While going through a divorce, a 36 year old Army Major incurred a \$37,000 debt. The divorce and debt appeared to be the only risk factors. He had previously deployed twice, had no known documented behavioral health issues and was not taking medication. His Family later informed investigators that he had thoughts of suicide. His Family did not contact his unit or chain of command because they did not want to damage his career. Co-workers stated they noticed warning signs but did not report them. He committed suicide in June 2009.

- Stigma is dangerous – Ask, Care, Escort.

Vignette 4 – Masking Stressors to Avoid Stigma

According to the Center for Health Promotion and Preventive Medicine (CHPPM); 82% of the Active Duty suicide deaths were found to have at least one significant stressor. These stressors include behavioral health diagnosis (48%) and/or a history of legal problems/law enforcement encounters (34%). Of those that had been diagnosed with a behavioral health issue, 26% had been diagnosed with an Adjustment Disorder, 18% had a substance abuse diagnosis, 9.1% had been diagnosed with post-traumatic stress disorder (PTSD) and 5.6% had a history of self-harm behavior.²⁵

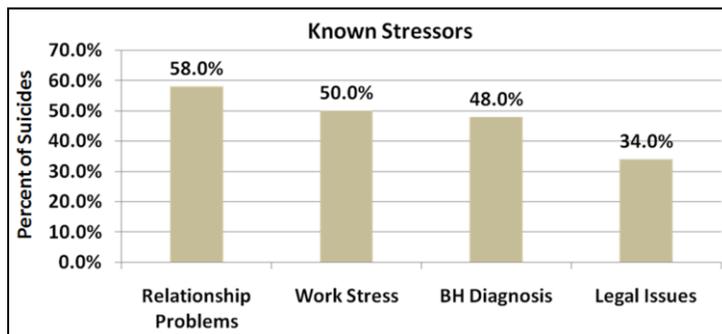


Figure 9 – Known Stressors

The most prevalent individual stressor indicated was relationship problems, which were present in 58% of the suicide deaths in 2009. Relationship issues have consistently been a contributing factor fluctuating between 53.2% and 58.4% from 2005 to 2009.²⁶ While this is identified as the largest

stressor it may be a catchall for other risk factors. Relationships can be affected by numerous contributing factors including financial pressures (likely aggravated by deployments or other separations), family pressures (child care, sick or ailing parents), substance abuse, legal issues, etc. Research into the root causes of relationship failures may help to more accurately define specific risk

²⁵ CHPPM, Epidemiological Report No. 14-HK-0BW9-10c, *Analyses of Army Suicides, 2003 – 2009*, 29 April 2010, p. 8.

²⁶ *Ibid*, p. 18.

factors associated with suicidal behavior. A clear delineation of risk factors is critical in developing specific training and education targeted to reduce suicidal behavior.

Military or work stress (as defined in the DoDSER) is recognized as the second most prevalent individual risk factor and has contributed to 50% of the suicide deaths from 2005 to 2009. This too may be a catchall for numerous risk factors. Work-related stress may include voluntary or involuntary separation from the Army, dangerous work environment (combat), or the increased OPTEMPO of an Army at war. This stress factor as an indicator for suicide has been steadily increasing over the past five years from 32% in 2005 to 57% in 2009.²⁷

A history of legal/law enforcement encounters and disciplinary/administrative actions were present in 34% of the suicide deaths between 2005 and 2009. While some Soldiers had more than one legal problem/law enforcement encounter, the majority of these problems were Article 15 punishment (15%) and civil legal problems (13%), followed by being absent without leave (AWOL) (6%), pending administrative separation proceedings (6%) and pending medical review/separation boards (6%). Court-Martial actions accounted for 2.9% of the legal problems.²⁸

RELEVANT STRESSORS IN FIELD GRADE OFFICER SUICIDES

A Lieutenant Colonel was apprehended by CID for bribery and solicitation related to contract fraud. On two separate occasions during ten days of pre-trial confinement, he was found possessing weapons (i.e., razor blade and nail) and told guards he intended to harm himself. Despite this information being presented to the appropriate authorities, the Lieutenant Colonel was released from confinement. He committed suicide approximately ten days later by ingesting poison.

From 2006-2009, criminal legal issues were the most prevalent individual risk factor for senior personnel and contributed to 39% (7 of 18) of field grade officer suicides. Marital difficulties were the next prevalent risk factor and contributed to 28% (5 of 18) of these suicides.

Source: Army Suicide Prevention Task Force

Vignette 5 – Relevant Stressors in Field Grade Officer Suicides

Early recognition of any or all of these risk factors represents an opportunity for leaders, law enforcement personnel, medical and other program/service providers to intervene in this high risk behavior and either rehabilitate through treatment or separate as appropriate. With an increasing number of young men and women returning from the battlefield with either mTBI from IED attacks or PTSD from the realities of conflict, leaders must be vigilant of these and other medical issues that are indicative of potential suicide risk factors.

CONCLUSIONS

- ✪ Individual relationship stressors, life conditions, high risk behavior and medical conditions have been found to increase the likelihood of suicide. (page 23)
- ✪ The individual stressors most frequently cited in suicide death investigations are relationship stress (58%) and work stress (50%), which may be catchall categories for other risk factors. (page 24) (Continued)

²⁷ Ibid.

²⁸ Ibid.

- ✪ Early recognition and intervention of legal, medical and disciplinary risk factors presents an opportunity for leaders, law enforcement personnel and program/service providers to prevent negative outcomes. (page 25)

RECOMMENDED ACTIONS

- ✪ [HQDA] Research the risk sub-factors that make up larger catchall stressor categories such as relationship and work stress to identify and target specific factors contributing to suicidal behavior.
- ✪ [HQDA] Coordinate with OSD to modify the DoDSER to implement future research findings regarding specific risk sub-factors associated with larger catchall stress categories.
- ✪ [ALL] Identify and mitigate stress during the critical window of legal/law enforcement encounters and subsequent adjudication actions.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 6 – Awareness of Risk Factors

c. Medical Issues

There are a number of medical issues, previously identified as risk factors for suicide, which are somewhat unique to the Army and Military populations. Soldiers who receive one or more of the diagnoses listed on pages 26-27 are in the inter-event stage of the Care Continuum. Receiving a serious behavioral health diagnosis is a life changing event for any Soldier. For some, the reluctance to continue care, perceptions of stigma for seeking treatment and a long term prognosis combine to create real stress that contributes to suicidal behavior.

(1) Post Traumatic Stress (PTS) and PTSD

Post Traumatic Stress (PTS) is the normal reaction to extraordinary circumstances. Post Traumatic Stress Disorder (PTSD) is the medical condition that develops when PTS adversely impacts normal activities of one's daily life. PTSD decreases marital satisfaction, exacerbates depression and may be related to other behavioral health problems and high risk behavior. PTSD requires medical intervention. Research indicates that when untreated, PTSD greatly increases the risk of suicidal behavior.²⁹ PTSD diagnoses have been steadily increasing in the Army over the past seven years. For these reasons, the Army's objective is to prevent PTS from becoming PTSD.

The 2008 *Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel* indicated that an estimated 13% of the Army met the screening criteria for PTSD. According to the Office of the Surgeon General (OTSG), the number of newly diagnosed cases of PTSD for Soldiers with a deployment history has increased from 2,931 in 2004 to 10,137 in 2008. Since 71% of the Army has deployed at least one time, the potential for PTSD is significant.³⁰ While on average only 9.1% of the suicide deaths between 2005 and 2009 had been diagnosed with PTSD, this percentage has steadily increased from 4.6% in 2005 to 14.1% in 2009.

²⁹ Committee on the Initial Assessment of Readjustment Needs of Military Personnel, Veterans, and Their Families, Institute of Medicine of the National Academies, *Returning Home from Iraq and Afghanistan: Preliminary Assessment of Readjustment Needs of Veterans, Service Members, and Their Families*, The National Academies Press, Washington, D.C., 2010, p. 67-69.

³⁰ Defense Manpower and Data Center, Number of Deployments for the Current Strength, as of February 28, 2010; prepared on March 24, 2010.

(2) mild Traumatic Brain Injury (mTBI)

Although mTBI has not been shown to be directly related to suicidal behavior, its impact on daily living activities are suspected to be an additional risk factor. The Army Surgeon General recently developed the *Army Campaign Plan for Warrior Mild Traumatic Brain Injury (mTBI) Management*.³¹ HQDA and leaders are using this plan to address mTBI – also known as “concussion” – to effect a cultural change across the Army. The goal is to ensure mTBI is recognized as a physical injury that must be appropriately identified, treated and tracked to prevent and mitigate long-term health consequences for Soldiers. The Army has implemented campaign plan tasks, continues to assess effects, and is incorporating lessons learned into future policy, structure, process and programs. This plan takes a comprehensive, multi-disciplinary approach towards mTBI in the Army. It prioritizes, synchronizes and implements education, treatment and tracking processes that emphasize health as a critical component in force readiness.

THE PAIN OF TBI

A married Lieutenant Colonel in his early fifties had deployed several times and experienced multiple concussions and head trauma. He suffered from traumatic brain injury, sleeping problems and dementia. He was assigned to a Warrior Transition Unit (WTU) and prescribed multiple medications. The day he died, he went to the emergency room seeking treatment to alleviate his headaches and pain. He was given a 30 tablet refill of Ambien (sleep medication). After the ER visit, he went to his car, drank four 50ml bottles of rum and ingested the entire prescription. His suicide note indicated that he could no longer stand the headaches and pain.

- Every medical contact is an opportunity for behavioral health screening.

Source: ASPTF

Vignette 6 – The Pain of TBI

(3) Drug and Alcohol Abuse

Drug and alcohol abuse is a significant health problem in the Army. The *Millennium Cohort Study* found that Army National Guard and Reserve Soldiers who deployed were significantly more likely to abuse alcohol than their non-deployed peers.³² Calendar year 2006 – 2008 data from the Armed Forces Health Surveillance Center indicate that the Army has the highest rate of acute alcohol diagnosis (22.7 per 1,000 per year) and substance abuse clinic treatment encounters (43.2 per 1,000 per year) within the Department of Defense.³³ Almost 30% of the Army’s suicide deaths from 2003 to 2009, and over 45% of the non-fatal suicide behavior from 2005 to 2009, involved the use of drugs or alcohol.³⁴ (For more information on the devastating effects of drugs and alcohol use within the Army, see Section III, “*The Lost Art of Leadership in Garrison*,” starting on page 35.)

³¹ OTSG briefing to the VCSA, “Post Traumatic Stress (PTS) and Mild Traumatic Brain Injury (mTBI),” 4 May 2010.

³² Hourani, L. L., Bray, R. M., et al. (2007). “2006 DoD Survey of Health Related Behaviors Among the Guard and Reserve Force.” Prepared for OASD(HA) under contract W81XWH-05-F-0917 by RTI International.

³³ Armed Forces Health Surveillance Center, “Medical Surveillance Monthly Report,” May 2009, pp 6-9.

³⁴ CHPPM, Epidemiological Report No. 14-HK-0BW9-10c, *Analyses of Army Suicides, 2003 – 2009*, 29 April 2010, p. 17.

(4) Medication Implications

The impact of increased use of antidepressant, psychiatric and narcotic pain management medications has not been comprehensively studied in a military population. The percentage of Soldiers who have been prescribed antidepressants within 90 days of deploying or during a deployment has increased from 1.1% in 2005 to 5% in 2008.³⁵ Oxycodone (Percocet) and hydrocodone (Vicodin) have become the second and third most frequently used pain management medications.³⁶ Increasing prescription use among the military has been the focus of numerous news stories and Congressional hearings.

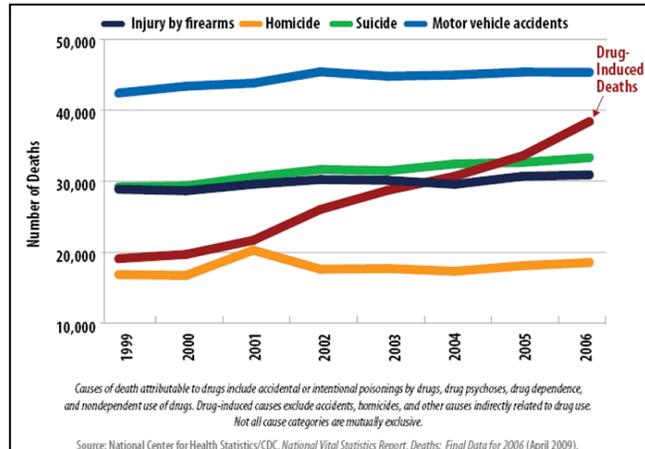


Figure 10 – National Drug Control Strategy, May 2010.
Based on CDC data.

This increase in prescription drug use is not just a military issue. In May 2010, the White House released the *National Drug Control Strategy*, which stated: “Overdoses, particularly from opiates, are a growing national crisis...” Figure 10 shows that drug-induced deaths have nearly doubled in the past ten years while other causes of death have gradually increased. Again, due to the process for determining the manner of death, it is difficult to ascertain how many of these “accidental” deaths may have been intentional. What is clear is that prescription and other drug use are becoming a significant factor in high risk behavior and death.

“We’re seeing ... a lot of Soldiers that are taking narcotics, a lot of Soldiers are taking anti-depressants, psychotropic class medications.”

– BG Richard Thomas, Asst. Surgeon General for Force Projection
Fighting the Emotional Toll of War, CNN, 30 March 2010

Quote 5 – BG Richard Thomas, 30 Mar 10

There is contradicting evidence on the association between the use of some antidepressant medications such as Selective Serotonin Reuptake Inhibitors (SSRIs) and suicidal behavior. The Agency for Healthcare Quality Research and the U.S. Preventive Services Task Force “... found at least fair-quality evidence that second-generation antidepressants (mostly SSRI) increase suicidal behavior in adults aged 18 to 29 years, especially those with major depressive disorder and those who receive paroxetine” (Paxil). The report also stated, “In treating patients aged 18 to 29 years, clinicians may want to select a psychotherapeutic approach or medication other than SSRIs because of the increased risk for suicidal behavior associated with the use of SSRIs.”³⁷ However, other research evidence shows the benefit of antidepressant use for the treatment of depression and anxiety, which are known suicide risk factors. With an increase in the use of antidepressants and, given that specific medications (i.e.,

³⁵ Armed Forces Health Surveillance Center, “Number of Service Members Deployed to OEF or OIF Who Were Prescribed Antidepressants by Year of Deployment Start,” undated.

³⁶ OTSG briefing to the VCSA, “Prescription Drug Use and Management,” 30 March 2010.

³⁷ U.S. Preventive Services Task Force, Agency for Healthcare Quality and Research, Department of Health and Human Services, “Screening for Depression in Adults,” *Annals of Internal Medicine*, 1 December 2009, p. 785.

paroxetine) have been shown to increase suicidal behavior within the predominant Army demographic (18 – 29 years), research needs to be done to determine those specific medications that will reduce anxiety and depression without increasing suicidal risk. The Army Medical Command (MEDCOM) is cognizant of this issue and is investigating the use of these and other medications to better manage care.

In addition to antidepressant medications, narcotics represent an increasing concern for the force. MEDCOM has recently developed a comprehensive pain management strategy that is a holistic, multidisciplinary and multimodal approach to optimize quality of life for patients with acute and chronic pain. The comprehensive pain management strategy has over 100 recommended changes to programs and policies that will be implemented by MEDCOM to standardize pain management Army-wide.³⁸

(5) Comorbid Complications in the Army Population

Comorbidity is defined as more than one medical diagnosis existing simultaneously with another medical condition. The diagnosis can be physical and/or psychiatric. The implication is that treatment of comorbid conditions is more difficult than treating the individual illness. Analysis of recent Army suicide deaths indicates comorbidity is a problem within the Army. A history of behavioral health diagnosis is strongly associated with increased incidence of high risk and suicidal behaviors. As depicted in Figure 11, the CHPPM estimates the suicide rate is markedly higher for Soldiers diagnosed with behavioral health disorders and PTSD than it is for Soldiers who have no history of a behavioral health diagnosis (indicated by the dashed line).³⁹

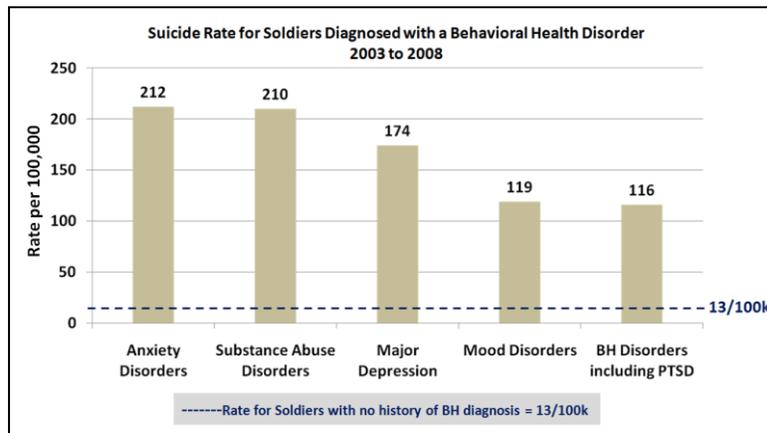


Figure 11 – Behavioral Health Diagnosis and Suicide Rates, 2003-2008

professional, etc.) or not, individuals who were positive for having a previous TBI on the self report screen were more likely to have comorbid complications. This may indicate that screening positive for mTBI is a non-specific indicator for other behavioral health issues.

In a Veterans Affairs study of psychiatric comorbidity with TBI, veterans who screened positive for a previous TBI experienced PTSD, depression, substance abuse, adjustment disorder and/or anxiety at significantly higher rates than those who screened negative for a previous TBI.⁴⁰ Interestingly, this included mTBI positive screening for both confirmed and unconfirmed incidence of TBI. In other words, regardless of whether TBI had been confirmed (by eye witness, medical

³⁸ OTSG, "Pain Management Task Force Final Report," May 2010.

³⁹ CHPPM, Epidemiological Report No. 14-HK-0BW9-10c, *Analyses of Army Suicides, 2003 – 2009*, 29 April 2010, p. 7-9.

⁴⁰ Carlson, K.F., et al., "Psychiatric Diagnoses Among Iraq and Afghanistan War Veterans Screened for Deployment-Related Traumatic Brain Injury." *J Trauma Stress*, 2010, 23(1): p. 17-24.

Comorbid complexity was explored in studies that have demonstrated that PTSD and PTSD-like symptoms can have a profound effect on post-deployment symptom reporting, including symptoms attributed to mTBI.⁴¹ This means there is a significant contribution from PTSD symptoms that must be addressed to alleviate the overall symptoms reported by Soldiers after coming back from war.

The treatment of multiple conditions is complex. Post-deployment health concerns likely involve a complex interaction of war-zone traumatic events, war-zone injuries (including mTBI/concussion), sleep deprivation, physiological manifestations of extreme physical stress (including PTSD), medications, substance abuse, etc. Even when multiple conditions have been identified, knowing the specific order for treating comorbid psychiatric conditions is difficult.⁴² There are no studies which address comorbid issues such as sleep deprivation or post traumatic stress that are routinely experienced in a deployed environment. The military needs to develop a better understanding of these interactions and develop effective mitigation strategies.

CONCLUSIONS

- ★ Diagnosed cases of PTSD have steadily increased in the Army since 2003. Untreated PTSD can lead to suicidal behavior. (page 26)
- ★ Drug and alcohol abuse is a significant health problem in the Army. Almost 30% of the Army suicide deaths from CY03-CY09 and over 45% of the non-fatal suicidal behavior from CY05-CY09, involved the use of drugs or alcohol. (page 27)
- ★ The use of antidepressant, psychiatric and narcotic pain management medications has increased within the Army. Although the use of some types of antidepressants has been shown to increase suicidal behavior, they reduce depression and anxiety, which are known suicide behavior risk factors. (page 28)
- ★ Comorbidity is a challenge within the Army, both for the Soldiers affected and the health care providers who must sequence treatment of multiple conditions. (pages 29-30)

RECOMMENDED ACTIONS

- ★ [MEDCOM] Implement standardized treatment protocols to identify other behavioral health issues in Soldiers who report or are diagnosed with mTBI/PTSD.
- ★ [HQDA] Enhance policies to increase alcohol and drug reporting and referral for early detection and treatment of substance dependency and/or abuse.
- ★ [HQDA] Conduct comprehensive research and analysis of the impact of increased use of antidepressant, psychiatric and narcotic pain management medications on the force.
- ★ [HQDA] Conduct research to identify appropriate antidepressant medications that are beneficial to the treatment of depression and anxiety, but that will not increase risk for suicidal behavior.

(Continued)

⁴¹ Belanger, H.G., et al., "Symptom complaints following combat-related traumatic brain injury: relationship to traumatic brain injury severity and posttraumatic stress disorder." *J Int Neuropsychol Soc*, 2010, 16(1): p. 194-9.

⁴² Back, S.E., A.E. Waldrop, and K.T. Brady, "Treatment Challenges Associated with Comorbid Substance Use and Posttraumatic Stress Disorder: Clinicians' Perspectives." *Am J Addict*, 2009, 18(1): p. 15.

- ★ [MEDCOM] Clinicians need to carefully weigh the risks with potential benefits of using SSRIs when treating 18 to 29 year-old patients due to the increased risk for suicidal behavior.
- ★ [HQDA] Initiate research to develop effective mitigation strategies to counter the effects of comorbidity on Soldiers and address the full spectrum of war-related health concerns.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 7 – Medical Issues

d. Primary Care as the Initial Screen for Behavioral Health

A growing body of literature demonstrates that PTSD and depression are significantly correlated with physiological symptoms. In the case of PTSD, even before the recognition of diagnosable symptoms, other physiological conditions such as chronic musculoskeletal pain, high blood pressure, obesity and heart disease emerge.⁴³ Mild cognitive impairment (which can occur from a variety of causes) has been associated with hostility, aggression and impulsivity.⁴⁴ Symptoms that are typically considered in the category of persistent post-concussion symptoms such as physical and cognitive fatigue, depressive behaviors, sensitivity to noise, social withdrawal, irritability, concentration and problem solving difficulties, loss of libido and difficulty making decisions are also commonly reported in association with other health conditions.⁴⁵

While Soldiers may be resistant to seeking behavioral health care, they are required to be assessed annually by a primary care physician as part of their periodic health assessment. In fact, it is reported that approximately 90% of Soldiers in a given year have at least one primary care visit.⁴⁶ This encounter creates an opportunity for identification of physical symptoms associated with behavioral health conditions. Individuals in military type careers (including police and firefighters) are more prone to seek medical care based on physical rather than behavioral health symptoms.⁴⁷

Early detection of behavioral health conditions can result in an increased willingness to begin treatment and better resolution of symptoms [and presumably better treatment outcomes].⁴⁸ To ensure earlier diagnosis, patients who enter medical treatment for other than behavioral health care reasons should be screened for behavioral health issues. Studies examining non-behavioral health care utilization rates reveal that military personnel and veterans with behavioral health conditions access primary care and other non-behavioral health care at greater rates than those with no behavioral health

⁴³ McFarlane, A.C., "The Long-Term Costs of Traumatic Stress: Intertwined Physical and Psychological Consequences." *World Psychiatry*, 2010, 9(1): p. 3-10; and Babic, D., et al., "Metabolic Syndrome and Combat Post-Traumatic Stress Disorder Intensity: Preliminary Findings." *Psychiatr Danub*, 2007, 19(1-2): p. 68-75.

⁴⁴ Clement, F., et al., "Personality and Psychological Health in Persons with Mild Cognitive Impairment." *Can J Aging*, 2009, 28(2): p. 147-56.

⁴⁵ Rees, R.J. and M.L. Bellon, "Post Concussion Syndrome Ebb and Flow: Longitudinal Effects and Management." *NeuroRehabilitation*, 2007, 22(3): p. 229-42.

⁴⁶ Engel, C.C., "Improving Primary Care for Military Personnel and Veterans with Posttraumatic Stress Disorder – The Road Ahead." *Gen Hosp Psychiatry*, 2005, 27(3): p. 158-60.

⁴⁷ McFarlane, A.C., et al., "Physical Symptoms in Post-Traumatic Stress Disorder." *J Psychosom Res*, 1994, 38(7): p. 715-26; Hoge, C.W., et al., "Association of Posttraumatic Stress Disorder with Somatic Symptoms: Health Care Visits, and Absenteeism Among Iraq War Veterans." *Am J Psychiatry*, 2007, 164(1): p. 150-3; and Simon, G.E. and M. VonKorff, "Somatization and Psychiatric Disorder in the NIMH Epidemiologic Catchment Area Study." *Am J Psychiatry*, 1991, 148(11): p. 1494-1500.

⁴⁸ Bobo, W.V., C.H. Warner, and C.M. Warner, "The Management of Post Traumatic Stress Disorder (PTSD) in the Primary Care Setting." *South Med J*, 2007, 100(8): p. 797-802; and Bronson, D., K. Franco, and K. Budur, "Posttraumatic Stress Disorder in Primary Care Patients." *Compr Ther*, 2007, 33(4): p. 208-15.

conditions.⁴⁹ Cohen *et al.* concluded that veterans with a behavioral health diagnosis were 71 – 170% more likely to access some form of medical care outside of the behavioral health system. Of those with a behavioral health diagnosis, PTSD patients had a 91% greater utilization rate of non-behavioral health care.⁵⁰

Primary care represents the best opportunity to identify behavioral health issues in a population resistant to seeking behavioral health care

In recognition that primary care represents the best opportunity to identify behavioral health issues (in a population resistant to seeking behavioral health care), the Army instituted a model of care called RESPECT- MIL (Re-Engineering Systems of Primary Care Treatment in the Military). A similar concept was already validated for depression (RESPECT for Depression, or RESPECT-D)⁵¹ and when expanded to include PTSD was found to be successful in a military setting.⁵²

e. Promoting Resiliency through Comprehensive Soldier Fitness (CSF)

The CSF program is not medical or psychological treatment. It is a holistic program designed to provide members of the Army community the knowledge, and thinking skills to develop behaviors that will enable them to successfully cope with life's challenges and adversities.⁵³ The program trains specific skill sets along the five domains of human health and fitness (Physical, Social, Emotional, Spiritual and Family). Integration of CSF as a key component to health will result in the development of resilience (i.e., the sum of each individual's assets and resources in each of these domains).

CSF is a programmatic first step towards teaching members of the Army community to understand how and why they think a certain way. Once people take this step, they are better postured to adopt new strategies that will likely result in desirable outcomes. The program recognizes two important factors: better outcomes are realized by leveraging existing personal strengths and a one-size-fits-all training approach is inappropriate/inefficient.

The CSF program recognizes that developing human resilience is a life-long process because there is no "end state," as individuals can always improve. With this in mind, CSF's maximal benefit will be realized when incorporated early and used continuously. Because the requirement for developing human resilience is enduring, the CSF Program will continue to evolve as the Army community's resilience continues to improve.

⁴⁹ Cohen, B.E., et al., "Mental Health Diagnoses and Utilization of VA Non-Mental Health Medical Services Among Returning Iraq and Afghanistan Veterans." *J Gen Intern Med*, 2010, 25(1): p. 18-24; and Richardson, J.D., J.D. Elhai, and D.J. Pedlar, "Association of PTSD and Depression with Medical and Specialist Care Utilization in Modern Peacekeeping Veterans in Canada with Health-Related Disabilities." *J Clin Psychiatry*, 2006, 67(8): p. 1240-5.

⁵⁰ *Ibid.*, Cohen, B.E., et al.

⁵¹ Dietrich, A.J., et al., "Re-Engineering Systems for the Treatment of Depression in Primary Care: Cluster Randomised Controlled Trial." *BMJ*, 2004, 329(7466): p. 602.

⁵² Engel, C.C., et al., "RESPECT-Mil: Feasibility of a Systems-Level Collaborative Care Approach to Depression and Post-Traumatic Stress Disorder in Military Primary Care." *Mil Med*, 2008, 173(10): p. 935.

⁵³ "Army community" includes Soldiers, Family members, and Department of the Army Civilians

CONCLUSIONS

- ★ Early detection of behavioral health conditions results in increased willingness to begin treatment and better resolution of symptoms. (page 31)
- ★ Primary care represents the best opportunity to diagnose behavioral health issues in a population resistant to seeking behavioral health care. (page 32)

RECOMMENDED ACTIONS

- ★ [MEDCOM] Expand Primary Care provider screening of patients for behavioral health issues (e.g., RESPECT-MIL).

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 8 – Primary Care as Initial Behavioral Health Screen

3. Summary

The rising rate of suicide in the Army spurred efforts to mitigate this trend. The Army rallied experts, academia and industry in addition to marshaling its own resources in an attempt to define causal factors that contribute to suicidal behaviors. While several factors relating to demographics, life conditions, risk-taking behavior and medical issues are recognized as potential stressors, it is not known if these factors alone, and in what combination, would cause people to take their life.

Leaders need to be aware of certain risk-taking behaviors that could lead to suicide. Behavioral health issues, substance abuse and high risk behavior can result in a negative spiral in which Soldiers feel there is little chance for recovery. Diagnosed or undiagnosed medical or behavioral health conditions can lead to high risk or suicidal behaviors. The treatment for PTSD, symptoms attributed to mTBI, sleep disorders, depression, mood and anxiety disorders or physical health problems, can also lead to unintended consequences such as interactions or side effects of medications prescribed by different providers. Correspondingly, drug induced deaths have almost doubled in the last decade in the United States.

Stigma continues to be the biggest deterrent to seeking help. Although help-seeking behavior is increasing in the Army, many still believe that seeking behavioral health counseling would negatively impact their careers. Help-seeking is imperative because early diagnosis and treatment for most behavioral health conditions including PTSD and mTBI have proven to be highly effective. Until stigma is eliminated, innovative means for early detection and accessible treatment are critical in addressing those behavioral health conditions that may contribute to suicide.

a. Looking Ahead at FY 2010

Although this report is scoped through FY 2009, FY 2010 data indicate suicides continue to increase. While active duty suicides are at a comparable rate to the FY 2009 total (i.e., 120 through 3rd QTR versus 160 in FY 2009), the rate of suicides among non-mobilized RC Soldiers has increased. Statistics reflect a shift in demographics with 84 non-mobilized RC Soldier suicides thru 30 June. So while the overall total to date is approximately the same as last year, non-mobilized RC Soldier suicides have already surpassed FY 2008 and 2009 numbers (61 and 79 respectively).

Of the 120 active duty suicides thru 30 June 2010, 59% (71) involved Soldiers within their first five years of service. Of these 71, 96% (68) involved Soldiers who never deployed or deployed just once. Additionally, active duty suicide attempt data are consistent with the FY 2009 total. During the first two quarters of FY 2010, 787 active duty Soldiers, or 46% of the FY 2009 total, attempted suicide.

Suicide prevention, regardless of component, is a daunting challenge for leadership. However, early recognition of legal, medical and disciplinary risk factors, and subsequent intervention, afford unit leaders the best opportunity to shape positive outcomes.

Next: The Lost Art of Leadership in Garrison

III – The Lost Art of Leadership in Garrison

“[We must] maintain our combat edge at an appropriate tempo while re-establishing garrison systems for an ARFORGEN Model.”

– GEN George Casey, Chief of Staff, Army
Army Training and Leader Development Conference, 13 July 2010

Quote 6 – GEN George Casey, 13 Jul 10

1. Introduction

In calendar year (CY) 2008, the number of Army suicides surpassed historical civilian averages for the first time since the Army began keeping suicide statistics in the early 1980s. By the end of the year, 140 Soldiers had taken their lives and the Army suicide rate had surpassed 19.4 suicides per 100,000. The Army realized too late that there was a very serious problem. To take the pulse of the force, the Vice Chief of Staff of the Army (VCSA) led a team on a tour of camps, posts and stations. This section confirms the team’s initial findings, conclusions and recommendations which were briefed to the Secretary of the Army (SecArmy) in March 2009.

Looking across the Army, the VCSA’s team found that there appeared to be an overall increase in high risk behavior. The Army’s HP/RR/SP programs were fragmented and unbalanced and leader accountability had atrophied. There were too many gaps and seams in programs and processes that allowed high risk behavior to continue undetected and seemingly unchecked.

To maintain situational awareness, the VCSA received monthly briefs regarding the facts of every suicide within the Army. That trip and these briefings revealed that the Soldiers who ultimately take their lives have typically been engaging in high risk behavior long before their tragic end. Senior Army leaders intuitively recognized the problem was the result of atrophied garrison leadership skills. (For more information on the VCSA’s trip report see Section V, “*The Army Suicide Prevention Campaign*, starting at page 111.)

In the context of this section/report, leadership refers to the garrison community (post, camps and stations) comprised of commanders, staffs and program/service providers; both military and civilian.⁵⁴ Leadership must rely on the communication, collaboration and experience of this full range of leaders to provide situational awareness and inform decisions regarding mitigation of environmental risk and individual high risk behavior. For example, an incident of drug abuse requires the commander, ASAP service providers, medical service providers, law enforcement and judge advocates working together to resolve both the incident and the broader implications of potential trends.

⁵⁴ The term “garrison” is used in the traditional sense to reflect military activities at home station rather than in forward deployed theaters. The garrison environment includes the activities of all units, staffs, and agencies while at home station.

This section amplifies the trip's initial findings. Illicit drug use surveillance and detection systems are inadequate (e.g., over 1,318 Soldiers who had failed multiple drug tests (two or more) are still serving). Prescription drug use is on the rise with over one third of the force on prescription medication; for example, 14% of the force is taking some form of opiate medication.⁵⁵ Gaps in current process and systems are masking potential illicit drug use. To make matters worse, not all Soldiers are being tested for drug use. Of those who test positive, not all are being referred for evaluation or treatment. As outlined in this section, the potential climate for abuse is obvious.

Also, crime is on the rise and discipline is seemingly going unchecked. In fact, approximately 1,054 Soldiers who have committed two or more felony offenses are still serving in the Army today.⁵⁶ Systems designed to collect data on all of these issues are not synchronized and as a result do not inform leaders. Additionally, there are gaps in the Army's reporting, investigation, referral, discipline and separation policies.

This section discusses the gaps in the Army's surveillance, detection and intervention process and systems. It confirms leaders have lost situational awareness; signs and symptoms are being ignored, Soldiers are taking more and more risks, and gaps in policies are allowing it to happen. Ultimately, it poses the question: "Where has the Army's leadership in garrison gone?"

a. Leading a High Risk Population

Leadership in a garrison environment requires seasoned leaders who understand and enforce Army policies. Seasoned leaders recognize the importance of professional development; demand good order and discipline; recognize the need for risk reduction; and value Soldier and Family wellbeing. Correspondingly, most individual policies, processes and programs are designed to provide commanders with a certain amount of flexibility and discretion so that they may execute these leadership duties. Today's operational tempo, however, has eroded the technical skills and experiential knowledge needed to lead and manage effectively in the garrison environment.

The Army has unintentionally limited garrison leadership and management requirements (e.g., Professional Military Education (PME) curricula) by emphasizing combat, technical and tactical training. Time and unit resources are now focused on reset, readiness cycles, and pre-deployment preparation. These activities have tipped the balance from institutional readiness, measured by Soldier/Family wellbeing and unit good order and discipline in garrison, to combat readiness, as measured by ARFORGEN and tactical skill in theater.

A type of duality has been created in garrison. While Army Transformation resulted in the creation of Installation Management Command (IMCOM) and the standard garrison organization, it effectively resulted in the decoupling of field commands from garrison management. While such separation left commanders of combat formations unencumbered by many of their former garrison responsibilities, it also severed many formal and informal linkages between garrisons and units.

⁵⁵ OTSG briefing to the VCSA, "Prescription Drug Use and Management," 30 March 2010.

⁵⁶ For the purpose of this study, Soldiers referenced in conjunction with crime statistics were the subjects of founded misdemeanor or felony offenses. It is unknown whether commanders or civilian courts adjudicated these offenses. The determination that a founded offense exists is made by law enforcement personnel based on probable cause on review of the totality of the circumstances. It is not dependent upon judicial decision.

For the most part, units and Soldiers have become transient tenants of garrisons. They come and go in formations, groups and as individuals while they mobilize/demobilize, deploy/redeploy, serve under Worldwide Individual Augmentation System (WIAS), Permanent Change of Station (PCS) or travel under Temporary Duty (TDY). They are no longer linked to garrisons by a chain of command or senior commander but are regulated only by Army policies, programs and processes. This has created new requirements for garrison and unit commanders to work in tandem to provide visibility and accountability of formations and Soldiers on the constant move.

“The entire IMCOM command is devising a collective strategy to help the garrison commanders and their staffs do the very best they can to support the senior commander...”

– LTG Rick Lynch, IMCOM Commander
ARNEWS, Heidelberg GE, 11 March 2010

Quote 7 – LTG Rick Lynch, 11 Mar 10

The separation of command and garrison management responsibilities has, in a large part, served the Army well. Through the extraordinary and dedicated efforts of garrison command and staff along with unit commanders, deploying units have been able to maintain a demanding and protracted expeditionary focus. However, with change comes unexpected costs. The combination of Army transformation coupled with prolonged, recurring combat rotational requirements has resulted in young and mid-level leaders whose only command experience is meeting the demands of the deployment-to-combat-to-redeployment cycle.

While our commanders and subordinate leaders are phenomenal warriors, they are unaccustomed to taking care of Soldiers in a garrison environment. Value of and appreciation for good order and discipline practices such as unannounced health and welfare checks in the barracks accompanied by Military Police Working Dog sweeps, unannounced 100% urinalysis tests, privately owned vehicle (POV)/motorcycle safety inspections, counseling, ceremonies and accountability formations have been lost. There are instances where a leader’s lack of Soldier accountability resulted in suicide victims not being found until they had been dead for three or four weeks. In an organization that prides itself on never leaving a Soldier behind, this sobering example speaks to the breakdown of leadership in garrison, which appears to be worsening as the requirements of prolonged conflict slowly erode the essential attributes that have defined the Army for generations.

TRANSITIONS

A 33 year old Sergeant First Class with three deployments was described as relaxed and easy going by unit members. He had been slated to attend Drill Sergeant School at Fort Jackson. Around this time, his friends noted that he started drinking more than usual. He told them he had nightmares about OIF and that he slept with a gun under his pillow. His First Sergeant later reported that the Sergeant First Class was depressed about his friends leaving the unit and he was not happy about going to Drill Sergeant School.

On 13 February, the Sergeant First Class was released from his unit to attend Drill Sergeant School. One month later, his unit received a call from his landlord stating that he had not paid his rent. The unit attempted to contact him at Drill Sergeant School and found that he never arrived. The next day he was found in his bed with a gunshot wound to his head and a pistol in his right hand. He had been dead for approximately five weeks.

- Transitions can be particularly stressful; in-transit accountability and integration are essential to mitigating transitional stress.

Vignette 7 – Transitions

CONCLUSIONS

- ★ The Army's professional development priorities and operational tempo have eroded the technical skills, communication skills and experiential knowledge needed to lead/manage effectively in the garrison environment. (page 36)
- ★ Army Transformation and the creation of IMCOM have resulted in the decoupling of field commands from garrison management creating a permissive environment for high risk behavior. (page 36)
- ★ The demands of a protracted conflict have created a transient population with units and Soldiers on a constant move. Confused roles and responsibilities coupled with a loss of situational awareness have eroded accountability in the force. (page 37)

RECOMMENDED ACTIONS

- ★ [TRADOC/IMCOM] Ensure PME, pre-command course (PCC) and local CDR/1SG courses provide leaders with the requisite skills to mitigate the challenges of leading Soldiers in garrison.
- ★ [AII] Implement integration and reintegration programs at garrisons and units to ensure reception, integration and accountability of Soldiers and Families. Place special emphasis on the integration of young leaders and first term Soldiers.
- ★ [CDRs] Implement programs to ensure accountability and discipline in the barracks including clear policies, non-commissioned officer (NCO) supervision and charge of quarters.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 9 – Leading a High Risk Population**b. Creating and Sustaining a High Risk Population: A Cautionary Tale**

Army service may attract those who are predisposed towards risk-taking. A protracted engagement in OEF/OIF has only exacerbated this phenomenon. Soldiers enlist fully knowing that they will serve in a combat zone. In fact, Soldiers who deploy may even be more comfortable accepting high levels of risk and uncertainty in their lives. Consequently, good order and discipline are necessary to regulate a population inherently attracted to risk and maintain normal standards of behavior.

The Army regulates good order and discipline through enforcement of statutes (e.g., Uniform Code of Military Justice (UCMJ)) and policy. While statutes and policy define appropriate conduct, process and programs implement surveillance, detection and intervention as a means to address misconduct. Misconduct represents a conscious decision to accept both the risk associated with the prohibited activity (e.g., riding a motorcycle without a helmet), and the risk of being caught while violating the behavioral standard (e.g., the Army's helmet policy). When Soldiers are caught violating standards, the Army may identify them as "high risk." Emerging patterns of high risk behaviors among Soldiers define data requirements that necessitate the development and maintenance of official databases. Behavior not formally identified as high risk is unlikely to be tracked by specific databases.⁵⁷ Therefore, this report section is limited to currently available databases to draw conclusions about an increasing number of high risk Soldiers.

⁵⁷ Huffing, lack of seatbelt/helmet use and texting while driving, once unregulated and unmonitored, are examples of high risk behavior that the Army now prohibits and therefore monitors and tracks via its law enforcement databases.

consequences. The center, in blue, represents suicides and high risk deaths. The model is analogous to a maze; each subsequent passage adding complexity and increasing potential severity of behavioral consequences. Escape from the maze will generally require help-seeking behavior and/or leader intervention to arrest the spiral toward the center.

It is often said that the Army is a “microcosm of society.” In an era of an all-volunteer Army however this is not exactly true. The demographics of the Army do not realistically reflect the society as a whole. While it is true that individuals in the Army are not immune to overall societal pressures and influences, we should be cognizant of the individuals who now “self select” and drive the makeup of the all-volunteer Army.⁵⁸ To ensure the Army embodies fundamental standards, there are enlistment, retention and separation criteria designed to shape the composition of the force. These criteria are communicated and set by policy based on clear standards of conduct. By not fully complying with established policy, commanders are in fact communicating to their troops that Army standards of conduct are less important in the scope of the overall mission.

When standards slip, we begin to see dangerous trends in behavior. However, by enforcing policy in a fair, judicious, and equitable manner, leaders can once again determine what kind of culture the Army is building. This refinement is accomplished through selective enlistment, retention and separation, as well as the second order effects of those practices (e.g., deterrence of risky behavior, etc.). This section will demonstrate that we are creating and sustaining a high risk population that is a subset of the Army population. Several factors including an increase in enlistment waivers (e.g., misconduct) combined with a decrease in separations have led to a small cohort that may be more likely to abuse drugs and alcohol while engaging in increased levels of high risk and criminal activity.

LOST IN THE MAZE

A 28-year-old Private First Class with 4 years in the Army was separated from his wife. He deployed twice and had a history of suicidal gestures. He was assigned to a Warrior Transition Unit (WTU) and received treatment for Post Traumatic Stress Disorder (PTSD). He had previously attempted to kill his wife and himself. He was under investigation for testing positive twice for marijuana. The Private also had financial difficulties and had recently lost his home and car. On his Post-Deployment Health Reassessment (PDHRA), he reported having days with “little interest or pleasure in doing things.” His health care provider noted depression symptoms and referred him to behavioral health. He was also awaiting results of a Phase II Medical Board. His best friend had moved away, and he stopped talking to his chain of command. He was command referred to mental health where he was diagnosed with a personality disorder and deep depression. His medications included trazodone (sleeping pills), Paxil (anti-depression), cyclobenzaprine (muscle relaxer), prazosin (high blood pressure) and oxycodone (pain relief). He had suicidal ideations daily with several plans developed to take his own life. The Private threw away his possessions and euthanized his pet. On the day he failed to report for duty, a suicide note was found in his room. Four days later, the Private was found dead from an apparent self-inflicted gunshot wound to the head.

- It is essential to identify and recognize indicators of stress/high risk behavior for early intervention and treatment.

Vignette 8 – Lost in the Maze

⁵⁸ The all-volunteer Army attracts and recruits individuals who enlist knowing they will be sent into harm’s way. A segment of this population is not only aware of the risk but may be attracted to risk-taking behavior.

Unchecked risky behavior favors a dangerous outcome. Until Soldiers recognize that risky or criminal behavior puts them at risk for an adverse and sometimes lethal consequence, they may continue to push the envelope until it's too late (see Figure 12). Of the non-combat Soldier deaths from FY 2006 – FY 2009, 1,058 were investigated by the U.S. Army Criminal Investigation [Division] Command (CID); this excludes traffic fatalities and natural deaths. Of these, 916 (87%) were the direct result of high risk behavior (i.e., murder, suicide, accidents or of an undetermined manner). Of these 916 high risk behavior deaths, nearly half (417 or 46%) involved drugs or alcohol use at the time of death. Of these, 188 were solely due to drug or alcohol overdoses. This section provides disturbing statistics that will command a review of disciplinary and administrative actions across the Army.

The following statistics were pulled from the pages of this section as a sample of some of the analyses and conclusions regarding high risk behavior. These statistics clearly indicate that if the Army doesn't change high risk personal behavior in its ranks, next year will only be worse.

- Suicide and High Risk Deaths:
 - In FY 2009, the Army had 306 high risk deaths; 160 were suicides, 87 were accidental and undetermined fatalities stemming from high risk behavior, and 59 involved murder. (page 39) (Figure 12)
 - Drug/alcohol toxicity was the cause of death in 45% of all cases involving drugs and alcohol. (page 45)
 - From FY 2005 to FY 2009, 29% of the suicides involved alcohol or drugs (page 43); 47% of accidental or undetermined deaths involved multiple drug toxicity (i.e., overdose). (page 56)
- High Risk Behavior:
 - In FY 2009, 1,713 Soldiers attempted suicide; many of these attempted suicides were saved due to timely buddy/leader and medical intervention. (page 71)
 - Since FY 2004, misdemeanor cases have been on the rise by almost 5,000 per year. This means that in FY 2010 we can expect almost 55,000. (page 72)
 - There were 64,022 felony and death investigations from FY 2001 – FY 2009; 72% were drug related. (page 73)
 - If the rate of THC (marijuana) positives over the last 4 years continues, it is predicted that over 7,500 National Guard Soldiers will test positive for THC in FY 2010. (page 78)
 - CID estimates that 60% of all sexual offenses involved drug/alcohol use by subject and/or victim. (page 79)
- Disciplinary and Administrative Actions:
 - Disciplinary and reporting shortfalls by commanders, law enforcement and program/service managers create an unknown gap in visibility of criminal activity. (page 47)
 - 36% (78,410) of DA Forms 4833 (Commander's Report of Disciplinary or Administrative Action) were not completed from FY 2004 – FY 2009, leaving misconduct untracked in law enforcement databases. (page 59)
 - A decline in administrative separations since FY 2001 has increased the high risk population. An estimated 25,283 Soldiers who would have otherwise been separated in previous years, remained in the ranks. (page 68)
 - Only 70% of DUIs and 61% of positive urinalyses (UAs) from FY 2001 – FY 2009 resulted in Army Substance Abuse Program (ASAP) referrals. (page 70)
 - Retention of multiple drug offenders erodes readiness; 3,000 Soldiers are expected to test positive for the second or third time next year. (page 84)

- Drug Testing:
 - In FY 2009, 21% of 8,000 UA samples that tested positive for prescription drugs were found to be illicit use. (page 43)
 - 78,517 Soldiers were not tested for drugs in FY 2009, leaving a likely 1,311 offenders undetected (page 51)
 - Based on the average percent of illegally used pharmaceuticals from FY 2001 – FY 2009, the 5,505 drug positive cases that were never reviewed could have equated to approximately 2,004 Soldiers who were illicitly using pharmaceuticals. (page 54)
 - Prescription medication use continues to rise. Prescriptions issued with a "take as needed" label without an explicit termination date can harbor illegal use and distribution. (page 82)

The information presented here was not easy to collect and was not provided to the Report Team in a form that made it easy to understand. These data had to be extracted from several disparate databases and were electronically distributed to the Report Team from a small number of individuals who control and release these data. There was no easy way to pull these data without the assistance of these individuals, which effectively creates an information bottleneck. When data are this inaccessible, it is no surprise that our leaders are not getting an accurate, timely, aggregate picture of the consequences of Soldiers' risky behavior. Without visibility at the HQDA level, it is difficult to recognize problems, and therefore to enforce standards and accountability or close gaps created by policy, structure and process. At the unit level, it is difficult to obtain situational awareness of Soldier behavior within the ranks. These factors point to a few interconnected themes: the loss of enterprise visibility due to a lack of data integration, reduced accountability for policy/process execution and an aversion to making often difficult decisions regarding program/Soldier management, funding and disciplinary/administrative actions. When taken as a whole, these factors enable high risk behavior within the Army population.

By necessity, this report used data derived from criminal databases to make associations to high risk behavior (e.g., criminal and drug databases). These data were cross checked with personnel and medical databases during the Report Team's analysis to formulate conclusions and recommendations. Those who engage in some types of high risk behavior (e.g., financial irresponsibility, sexual promiscuity and other legal but risky behaviors) that has not lead to criminal charges/titling were not counted in these data. Therefore, the population reviewed/analyzed represents a subset of the overall at-risk population. Although this population is not large, it represents a significant number within the force. Data provided on at-risk behavior (including positive drug and alcohol abuse), informed the at-risk model [Maze] but the model can be applied to any set of behaviors.

CONCLUSIONS

- ★ The composition of the Army does not realistically reflect the society as a whole; individuals who "self select" during persistent conflict drive the makeup of the all-volunteer Army. (page 40)
- ★ By enforcing policy in a fair, judicious and equitable manner, leaders can determine Army culture through selective enlistment, retention and separation. (page 40)
- ★ There were 1,058 non-combat Soldier deaths investigated by CID from FY 2006 to FY 2009:
 - 916 deaths were the direct result of high risk behavior including murder, suicide, accidents or of an undetermined manner.
 - Of the 916 deaths, 417 involved drugs or alcohol use at the time of death.
 - 188 were the result of drug or alcohol overdose. (page 41)

(Continued)

- ★ Report data had to be extracted from several disparate databases from a small number of individuals who control and release these data. (page 42)
- ★ An increase in high risk behavior was caused by the loss of enterprise visibility due to a lack of data integration, reduced accountability for policy execution and an aversion to making often difficult decisions. (pages 42)

RECOMMENDED ACTIONS

- ★ [HQDA] Research the relationship between the “self selection” bias and the propensity to engage in high risk behavior to inform policy governing good order and discipline.
- ★ [HQDA] Use the “Maze Model” to inform senior leaders at Star Conferences, PCCs, etc., as part of HP/RR/SP awareness education and training.
- ★ [HQDA] Design integrated databases to account for Soldiers exhibiting high risk behavior to narrow gaps in the Army’s reporting, investigation, referral, discipline and separation policies.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 10 – Creating and Sustaining a High Risk Population

c. Surveilling, Detecting, Reporting and Disciplining a High Risk Population

The following portions of this section cover surveillance, detection, reporting, action and outcomes of risk-taking and high risk behavior. While the construct of *surveillance, detection, reporting and action* informs recommendations which result from the analysis of high risk behavior data, this construct is exportable to any set of behaviors that impact health promotion and risk reduction. Our examination of risky behavior metrics strongly corroborates an increase in criminal and drug activity over the last five years. These activities not only affect the individuals who perpetrate the crimes, but also send a ripple effect throughout the force. These actions affect all those who come in contact with these individuals including their battle buddies, Families and the victims of their crimes. As these ripples spread, they contribute to high risk related outcomes such as suicide, homicide, accidental or undetermined deaths. This transference of effects compounds reduction in readiness and contributes to an overall erosion of Army values.

Data collected since FY 2005 consistently show that approximately 29% of suicides included either drug or alcohol use. In addition, 25% of suicide victims were subject to some closed or pending criminal investigation.⁵⁹ However, these numbers may be underreported because overall reporting of misconduct to law enforcement is on the decline. This phenomenon creates a widening gap between the extent of high risk behavior and leaders’ situational awareness, which permits a high risk population of individuals to move undetected through the ranks. For example, in FY 2009 alone, 15,074 cases of Soldier misconduct reported by law enforcement to the Soldiers’ unit commanders cannot be linked to any known disciplinary or corrective action. This disconnect arose because unit commanders either did not receive or failed to return completed DA Forms 4833 (Commander’s Report of Disciplinary or Administrative Action) to law enforcement.

⁵⁹These data are consistent with recent CHPPM findings. Epidemiological Report No. 14-HK-0BW9-10c, *Analyses of Army Suicides, 2003 – 2009*, 29 April 2010.

These data further reveal that drug use and criminal behavior is on the rise. While abuse of illegal drugs appears to have remained stable over the last five years, the use of approved prescription drugs has increased dramatically. This trend is based on the number of pharmaceutical positives that must be reviewed by a physician to determine legal use, which has more than tripled over the last five years (up to 8,390/year vs. 2,693/year, see Table 23, Annex E, Medical Review Officer (MRO) Evaluations: (Un)Resolved/(Un)Authorized Use, FY 2001 – 2009 Data). Current policies do not address this increase in pharmaceutical use. Last year over 8,000 samples tested positive for a MRO reviewable drug. Of these, 21% were found to be illicit use.⁶⁰ Knowing that some drugs (i.e., oxycodone, oxymorphone, codeine, and morphine) are only tested on a rotational basis (i.e., only tested 20% of the time), the real number of overall prescription positives may have been closer to 30,401 with 3,925 being illicit use.

The true extent of these last two numbers is unknown due to gaps in our testing policies. There is concern that potential prescription drug abuse is masked in our current system. This is the result of the increase in prescriptions which expands the population authorized to use pharmaceuticals. For example, the growing population who has obtained prescriptions for amphetamines has resulted in an increased rate of authorized use. Unfortunately, there is no definitive method to ascertain if the use was authorized or illicit. As a result, we have masked a subset of that population who are either dependent or illicitly use drugs. Ultimately, if left unchecked, this gap facilitates a population of drug addicts and distributors.

Vignette 9 – Warrior Transition Units

WTUs: INADEQUATE SURVEILLANCE/DETECTION OF PRESCRIPTION DRUG ABUSE ENABLES EXPANSION OF THE HIGH RISK POPULATION

Warrior Transition Units (WTUs) provide primary care and case management for injured and ill Soldiers, establish conditions for healing and promote either timely return to duty or transition to civilian life. WTUs are unique in that they are comprised entirely of Soldiers undergoing medical treatment. These Warriors can be considered at-risk – almost all Soldiers in WTUs populate one or more of the outer rings in the “Army Population at Risk” maze shown in Figure 12. The prevalence of illicit drug use in WTUs is illustrative of this risk. Illicit drug use during FY 2009 within the seven WTUs surveyed for this report were 2.9 times the FY 2009 overall Army average; of the 5,385 WTU Warriors tested for drugs, 4.8% were positive, compared to the overall Army average of 1.67%.⁶¹

The prescription of opiate, antidepressant and anti-anxiety drugs is an important aspect of treatment provided to WTU Soldiers. The use of these medications is legitimate when they are taken in compliance with medical direction. When these drugs are used illicitly, however, Army policy requires that offenders be referred for counseling and disciplinary action as appropriate. The enforcement of these standards has been made problematic because of inadequate detection systems. The high number of WTU Soldiers on medication compounds this problem and increases the opportunities for abuse.

There are three key gaps in Army policy with regard to detecting potential prescription drug abuse. First, the Medical Review Officer (MRO) will excuse a positive urinalysis for a drug if the Soldier has a prescription for the drug, regardless of the date of prescription. Data surveyed from

⁶⁰ Illicit = street drugs plus unauthorized prescription use.

⁶¹ FY 2009 data from the WTU at Walter Reed Army Medical Center, Joint Base Lewis-McChord and Forts Bliss, Bragg, Campbell, Carson and Hood were reviewed for this report. The rate of illicit drug use by WTU cadre during FY 2009 was 0.54%, less than one-third of the overall Army rate.

**WTUs: INADEQUATE SURVEILLANCE/DETECTION OF PRESCRIPTION DRUG ABUSE
ENABLES EXPANSION OF THE HIGH RISK POPULATION**

seven WTUs indicated that the MRO “clearance rate” (the percentage of excused positive tests) for Warriors was 90% during CY 2009.⁶² Second, levels of drugs found by urinalysis tests do not utilize specific concentrations other than to confirm the existence of the drug. This is important because it prevents the MRO from determining if the Soldier was using the drug for therapeutic reasons, since the samples of substance abusers would reveal much higher levels. Finally, the percentage of Soldiers in WTUs that are actually tested is unknown, which prevents an accurate determination of the magnitude of the drug problem.

WTU leadership recognized these issues and took several affirmative steps to combat prescription drug abuse; including limiting the length and quantity of medication dispensed per prescription and requiring that Warriors receive their prescriptions from a single provider. While these measures serve to mitigate the problem, the gaps in detection systems “mask” the full extent of potential illicit prescription drug use in WTUs. Current data cannot show prescription drug abuse of Soldiers who have expired prescriptions for the drug or are taking the drug in excess of prescribed amounts. The effects of these detection gaps, together with the failure to test any Soldiers in a significant portion of WTUs, prevent WTU Commanders from effectively managing their at-risk populations.

One sobering fact uncovered by the Report Team is that 45% of accidental or undetermined deaths (188/417) over the last four years were caused by drug or alcohol toxicity (i.e., overdose). While pharmaceutical drugs are the smallest category of illegally used drugs, they are more lethal than street drugs. If use trends continue to rise at a rate of 24% per year (based on MRO review data), we can expect over 170 prescription drug deaths in FY 2010. Compounding this issue, pharmaceutical drugs are becoming more available to the general Soldier population. Currently, 76,463 Soldiers or 14% of the entire Army population are prescribed some form of opiate.

As we continue to wage war on several fronts, data would suggest we are becoming more dependent on pharmaceuticals to sustain the force. In fact, anecdotal information suggests that the force is becoming increasingly dependent on both legal and illegal drugs. This section examines these assumptions from both a medical and legal standpoint and identifies several interesting trends affecting the force.

It is unfortunate that it has taken record levels of suicides within the Army to initiate an HP/RR/SP enterprise-wide examination of behavioral trends, which may be degrading overall health promotion and risk reduction. It is disconcerting that commanders at all levels cannot easily retrieve specific data to shape their analysis and subsequent mitigation of trends. As trends shift, it is up to commanders, leaders and program/service providers to adjust efforts accordingly to optimize the health of the force. The recognition of trends depends on identification of those actions that are precursors to risky behavior. This recognition begins with surveillance.

⁶² 515 of the 572 Warrior samples that were positive for opiates/antidepressants/antianxiety drugs were cleared by an MRO. The clearance rate for cadre was similar (93% - 65 of 70).

CONCLUSIONS

- ★ An increase in the high risk population is strongly supported by an overall increase in criminal and drug activity over the last five years. (page 43)
- ★ Behavior of the high risk population transfers risk to the population at large. (page 43)
- ★ Approximately 29% of suicides since FY 2005 included either drug or alcohol use. In addition, 25% were subjects of prior misdemeanor or felony investigations. (page 43)
- ★ In FY 2009 alone, 15,074 cases of Soldier misconduct cannot be linked to any known disciplinary or corrective actions taken or recorded in law enforcement data. (page 43)
- ★ An increase in the number of prescriptions leads to potential masking of both drug addiction and distribution. (page 44)
- ★ Inadequate surveillance/detection of prescription drug abuse enables an increase in the high risk population. (page 44)

RECOMMENDED ACTIONS

- ★ [HQDA] Require completion of DA Forms 4833 (including the 15,074 delinquent forms) to document critical information in law enforcement databases and provide Army-wide visibility of the high risk population.
- ★ [HQDA] Revise policy to limit authorized use of prescription medication to one year after prescription issuance. For example, a Soldier with a prescription written in FY 2006 who tests positive for that drug in FY 2009 would not be medically cleared for authorized use.
- ★ [HQDA] Periodically evaluate WTU Soldiers who test positive for pharmaceutical drugs to determine potential abuse/dependence.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 11 – Surveilling, Detecting, Reporting and Disciplining

2. Surveillance of Drug, Alcohol and Criminal Activity

There is no other aspect of HP/RR/SP that is more important for preventing negative outcomes than the vigilance of the individual commander, supervisor, Soldier, law enforcement agent or program/service provider. Leaders, supervisors, and “Buddies” represent the first level for surveillance of high risk behavior. A large percentage of Army programs rely on “Battle Buddies” to act as the first line of defense against individual activities that may result in harm to the individual Soldier, Family or others. In order to ensure risk reduction, high risk behavior must first be recognized across the Army. For the individual and leader, this means using Army HP/RR/SP programs to be able to understand how to recognize high risk behavior (for more information on HP/RR/SP programs see the section *Managing the HP/RR/SP Program Portfolio* starting on page 161). Surveillance focused on awareness of potential problems is the first step in a series of steps that lead to risk reduction and health promotion.

While responsibility to recognize high risk behavior falls on the shoulders of every Soldier, leader, member of law enforcement and surveillance program manager (ASAP, Family Advocacy Program (FAP), Sexual Harassment/Assault Response and Prevention (SHARP), etc.), they all have a specific duty to take action in response to that high risk behavior. This includes investigations and inquiries into alleged criminal activity and disciplinary infractions. Surveillance and detection of high risk behavior is predominantly executed through the investigation of disciplinary infractions, misdemeanor crimes, felony crimes and illegal drug use.

a. Commanders (Disciplinary Infractions)

Commanders have primary responsibility for maintaining good order and discipline. The UCMJ, policy and other legal sources authorize commanders broad discretion to handle crimes and misconduct committed by their subordinates. For example, the disposition of minor disciplinary infractions (e.g., theft of property less than \$1,500 and simple assault) is left to the judgment of the unit commander. However, commanders must have an accurate composite view of the Soldier (prior misconduct, prior adjudication, program referrals/completion, etc.) to appropriately exercise their discretion. To that end, commanders may initiate an AR 15-6 investigation to determine the relevant facts of the case to discipline the Soldier as appropriate.⁶³ If the commander determines a more serious crime has been committed, it must be referred to either the provost marshal or CID for investigation.

The commander should weigh the outcome of the AR 15-6 investigation in the totality of the composite view of the Soldier to determine appropriate disciplinary and administrative action. Unfortunately, the results of the AR 15-6 investigation are only filed locally and therefore potentially unavailable to subsequent commanders. Given the transient nature of both Soldiers and commanders, this lack of centralized data tends to mask recurring or potentially escalating infractions committed by an individual. If there is any disciplinary action taken, it is not recorded in any official database unless the disciplinary action results in a command initiated DA Form 4833 or is reflected in the Soldier's permanent record (e.g., letter of reprimand, reduction in rank, etc.). Consequently, commanders lack visibility of information revealed by any earlier investigations/adjudication to weigh the risk and make an informed decision regarding Soldier disposition (discipline/separation).

b. Law Enforcement

(1) Provost Marshal – Misdemeanor Crimes

The provost marshal conducts investigations for most misdemeanor crimes and incidents, in accordance with AR 190-45⁶⁴ and AR 190-30.⁶⁵ Misdemeanor crimes are defined as those crimes with confinement of one year or less and as defined by AR 195-2.⁶⁶ They include driving under the influence, larceny, destruction of private property and simple assault.⁶⁷ All investigations are reported using a Military Police Report (MPR) and these data are entered into the Centralized Operations Police Suite (COPS). The investigative findings are sent via the DA Form 4833 to the commander, who reviews the case and decides on disciplinary action based on the case findings. The DA Form 4833 is then returned so the disposition of the offender and action taken can be entered into COPS. Unless the commander returns the DA Form 4833, there is no record of any disciplinary action taken as a result of the offense. (The COPS database was fielded in FY 2004; therefore, statistics in this report for provost marshal investigated offenses reflect data from FY 2004 – FY 2009.)

⁶³ AR 15-6, *Procedures for Investigating Officers and Boards of Officers*.

⁶⁴ AR 190-45, *Law Enforcement Reporting*.

⁶⁵ AR 190-30, *Military Police Investigations*.

⁶⁶ AR 195-2, *Criminal Investigation Activities*.

⁶⁷ Some crimes range from misdemeanor to felony depending on the severity (i.e., dollar amount or level of personal injury).

(2) CID – Felony Crimes

The United States Army Criminal Investigation [Division] Command (CID) is the sole agency within the U.S. Army responsible for the criminal investigation of felony crimes (offenses punishable by death or confinement for more than one year) in accordance with AR 190-45 and AR 195-2. CID investigates all non-combat Soldier deaths to determine whether criminality was involved (homicide, suicide, accident, natural death); use, possession, manufacture, or distribution of controlled substances; aggravated assaults resulting in hospitalization for more than 24 hours and sexual assaults.⁶⁸ CID uses Reports of Investigation (ROIs) to report the findings of investigations. Data from the ROIs are placed into the Automated Criminal Investigative and Intelligence System (ACI2). Again, the facts of the case are relayed to commanders using DA Form 4833. As is the case with misdemeanor offenses, unless the DA Form 4833 is returned, there is no record on file of final disciplinary action. (Statistics in this report derived from ACI2 reflect FY 2001 – FY 2009 data. In some cases, files were manually reviewed. Those cases manually reviewed cover either FY 2006 – FY 2009 or, in some data sets, FY 2009).

c. Surveillance Program Managers

(1) ASAP – Illicit Drug Use

ASAP is responsible for random drug testing of Soldiers on active duty. In accordance with AR 600-85, ASAP's mission is to strengthen the overall fitness and effectiveness of the Army's workforce, to conserve manpower and enhance the combat readiness of Soldiers by ensuring a drug free environment.⁶⁹ ASAP provides commanders with a mechanism for testing and treating those who have been identified as drug or alcohol abusers/dependent. While DoD mandates a minimum rate of testing of one random sample per active duty member each year, Army has no implementing guidance for this standard.⁷⁰ (Although AR 600-85 does not explicitly mandate testing 100% of unit strength, it may imply this standard in paragraph 4-23a, "Commanders will maintain enough testing supplies on hand to test 100% of their unit strength".) Any illegal drug use (street drugs or unauthorized pharmaceutical drug use) is entered into the Drug and Alcohol Management Information System (DAMIS) database for reporting purposes. This report will demonstrate that it is essential that ASAP findings (drug test positives) be coordinated with the unit commander, provost marshal and CID to ensure equity in treatment, discipline and administrative actions (e.g., separations) across the force.

This report identifies specific gaps in drug surveillance. Not all Soldiers are being tested. In fact, over the past nine years the average testing rate was 87%, with a low of 82% in FY 2008 (see Figure 14 on page 52). However, UA samples are only tested for select pharmaceutical drugs (oxycodone, oxymorphone, etc.) on a rotational basis (of less than 20% per year). Also, not all samples are being tested for pharmaceutical drugs with abuse potential. Finally, of the 42,028 prescription drugs positives that were submitted for review, 5,505 were never adjudicated. These gaps have allowed approximately 40,000 Soldiers to illicitly use drugs without being detected (see Table 6).

⁶⁸ CID does not investigate attended deaths; which are deaths as a result of illness or injury and attended by a medical care provider at a medical facility. Predominantly, accidental deaths resulting from high risk behavior (FY 2004 – FY 2009) stem from drug/alcohol overdose, traffic accidents involving alcohol, and accidental shootings.

⁶⁹ AR 600-85, *The Army Substance Abuse Program*.

⁷⁰ DoDD 1010.1 *Military Personnel Drug Abuse Testing Program*, 09 Dec 94.

Gap Source (Test or Test Deficiency)	Abusers Detected	Gap	Potential Abusers Missed	Known + Potential Abusers
MRO Finds Illicit Prescription Drug	6,926	20% (Sample Rate of Rotational Drugs)	14,330	21,256
Illicit Drug Positives	58,687	87% (Testing Rate)	19,957	78,644
Unauthorized MRO (Amp)	6,375	14% (Unresolved Rate)	3,506	9,881
Drug Panel Deficiency – Hydrocodone	0	Currently Not Tested	1,770	1,770
Totals:	71,988 Soldiers		39,563 Soldiers	111,551 Soldiers

Of the 2,218,661 Soldiers who could have been tested from FY 2001 through FY 2009, only 1,622,004 Soldiers (87%) were actually tested. This means there were potentially 25,855 Soldiers never identified by drug testing (1.38%) who were likely using drugs but were never seen or treated by ASAP.

Table 6 – Gaps in Drug Use Surveillance (FY01–FY09)

(2) FAP and SHARP – Other Surveillance

The Family Advocacy Program (FAP) leads the Army's efforts to prevent domestic violence, child abuse and neglect by providing a variety of services to strengthen Army Families and enhance resiliency. FAP provides a range of prevention programs to enhance individual, couple and Family functioning as well as to coordinate intervention and treatment. Soldiers involved in spouse or child abuse incidents should be referred to the clinical FAP for an assessment to determine the needs of the Family. Once an assessment is completed, a case will be referred to the Case Review Committee to determine if a case is substantiated or unsubstantiated for abuse and what training regimen can help mitigate the Family stressors. Substantiated cases of domestic violence and child abuse/neglect are reported in the Army Central Registry.

The Sexual Harassment/Assault Response and Prevention (SHARP) Program reinforces the Army's commitment to sexual assault prevention through a comprehensive policy that centers on awareness and prevention, training and education, victim advocacy, response, reporting and accountability. (For purposes of this report, SHARP data that correspond to criminal offenses are included in the Sexual Offenses section beginning on page 78.)

The programs mentioned above and outlined in the "Investigations and Reporting" section beginning on page 183, provide commanders, leaders and program/service providers with a means to recognize high risk behavior through surveillance. While surveillance is a constant activity, surveillance findings are of little value if they are not cross walked with other surveillance entities in order to recognize and detect trends in risky behavior.

CONCLUSIONS

- ★ There is no other aspect of HP/RR/SP that is more important for preventing negative outcomes than the vigilance of the individual commander, supervisor, Soldier, law enforcement agent or program/service provider. (page 46)
- ★ Commanders, leaders, Soldiers and program/service providers have a specific duty to take action in response to high risk behavior. (page 46)

(Continued)

- ★ Commanders lack visibility of information revealed by any earlier investigations/adjudication to weigh the risk and make an informed decision regarding Soldier disposition (discipline/separation). (page 47)
- ★ Gaps in ASAP potentially have allowed approximately 40,000 Soldiers to illicitly use drugs without being detected. (page 48)

RECOMMENDED ACTIONS

- ★ [CDRs] Ensure compliance with DA Form 4833 requirements to enhance situational awareness and the ability to track/trend high risk behavior. An accurate composite view of Soldier behavior (past and present) should be considered in weighing the risk and informing decisions regarding Soldier disposition (discipline/separation).
- ★ [HQDA] Develop and field a central database (compatible with law enforcement databases) for AR 15-6 investigations of disciplinary infractions in support of the recommendation above.
- ★ [HQDA] Revise policy to expedite urinalysis testing (on an expanded drug panel) of new/emerging pharmaceuticals with potential for abuse/dependence.
- ★ [HQDA] Revise policy to test all panel drugs at 100% rather than DoD directed 20% for some pharmaceuticals.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 12 – Commanders, Law Enforcement, and Surveillance Program Managers

3. Detection of High Risk Behavior

Surveillance of high risk behavior is meaningless unless there is a threshold for detection of potential harmful activity. Leaders establish standards within their unit and therefore set the tone and thresholds for behavioral tolerance. Effective leaders know where to draw the line, but once the line is crossed, there should be consequences. Some thresholds are already set by policy, taking some level of tolerance out of the commander's hands. This section describes the processes in place to detect potentially high risk behavior. It is the duty of every leader to understand the mechanisms in place that are designed to identify this behavior and prompt appropriate action.

a. Drug and Alcohol Detection

There are several ways that a Soldier who is using or abusing drugs/alcohol can be identified within the Army population. The commander may determine drug use based on random unit inspections, Soldier behavior or witness reporting. ASAP's random drug testing program provides detection based on UA and positive UA reporting. Additionally, law enforcement encounters as a result of public complaints, mutual law enforcement reporting, or criminal engagement will initiate an investigation into illicit drug activities. Investigations of single drug incidents routinely discover additional subjects due to the social nature of illicit drug use. In fact, 25% of 34,962 CID drug investigations between FY 2001 – FY 2009 included multiple subjects. In one case, 29 subjects were investigated by CID for one or more offenses of possession, use and distribution.

DRUG ABUSE AND DISCHARGE

A 26 year-old Specialist tested positive for cocaine in March 2002 and was reduced to Private First Class. He tested positive for cocaine again in August 2002 and for marijuana the following month. According to the DA Forms 4833, no action was taken on the latter two offenses because the Soldier was a fugitive. It is unknown if he was reported AWOL. The Soldier ETS'ed (expiration term of service) in February 2003. His DD Form 214 reflects an Honorable Discharge and a reentry code of "1" which characterized him as fully qualified for enlistment. He subsequently re-entered the Army in April 2005 and tested positive for cocaine in May and July 2007. Reduced to Private, he was separated for misconduct in October with an Under Honorable Conditions (General) Discharge.

- Surveillance and detection are essential to providing commanders with situational awareness and inform appropriate disciplinary and administrative actions.

Vignette 10 – Drug Abuse and Discharge

ASAP, as outlined in AR 600-85, routinely tests Soldiers on Active Duty to screen for illicit drug use. DAMIS data in Table 7 show that, while the overall percentage of the force that tested positive for illicit use over the previous nine years is low (at 3.53%), the total number is substantial at over 58,000. Of this population, the majority were first time offenders. What is remarkable is that 38% of those who tested positive had actually tested positive as a multiple offender (defined as two times) or a serial offender (defined as three or more times).

These data clearly indicate that if left in the force, Soldiers who illicitly use drugs will continue to use drugs.

Drug Testing Data (FY01–FY09)

Soldiers Tested	Soldiers Positive for Illicit Use	Soldiers 1 st Time Positive	Soldiers Multiple Positives	Soldier Serial Positives
1,662,004	58,687 (3.53%)	36,470 (62%)	11,828 (20%)	10,389 (18%)

Table 7 – Testing for Illegal Drug Use

Over the last nine years, the percent of individual Soldiers being tested per year has averaged 87%. This percentage has been dwindling each year since 2001, with the Army reaching only 85% testing coverage in FY 2009.

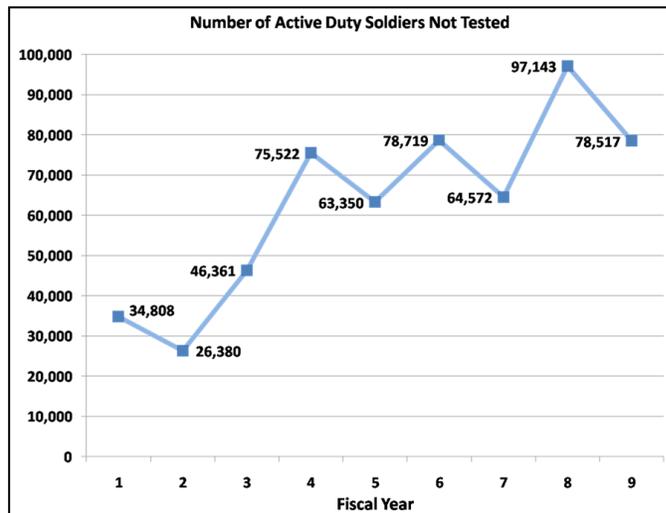


Figure 13 – Number of AD Soldiers Not Tested

As the force has grown, the number of samples taken per year has not adjusted accordingly. While this may seem like an insignificant number of individuals, examination of last year alone reveals that over 78,517 Soldiers were never tested which may have left 1,311 drug offenders undetected (see Figure 13).⁷¹

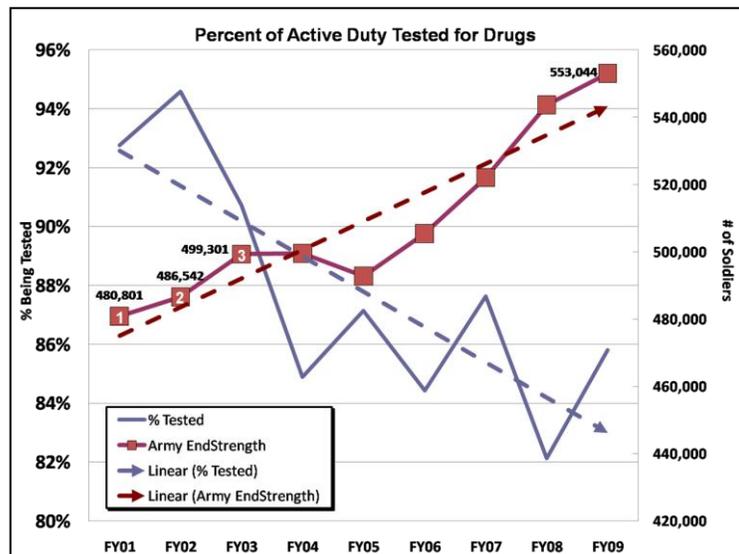
ASAP drug testing is designed to act as a deterrent by utilizing random drug testing which is intended to cover 100% of the unit end strength every year. This means the denominator is simply the unit's assigned strength and not the number of actual Soldiers tested nor the total number of

⁷¹ While the FY 2009 illicit drug use rate was 1.67%, the Report Team used the historic FY 2001 – FY 2009 illicit drug use rate of 3.53% to compensate for emerging gaps in ASAP surveillance of pharmaceutical drug use.

Soldiers who have passed through the unit as part of the transient population. This leads to an under sampling of transient and cross-leveled Soldiers, a phenomenon increasingly frequent with increased operational tempo. If a unit's assigned strength is 800 Soldiers, the battalion commander is only responsible for 800 UA samples per year and not samples from 800 unique Soldiers by SSN. For example, 112 Soldiers may not have been tested either because their SSN was not selected under the random sampling or because they transitioned quickly through the unit due to deployment, PCS, TDY and/or demobilization. In this example, this means that while a commander who provides 800 UA tests per year is in compliance with the ASAP regulation, in reality the unit UA coordinators only tested 86% of the troops in their unit that year. (Some individuals may be repeatedly tested leaving others not tested at all.)

A review of overall ASAP numbers per year vs. end strength, as shown in Figure 14, illustrates this issue. As of FY 2001, approximately 480,801 Soldiers served on Active Duty, as shown by point (1) in the Figure. In accordance with AR 600-85, all 480,801 Soldiers should have been tested. In fact, at that time, only 93% of the Soldiers (445,993) underwent UA. That left 34,808 Soldiers not tested during FY 2001. Presumably, a portion of those 34,808 Soldiers abused drugs during that time and escaped detection because they were not subjected to surveillance.

Similarly, at point (2) in the Figure, only 460,162 (95%) of the 486,542 Soldiers on Active Duty underwent testing in FY 2002, leaving 26,380 untested. Point (3) shows only 452,940 (91%) of the 499,301 Soldiers on Active Duty underwent testing in FY 2003, leaving 46,361 untested. From FY 2001 – FY 2009, 565,372 Soldiers were not tested in at least one of those years. This means if a Soldier was not tested in FY 2006 he would be counted once. If the same Soldier was not tested in FY 2006 and FY 2009, he would be counted twice.



The ASAP drug testing program is designed to randomly test the equivalent of 100% of the force per year. This standard is set only by the number of urinalyses performed, not by the number of individual Soldiers tested. An examination of testing rates using Soldier SSNs per year indicates not all Soldiers are being tested and the percent is decreasing. It is not known if this is due to the increase in overall end strength or the effects of deployment.

Figure 14 – Percent of Active Duty Tested for Drugs

CAREER LONG ALCOHOL DEPENDENCE

A Sergeant had four years of ASAP referrals, evaluations and enrollment with a well-documented history of alcohol dependence. He was also suspected of having post-deployment traumatic brain injury and was prescribed antidepressant medication for anxiety and depression; but, he continued to suffer from nightmares. After two months he stopped taking the medications without telling his healthcare providers because he felt he did not need them anymore. Within days of stopping the medication he was found dead as a result of suicide in his off-post quarters.

- Communication among Soldier-patients, commanders and program/service providers is critical for collective situational awareness and to inform decisions regarding Soldier health.

Vignette 11 – Career Long Alcohol Dependence**CONCLUSIONS**

- ★ Investigations of single drug incidents indicate the social nature of illicit drug use; 25% of 34,962 CID drug investigations between FY 2001 and FY 2009 include multiple subjects. (page 50)
- ★ From FY 2001 – FY 2009, a total of 1.6 million individual Soldiers were tested for illegal drug use. Of those, 58,687 were positive for an illegal substance. (page 51)
- ★ 38% of those Soldiers who tested positive had actually tested positive as a multiple (two times) or a serial (three or more times) offender. (page 51)
- ★ As the force has grown, the number of samples taken per year has not adjusted accordingly. Last year over 78,517 Soldiers were not tested which may have left 1,311 drug offenders undetected. (page 51)

RECOMMENDED ACTIONS

- ★ [HQDA] Prompt research to examine the social behavior of drug abuse with specific emphasis to identify the prevalent conditions (e.g., barracks introduction) that lead first term Soldiers to abuse drugs.
- ★ [HQDA] Revise ASAP policy to require mandatory urinalysis testing of 100% of individual Soldiers annually as opposed to unit end strength testing or other metrics less than 100% of unique Soldiers (by Social Security Number). For example, mandate random testing of 4% of Soldier population weekly; require *random* 100% urinalysis testing twice annually.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 13 – Drug and Alcohol Detection**b. ASAP Drug Testing Program**

As discussed, ASAP requires random drug testing each year to deter and survey the Army for drug use. Urinalysis samples are collected and sent to the Forensic Toxicology Drug Testing Laboratory (FTDTL) for analysis. These samples are then tested against a panel of drug candidates, which include both street drugs and potentially legal pharmaceuticals. Every urine sample is tested against the mandatory drug panel, which includes cocaine, amphetamines, marijuana, heroin and designer amphetamines such as ecstasy.

The Department of Defense requires a minimum of 20% of all samples be tested against the rotational drug panel, which includes opiates (codeine and morphine), synthetic opiates (oxycodone and oxymorphone) and PCP (angel dust). The Army's testing rate for the rotational panel last year was 18%. Because some substances are both pharmaceuticals (implying prescription use) and street drugs (illegal use); when detected, they will be reported as positive. Therefore, there is a process for reviewing positive samples to differentiate legitimate from illicit use.

(1) Illicit Pharmaceutical Use

When a urine sample is found to contain a potentially prescribed medication (i.e., positive for oxycodone) that sample is reviewed by a Medical Review Officer (MRO) to determine legitimate use. The MRO reviews the Soldier's medical record to ascertain if the substance has been medically prescribed, in which case it would be deemed "authorized use." If, however, there is no record of a valid prescription, then the MRO deems the sample to be "unauthorized use." Unauthorized use of prescription medication is considered an illicit use of a pharmaceutical and is a felony criminal offense.

Illicit use information is recorded in DAMIS, along with any ASAP screening and/or treatment history. Commanders are notified when Soldiers are found to have been illicitly using drugs. Drug positive information, previous drug positives and/or treatment history is forwarded to the commander for review, reporting and action. By regulation, even if it is the first positive UA, the commander must initiate separation and refer the Soldier to ASAP for clinical evaluation and to law enforcement for investigation. After referral, an ASAP counselor determines whether to recommend enrolling the Soldier into the rehabilitation program due to drug abuse or dependency concerns. The unit commander then decides whether to accept the recommendation.

(2) Illicit Drug Use

There is no review process for street drugs (e.g., cocaine, heroin, marijuana, etc.) because there is no legitimate medical use for those drugs. Therefore, every sample that is found to contain substance street drug (except for certain amphetamines) is considered illicit use and should be investigated by law enforcement under current policy.

(3) Determination of Authorized/Unauthorized Use of a Drug

Any drug positive that may have a potential legitimate pharmaceutical use (e.g., oxycodone) is sent to an MRO for adjudication. Medical reviews are conducted by licensed physicians, who are located at MTFs throughout the Army. As a physician, their primary job is to diagnose and treat patients. When tasked as an MRO, their role as a reviewer of drug positive cases is secondary to their primary mission.

Over the past nine years, there have been 42,028 drug positives that required a MRO disposition (See Table 8). During this time, there was a total of 5,505 (13.9%) that were not adjudicated and remain unresolved (due to administrative closure, unavailable Soldier or are still pending). This indicates a serious gap in the ASAP process that may allow illicit drug use to go undetected. Based on the overall average of the percent of samples that result in an unauthorized use disposition (36.4%), the 5,505 unresolved positive samples (which can include multiple drugs per UA) could equate to approximately 2,004 Soldiers who are illicitly using pharmaceuticals.

Noncompliance with MRO reviews may be the result of natural conflicts between the physician’s primary role as treatment provider and his/her role as MRO. Today’s operational tempo may also foster noncompliance. There is hope that the new MRO review system instituted by The Army Center for Substance Abuse Programs (ACSAP) will improve the reporting compliance rate (95% for FY 2009), but until the new system is utilized by all MROs across the Army, compliance will remain substandard.

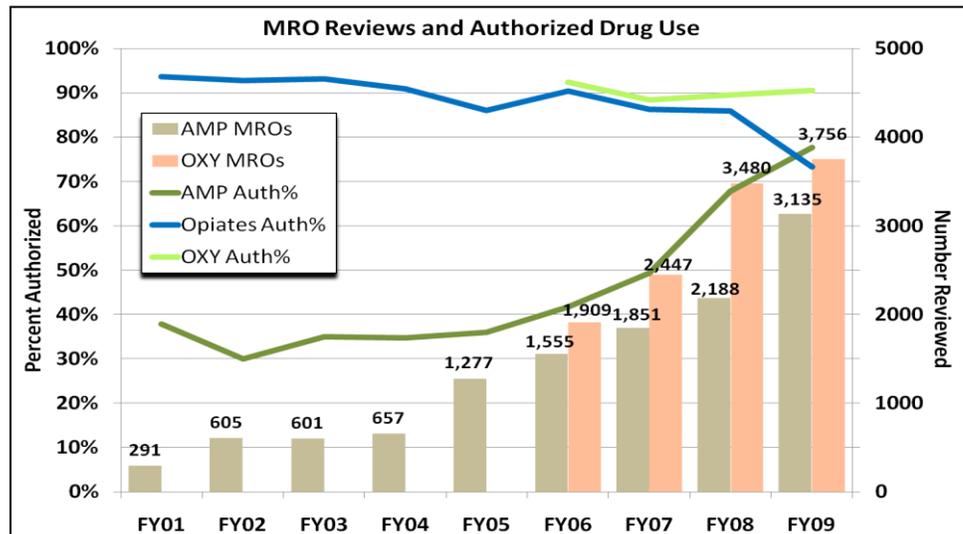
Medical Reviews of Potentially Legal Use Drugs (FY01-FY09)

MRO Evaluations Required by Drug Positive	Unresolved (%)	Resolved (%)	Authorized (%)	Unauthorized (%)
42,028	5,505 (13.9%)	36,523 (87.0%)	23,222 (63.6%)	13,301 (36.4%)

Over a nine year period, a total of 42,028 cases were referred to Medical Review Officers (MROs) to determine authorized vs. unauthorized use. Of those, 13.9% percent remain unresolved. The majority of the cases referred for MRO review (63.6%) come back as legal use. The remainder (36.4%) was determined to be use of a controlled drug without a prescription.

Table 8 – Referrals to Medical Review Officers, FY01 – 09

MRO data from FY 2001 to FY 2009 indicate a steady increase in the number of MRO reviewable drugs (see Figure 15). Initially, the largest category of MRO reviewable drugs included amphetamines which are used for Adult Attention Deficit Hyperactivity Disorder (ADHD). Between FY 2005 and FY 2006, testing for oxycodone began and resulted in a significant increase in the number of drug positives that had to be reviewed. In addition, the amount of amphetamines being prescribed skyrocketed (doubling between FY 2006 and FY 2009). The combination of increased amphetamine prescription and the new oxycodone screening effectively doubled the rate of



From FY 2001 to FY 2009 the number of reviewable drugs has steadily increased. This trend is driven by the number of Amphetamine (Amp) and Oxycodone (Oxy) samples that must be reviewed each year. Last year Amp and Oxy equated to 6,891 reviews or 86% of the 7,980 drug positives reviewed. While the percent of approved use for Oxy has remained steady (at ~90%/year), Amp approval rates have been steadily increasing. The overall rate of authorized Opiate use, which makes up only a small percentage of reviewable drug numbers at ~8%, dipped last year. This dip is thought to be a result of increasing heroin use within those tested.

Figure 15 – MRO Review (Amphetamine and Oxycodone)

MRO reviews (see Table 23 in Annex E) and began a sudden increase in authorized use of drugs. In FY 2009 alone, almost 80% of all MRO reviewable drugs were deemed “authorized use” compared to the low point in FY 2005 of 33%. The steady increase in both amphetamine and oxycodone positive rates, combined with the high authorized use rates in FY 2009, illustrates the amount of pharmaceuticals with serious abuse potential that are currently being prescribed across the force.

There is also concern, due to open-ended prescriptions with no expiration date, that MRO authorizations may be masking opiate and other legal drug dependence and illicit drug use. Soldiers who receive MRO authorization are not referred to ASAP for evaluation, which begs the question; “How many of these authorized positive UAs are actually the result of dependence?”

An additional concern is that the MRO review does not take into account the concentration of the drug found within the sample. Since UA positives are detected at low nanogram quantities, there should be some expectation as to normal pharmacological and therapeutic limits, which could discern legitimate from illicit use. Abnormally high pharmacological limits, for instance, may move some legitimate use samples to potential abuse samples prompting additional testing and referral of the Soldier to ASAP for screening of drug dependence.



MRO INVESTIGATOR EMAIL

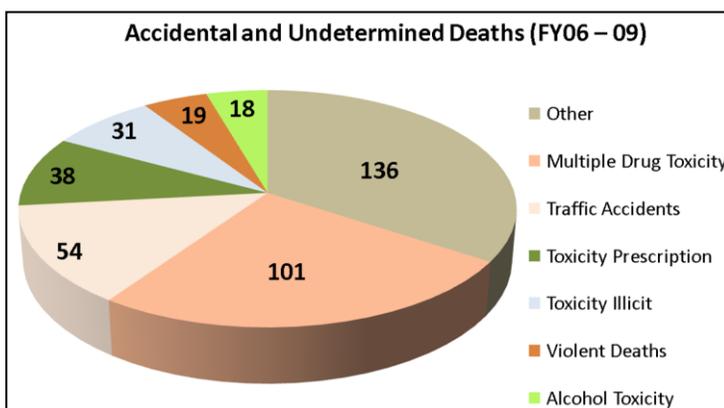
A Medical Review Officer requested assistance because he was unsure of the limitations of his role as a reviewer. During review of a Soldier’s prescription history, he realized the Soldier was on an unusual mix of prescriptions. The following is an actual excerpt from this MRO’s request for clarification:

“What I don’t know is, can I do anything? I have reviewed the medical records as an Investigating Officer and have found appropriate documentation to support legitimate use. As a psychiatrist I am highly concerned that this case should have further eyes on. Being on a high dose [of] amphetamines and benzodiazepines appears to be a vicious cycle that may have deleterious effects on the Soldier and his mission.

So, can I act on this information? If I act, are there limitations on what I can do? I am nervous of inaction and having a bad outcome [when] I could have intervened earlier. I also do not wish to act and be found to have acted inappropriately due to [the] differing roles I fill.”

- Clear guidelines are required to establish rules of engagement for Medical Review Officers; medical reviews offer opportunities for intervention.

Vignette 12 – MRO Investigator E-Mail



A total of 397 accidental or undetermined cause of death cases were investigated from FY 2006 – 2009. Of the 397, 47% involved drugs or alcohol. Of these, 74% involved prescription drugs.

Figure 16 – Review of FY 06-09 Accidental/Undetermined Deaths

Last year, while prescription drugs accounted for only 18% of all illicit use cases and made up only 3.1% of felony use or possession cases, prescription drugs were involved in almost one third of the active duty suicides. Expanding this view to FY 2006 – FY 2009, 47% of undetermined or accidental Soldier deaths were due to the excessive use of both legal and illegal drugs and/or alcohol. Of the 188 accidental or undetermined deaths caused by drugs or alcohol during this period, 139 (74%) were caused by prescription drugs (multiple cocktail or individual overdose, see Figure 16).

CONCLUSIONS

- ★ DoD requires a minimum number of samples (20%) be tested for controlled substances. The Army's testing rate for controlled substances last year was actually (18%). The Army has yet to meet the 20% standard set by DoD. (page 54)
- ★ There were 5,505 unresolved positive samples between FY 2001 – FY 2009, which equates to approximately 2,004 Soldiers who are illicitly using pharmaceuticals. (page 54)
- ★ The amount of amphetamines being prescribed has more than doubled between FY 2006 and FY 2009. (page 55)
- ★ The combination of increased amphetamine prescription and the new oxycodone screening effectively doubled the rate of MRO reviews. (pages 55)
- ★ In FY 2009 alone, almost 80% of all MRO reviewable drugs were deemed "authorized use" compared to the low point in FY 2005 of 33%. This illustrates the amount of pharmaceuticals with serious abuse potential that are currently being prescribed across the force. (page 55)
- ★ Since UA positives are detected at low nanogram quantities, there should be some expectation as to normal pharmacological and therapeutic limits, which could discern legitimate from illicit use. (page 56)
- ★ Pharmaceutical drugs account for only 18% of the illicit drug use cases and make up 3.1% of felony use or possession cases but were involved in almost one third of the active duty suicides last year. (page 56)
- ★ Of the 188 accidental or undetermined deaths caused by drugs or alcohol from FY 2006 – FY 2009, 139 (74%) were caused by prescription drugs. (page 56)

RECOMMENDED ACTIONS

- ★ [HQDA] Revise policy to test all panel drugs at 100% rather than DoD directed 20% for some pharmaceuticals.
- ★ [HQDA] Revise policy to limit authorized use of prescription medication to one year after prescription issuance to determine authorized use. For example, a Soldier with a prescription written in FY 2006 who tests positive for that drug in FY 2009 would not be medically cleared for authorized use.
- ★ [HQDA] Research the normal therapeutic range for different prescription drugs to determine how to better assess potential abuse of pharmaceuticals.
- ★ [CDRs] For positive drug tests, commanders must comply with current policy to initiate separation and refer the Soldier to ASAP and law enforcement.
- ★ [HQDA] Issue an ALARACT or MEMO requiring use of the new MRO review system in DAMIS. Track utilization of the new system and improvement of MRO review rates. If there is no improvement, address the governing policy.
- ★ [OPMG] Increase law enforcement training on the surveillance, detection and reporting of illicit pharmaceutical drug use.
- ★ [HQDA] Implement an information campaign to inform leaders of the potential for prescription abuse within the force; include examples of Soldiers' abuse and subsequent deaths.

Refer to Annex B for additional detail and supporting actions

4. Reporting Criminal Behavior

Reporting disciplinary infractions is essential to provide a record of prior offenses and to help establish a unit culture and expectation of intolerance for high risk behavior. The Report Team found that due to a serious lack of reporting, some Soldiers were allowed to slip through the cracks and unfortunately took their own lives. Without the visibility provided by reports, commanders cannot get a composite view of the Soldiers in their command. Effective reporting will provide the situational awareness for leaders to detect patterns of risk that may not be discerned when viewing single incidents in isolation. Unless commanders intervene to correct high risk behavior (either by discipline or through medical intervention), it often continues to escalate in increasing severity. Unfortunately, it is only in hindsight that we see indications of undocumented high risk behavior that should have prompted intervention. The DA Form 4833 (Commander's Report of Disciplinary or Administrative Action) serves this purpose.

Use of the DA Form 4833 provides a record of misconduct and disciplinary history of the individual Soldier. Moreover, a review of these forms for Soldiers disciplined within a unit allows commanders to see patterns of misconduct at every echelon. It also enables leaders to assess the appropriate disposition of misconduct cases and ensure even-handed discipline across the force. The importance of reporting, and the detriment caused by a lack of reporting, is a key theme that will be discussed throughout this report.

a. Criminal Activity Reporting

To maintain good order and discipline and to ensure readiness and competency within the force, commanders and law enforcement personnel, in accordance with AR 190-45, AR 195-2 and AR 15-6, are required to take specific actions when an alleged criminal offense has been committed. If the offense is brought to the attention of commanders, they must determine the appropriate authority to handle the investigation. If the offense falls below law enforcement's investigative purview as specified in AR 195-2, the commander may initiate an AR 15-6 investigation. Pending the review of the AR 15-6 investigation, the commander will decide the appropriate action. This could include no action taken, an official reprimand, UCMJ action and/or administrative separation.

If the offense meets the thresholds for misdemeanor and felony conduct, the commander must report the crime to either the provost marshal or CID. The provost marshal in coordination with CID will determine which agency has purview over the case in accordance with the regulations. If it is a misdemeanor offense, the military police investigators (MPI) will handle the investigation and report their findings to the commander using a Military Police Report (MPR). If the offense is a felony, then CID (or MPI, as appropriate) will report their findings to the commander using a Report of Investigation (ROI). Both completed investigations are forwarded to the commander with a DA Form 4833.

Once the investigation is completed and the CID ROI or provost marshal MPR has been submitted, the commander must coordinate with the installation's legal team for assistance in determining and preparing disciplinary action (judicial or non judicial punishment). Once the disciplinary action is completed, the commander will annotate the final disposition on the DA Form 4833, including punishment, referrals to ASAP/FAP and administrative action such as separation from service. The commander will return the DA Form 4833 to the originating office to document the final case disposition. The final DA Form 4833 will be added to either the MP database (COPS) or the CID database (ACI2). When the disciplinary action results in a field grade Article 15 or above, the Soldier's fingerprints

will be forwarded with the DA Form 4833 disposition to the FBI National Crime Information Center (NCIC) Database.

Additionally, commanders, provost marshals and CID must report crimes to the Defense Incident-Based Reporting System (DIBRS) for input into the National Incident-Based Reporting System (NIBRS) as required by the Uniform Federal Crime Act. This includes active military personnel accused of –

- Criminal offenses under the UCMJ, investigated by a military law enforcement organization;
- **Attempted or completed suicide;**
- Fraternalization, sexual harassment, a sex-related offense, a hate or bias crime or a criminal offense against a victim who is a minor and **investigated by a commander**, military officer or Civilian in a supervisory position (AR 15-6);
- Criminal incident, which is not investigated by a military law enforcement organization, but which results in referral to trial by court-martial, imposition of non-judicial punishment or an administrative discharge;
- Crimes prosecuted by civilian authorities as felony offenses as defined by state or local law; and
- Offenses reportable under the Brady Handgun Violence Prevention act as required by DoD 7730.47M.

The DIBRS/NIBRS reporting requirement is not currently addressed by Army regulations, but law enforcement practices generally meet required reporting. Commanders, however, present a different picture. Although DoD Manual 7730.47M specifically mandates that “In some instances, commanders shall be required to initiate DIBRS reporting when a military law enforcement activity is not involved,” there is little evidence that this is the reality. This highlights another example of a gap in crime reporting and data. The DA Form 4833 is the only mechanism for reporting offenses as tasked to commanders by the provost marshals or CID in response to investigations. Given commanders’ current DA Form 4833 reporting noncompliance rate of 36%, it is doubtful that crime reporting by commanders will improve without stronger Army implementing guidance.

b. Drug Positive (Illicit Use) Reporting

When an ASAP urinalysis sample contains any illegal street drug and/or illicit use of a pharmaceutical drug, the result of the test is forwarded to the commander. At this point there are several specific actions mandated by regulation which the commander must execute. These include command referral to ASAP for clinical evaluation, initiation of separation action and report of the positive result to law enforcement for investigation. The individual offense is then immediately entered into the ASAP drug database (DAMIS) by the Soldier’s SSN as illicit use.

Use of marijuana may be referred to the provost marshal’s MPIs but all other illicit drug use will be referred to CID, including illicit use of pharmaceuticals. The commander’s notification to law enforcement prompts several critical actions: (1) initiation of a criminal investigation to ascertain criminality associated with the alleged illicit drug use, including other Soldiers who may be involved (as described above); (2) submission of the DA Form 4833 to track and document offense adjudication; and (3) input of the drug and alcohol related offenses into the Army and DoD law enforcement data network.

Because a positive drug test result only goes to commanders, there is no guarantee they will notify law enforcement. This leaves gaps in reporting felony drug offenses and can result in underreporting of

drug crimes across the Army. If we examine the difference between DAMIS and ACI2 data, we find that in FY 2009 there were 1,415 illicit drug use positives (excluding marijuana) that were not reported to law enforcement. This means there were more than 1,415 individuals (including an unknown set of double-counted Soldiers) who had no investigation into the events surrounding drug related offenses. If we consider the fact that 25% of all investigated drug cases lead to multiple subjects, this number could be closer to 2,000 drug related subjects. This lack of referral compounds the DA Form 4833 reporting gap. Unless commanders report these crimes, there is no tracking of the final disciplinary action, no characterization of service and no entry of felony level offenses into DIBRS and NCIC.

c. Disciplinary Infraction and Criminal Reporting

At the commander level, information about possible criminal misconduct is immediately referred to law enforcement. If in doubt, the commander can initiate an AR 15-6 investigation to identify a potentially criminal offense or other misconduct. If the investigation finds that there was no criminal offense committed, the commander may exonerate the Soldier or take other action for other misconduct. In cases where the commanders find criminal offenses during the course of the AR 15-6 investigation, they are required to report the incident to law enforcement. It is worth noting that illicit use of pharmaceutical drugs is a felony offense under the UCMJ. It is the commander's responsibility to inform law enforcement authorities of all drug offenses (including illicit use of pharmaceuticals) so investigations into possession, use and distribution are investigated.

The process of the AR 15-6 investigation is very similar in concept to the urinalysis and MRO reviews discussed in the previous section. The commander must find evidence to support any claim. All known facts are collected and the investigation is reviewed from the totality of the circumstances and findings to determine if the allegations are substantiated. This parallels the MRO review that is conducted to determine if the use is authorized or not. In both situations, the criminal activity must be "detected" so that action can take place.

There is no single database or method to integrate these data so commanders can examine to get a holistic picture of a Soldier who allegedly committed an offense. Instead, the commander must depend on ASAP, COPS and ACI2 data but in reality may not look to these sources at all. The result of an AR 15-6 investigation leads the commander to decide on the appropriate disciplinary action. This action may include formal disciplinary action or may require initiation of certain reports in order to notify law enforcement.

d. DA Form 4833

The installation provost marshal (in concert with the military police) utilizes DA Form 3975 to record all information or complaints received or observed by the military police. Once an incident is considered a founded offense, the information is recorded in the DIBRS utilizing the COPS. An individual Soldier will be reported as the subject of an offense on DA Form 3975 when probable cause exists that the individual has committed a criminal offense.⁷² This form is then forwarded to the commander along with the DA Form 4833.

⁷² DA Form 3975, *Military Police Report*, Dec 98.

CID also depends on DA Form 4833 when a felony level offense against a Soldier has been founded. Once the case has been reviewed and adjudicated, the commander must return the DA Form 4833 so the appropriate information can be entered in ACI2 and, in some instances, the NCIC database. These requirements are in place so that when a Soldier moves from one installation to another, there is a record of both offenses and actions taken. With no DA Form 4833, the Army has no ability to track these Soldiers, allowing possible criminals to move more freely through both the Army and our society once retired or separated.

e. Statistics On Delinquent DA Forms 4833

Commanders have 45 days to complete the disposition and report the action taken using DA Form 4833. While commanders can self-initiate DA Forms 4833, data in Figure 17 describe only those forms initiated by law enforcement. Therefore, these numbers underestimate the potential criminality within the force. While the total number of DA Forms 4833 being sent to commanders for action has increased by almost 147% since 2004 (a specific increase by a factor of 1.47), the compliance percentage has leveled off at 64%. This means that the gap between criminal offenses and reported adjudication is increasing year over year with 15,074 DA Forms 4833 not submitted in FY 2009. Given that we have a 36% non-compliance rate, this trend will continue to mask criminal behavior and disposition in the force.

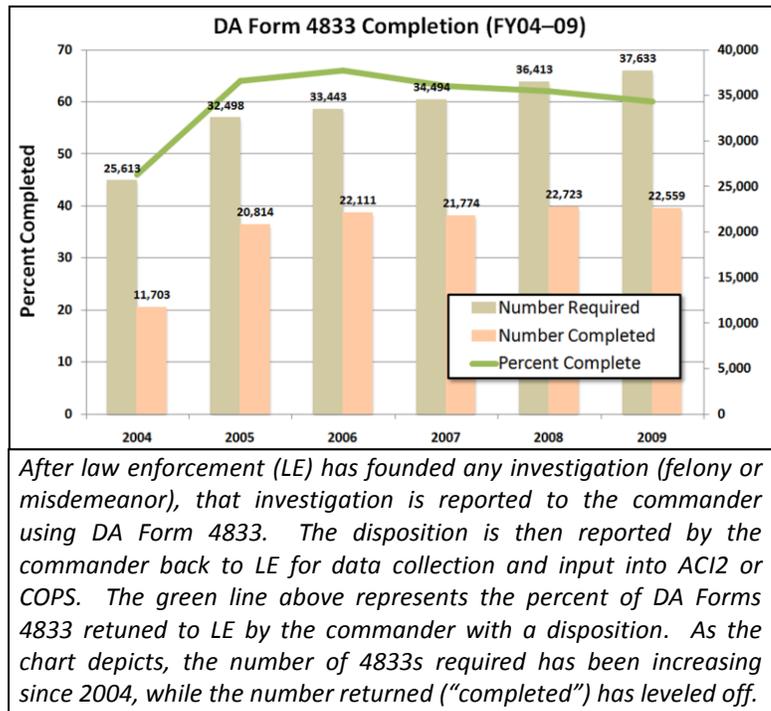


Figure 17 – DA Form 4833 Completion Rates

With the exception of illicit drug use, policy does not establish clear thresholds for separation for most criminal offenses. Instead, commanders must rely on the DA Form 4833 to inform subjective decisions on Soldier disposition. This requires an accurate history of Soldier offenses and previous commander actions. Unfortunately, without DA Forms 4833 to provide this record, many incidents are viewed in isolation. Consequently, a repeat offender can be misconstrued as a one-time offender and every trend dismissed as an isolated incident. DA Forms 4833 increase a commander’s objectivity when adjudicating offenses. Access to accurate records means that a Soldier who may not have been separated for what appeared to be a single innocuous event, could now be separated for the totality of his/her history.

CONCLUSIONS

- ★ It is often only in hindsight (post mortem) that we see indications of undocumented high risk behavior that provided opportunity for life saving intervention. (page 58)
- ★ Senior leaders determine when a DA Form 4833 should be command generated in order to establish a record of potentially criminal activity. The current language for “command referred” DA Form 4833 contained in ARs 190-30, 190-45 and 195-2 is ambiguous and does not provide commanders a clear indication of when initiation is required. (pages 58-60)
- ★ Commanders and law enforcement must report crimes to DIBRS for input into NIBRS as required by the Uniform Federal Crime Act. This includes active military personnel accused of:
 - Attempted or completed suicide.
 - Fraternalization, sexual harassment, a sex-related offense, a hate or bias crime or a criminal offense against a victim who is a minor and investigated by a commander, military officer or Civilian in a supervisory position (AR 15-6). (page 59)
- ★ Gaps in reporting felony drug offenses result in underreporting of drug crimes across the Army. If we examine the difference between DAMIS and ACI2 data, we find that in FY 2009 there were 1,415 illicit drug use positives never reported to law enforcement. (page 60)
- ★ There is no single database that commanders can examine to get a holistic picture of Soldier misconduct; they must depend on “silo’ed” databases (ASAP, COPS and ACI2). (page 60)
- ★ With no DA Form 4833 on file at the Crime Records Center, the founded offense cannot be closed and the final disposition remains unknown to law enforcement and the Army. (page 60)
- ★ The total number of DA Forms 4833 being sent to commanders for action has increased by almost 147% since 2004; the compliance percentage has leveled off at 64%. (page 61)
- ★ The gap between criminal offenses and reported adjudication is increasing year over year with 15,074 DA Forms 4833 not submitted in FY 2009. (page 61)
- ★ With the exception of illicit drug use, policy does not establish clear thresholds for separation for most criminal offenses. (page 61)

RECOMMENDED ACTIONS

- ★ [HQDA] Publish implementing guidance for DIBRS and NIBRS reporting in accordance with DoD policy.
- ★ [HQDA] Revise AR 600-85 to direct ASAP to report all positive UAs for illicit drug use directly to both commanders and law enforcement; all positive UAs will be investigated as a criminal felony offense in accordance with AR 195-2.
- ★ [HQDA] Consolidate criminal and misconduct databases into a single portal providing automatic feed to improve situational awareness for commanders, law enforcement and program/service providers.
- ★ [AII] Implement DA Form 4833 reporting feedback forms/mechanisms at HQDA, IMCOM and garrison level to ensure 100% reporting compliance. Revise policy to limit reporting to 45 days upon receipt with extensions approved by the General Courts-Martial Convening Authority.
- ★ [HQDA] Create a centralized repository for DA Forms 4833 that are generated as a result of AR 15-6 investigations to capture Soldiers’ history of disciplinary infractions.

(Continued)

- ★ [HQDA] Amend policy to require commanders to initiate separation proceedings for all major felonies (at a minimum, crimes against persons), not just for drug felonies (e.g., positive UAs).
- ★ [AII] HQDA will require quarterly separation initiation/ASAP referral compliance reporting to ensure commanders initiate separation for positive drug test results and refer the Soldier to ASAP for clinical evaluation.
- ★ [HQDA] Revise policy to provide commanders a clear indication of when “command initiation” of a DA Form 4833 is required (COPS, ACI2, DIBRS and NIBRS).

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 15 – Reporting Criminal Behavior Including Drug and Alcohol Incidents

5. Required Actions in Response to Illegal Activity

Without action; surveillance, detection and reporting are meaningless. Inaction sends a clear message that high risk behavior is acceptable. Inaction in the face of unacceptable behavior undermines good order and discipline and erodes the health of the force. Every leader and commander has explicit responsibility to make hard decisions regarding discipline. Equally important is a commander’s responsibility to adhere to reporting and referral requirements. Without timely, accurate and complete reporting, visibility of high risk behavior is lost. Policy and process are in place to ensure good order and discipline are maintained within the ranks. Failure to utilize the established protocols for addressing misconduct only leads to the further erosion of Soldier accountability.

In this sense, required actions refer to those actions that commanders should take regarding alcohol/drug use associated with a criminal activity (positive UA, DUI, other alcohol/drug incident). It does not pertain to the self referral by a Soldier for alcohol and drug dependence/use prior to a criminal incident. The Confidential Alcohol Treatment Education Pilot (CATEP), for example, provides confidential means for Soldiers to refer themselves for ASAP treatment without command notification and subsequent administrative/disciplinary action. This pilot provides a means for Soldier reparation and return to readiness, while enhancing the Army’s anti-stigma objectives.

a. Requirements for Referring Soldiers to ASAP for Clinical Evaluation

When commanders believe their Soldiers have a drug or alcohol problem they must refer them to ASAP for clinical evaluation. This includes referrals as a result of positive UAs, alcohol/drug related incidents and when, by experience, there are indications of potential substance abuse. Commanders are required to use DA Form 8003 (ASAP Enrollment) to refer Soldiers for screening and enrollment. Unfortunately, use of DA Forms 8003 is not tracked and, therefore, there is no visibility of the number of command referrals. DAMIS data from FY 2009 indicate that while there were 7,907 Soldiers who tested positive for illicit drug use, only 4,111 were screened by ASAP. While UA positives can be tracked, other referrals for drug and alcohol cannot without the visibility provided by use of DA Forms 8003. Given the fact that referral rate for UA positives was 52% in FY 2009, rates for other types of referrals are suspected to be even lower.

b. Requirements for Separation Due to Illicit Drug Use

Army Regulation 600-85 directs commanders to initiate separation for Soldiers who test positive for illicit drug use:

“Separation initiation authorities, in accordance with AR 635-200 and AR 600-8-24 retain their authority to make personnel decisions except that initiation of administrative separation is mandatory for all Soldiers identified as illegal drug abusers, for all Soldiers involved in two serious incidents of alcohol-related misconduct within 12 months and for all Soldiers involved in illegal trafficking, distribution, possession, use, or sale of illegal drugs.”⁷³

The regulation is written to ensure drug abusers, distributors and those with multiple alcohol offenses are initiated for separation. While commanders “retain their authority to make a final personnel decision” (i.e., retain or separate), the regulation requires initiation of separation procedures to emphasize the serious nature of drug offenses. Initiating separation action is not an option under this regulation; however, it does not guarantee separation. Initiation of separations must be tracked to ensure these policy requirements are being met and that separation decisions are adjudicated before Soldiers PCS, are deployed, demobilized or sent TDY. This requirement to initiate separation has even more relevance today given the transient nature of the population.

In addition, AR 600-85 states that when a Soldier tests positive for illicit drugs a **second** time or is convicted of driving while intoxicated or driving under the influence a **second** time during his/her career, the separation authority shall administratively separate the Soldier unless the Soldier is recommended for retention by an administrative separation board or is retained by the first general officer in the chain of command.

Again, separation action is imminent. Only a General Officer or an administrative separation board can save the career of multiple offenders by recommending retention. However, when commanders fail to initiate separation and with no way to track initiation of separations at higher echelons, the regulation is meaningless. This gap in both policy and process retains multiple offenders and further erodes good order and discipline.

c. Separation Authority

The obligation and authority of a commander to levy consequence for action is a tool that every commander must use. All commanders struggle with striking the right balance between the judicious use of discipline and the severity of the consequences. On the one hand, there is opportunity to mentor and shape the career of a young Soldier. On the other, there is the need to remove a problem before it can take root and undermine the entire unit. Arguably the most important tool the leader has to manage the readiness, health, welfare, morale and discipline of the unit, is separation authority.

Although AR 600-8-24 provides separation policy for officers, high risk behavior is more prevalent among junior Soldiers (who, understandably, make up the majority of the force). As such, this report highlights AR 635-200, Army’s separation policy for enlisted, which outlines the set of administrative separations that can be used for a variety of reasons alluded to in each chapter’s title. Chapter selection

⁷³ AR 635-200, *Active Duty Enlisted Administrative Separations*.

is typically based on three criteria: the nature of the misconduct, characterization of service (Honorable, Other than Honorable, General or Uncharacterized) and expedience of the process. The following text outlines chapters commonly used to separate Soldiers based on suitability of service and conduct, as well as the characterization(s) of discharge permitted under each chapter –

- Chapter 5 – Separation for Convenience of the Government (Honorable, General, Uncharacterized);
- Chapter 6 – Separation because of Dependency or Hardship (Honorable, General, Uncharacterized);
- Chapter 7 – Defective Enlistments/Re-enlistments and Extensions (Honorable, Other than Honorable, Uncharacterized);
- Chapter 9 – Alcohol or Other Drug Abuse Rehabilitation Failure (Honorable, General, Uncharacterized);
- Chapter 10 – Discharge in Lieu of Trial by Court-Martial (Honorable, General, Other than Honorable, Uncharacterized);
- Chapter 11 – Entry Level Performance and Conduct (Uncharacterized);
- Chapter 13 – Separation for Unsatisfactory Performance (Honorable, General);
- Chapter 14 – Separation for Misconduct (Honorable, General, Other than Honorable, Uncharacterized); and
- Chapter 18 – Failure to Meet Weight Control Standards (Honorable or Uncharacterized).

d. Separation of Soldiers for Drug and Alcohol Abuse

There are two primary chapters used for drug-related administrative separations, Chapter 9 and Chapter 14. Neither chapter is ideally suited to respond to the Army's emerging drug use, high risk behavior and death trends. Chapter 9 (ostensibly designed to focus on alcohol/drug rehabilitation failures and multiple offenders) is fraught with limitations that often preclude its use. Chapter 14 has become the catchall for a wide range of criminal activities, misconduct and disciplinary infractions. The use of a Chapter 14 is convenient; however, it masks the Army's ability to analyze and predict trends regarding drug use and any emerging high risk population (in covering everything, it signifies nothing). Although AR 635-200 provides guidance to establish the "reason" for separation, it does not provide the mechanism to code this reason for subsequent query and analysis.

(1) Chapter 9

A Chapter 9 can only be initiated for a Soldier who is currently enrolled in ASAP and whose commander determines that conduct, duty performance and progress are unsatisfactory and that further rehabilitation efforts are not practical. Chapter 9 cannot be used to separate Soldiers who have another alcohol/drug incident at any time following successful completion of the ASAP. It also cannot be used to separate Soldiers who have been removed from ASAP for any reason. This policy is at odds with how ASAP defines recidivism, which is an alcohol/drug relapse within one year of completing alcohol/drug rehab. On one hand the Army (per ASAP) defines program failure as "recidivism" (rehab completion plus one year), while on the other (AR 635-200), it brackets use of the chapter associated with program failure to the rehab program window only.

Perhaps more problematic is the limited characterization of service associated with the Chapter 9. Use of this chapter restricts commanders to an Honorable or Under Honorable Conditions characterization.⁷⁴ As a result a Soldier may be a multiple drug offender but by the provisions of this chapter would receive a discharge as Honorable or Under Honorable Conditions. Consequently, commanders must make a decision between choice of characterization rather than the intent of the chapter. This may account for the infrequent use of Chapter 9 separations when compared to alcohol and drug rehab failure rates. For instance, there was an average of 277 Chapter 9 separations per year compared to an average of 2,208 drug rehab failures in each year between FY 2001 – FY 2009. Again, these numbers indicate a failure to appropriately use Chapter 9 separation for drug rehab failure. Finally, the use of Chapter 9 separations creates a policy-driven inequity in characterizations of service for alcohol and drug related offenses. Soldiers may receive an Honorable, General (Under Honorable Conditions) or Other than Honorable Characterization of Service for essentially the same misconduct.

REHAB FAILURE REENLISTS

A Specialist who tested positive for marijuana was enrolled in ASAP and eventually failed his rehabilitation. On the day he was discharged (Chapter 9 separation) he enlisted in the Army Reserve and received an enlistment bonus.

- Soldiers chaptered for rehabilitation failure will not meet individual readiness standards. Each case must be evaluated before allowing rehabilitation failures to transition to the Reserve Component.

Vignette 13 – Rehab Failure Reenlists

(2) Chapter 14

Chapter 14 is an administrative separation code that describes general misconduct. According to policy, Soldiers separated under Chapter 14 are normally discharged under Other than Honorable Conditions, but General and Honorable discharges can be approved under unusual circumstances.

MISCHARACTERIZATION OF SERVICE

A 19 year-old Soldier was apprehended and found guilty of the possession, use, and distribution of cocaine and marijuana and the possession and use of opiates, methamphetamines, and hallucinogens. He was previously apprehended for burglary, 1st degree theft and housebreaking. While his chain of command took appropriate non-judicial and judicial action and subsequently separated him for misconduct, his DD Form 214 reflects an Honorable Discharge.

- Appropriate characterization of service prevents high-risk Soldiers from returning to military service.

Vignette 14 – Mischaracterization of Service

A Chapter 14 can be initiated because of minor disciplinary infractions, a pattern of misconduct, commission of a serious offense, conviction by civil authorities, desertion and absence without leave.

⁷⁴ An uncharacterized discharge only applies to Soldiers separated while in entry-level status, i.e., during their first 180 days of active duty.

Because of the wide number of situations that fall under Chapter 14, it is typically being used to separate high risk Soldiers, including those who have committed multiple drug or criminal offenses.

(3) The Need for an Additional Drug/Alcohol Chapter

There is a real need, at least from a reporting and tracking stand point, to have a separation Chapter action that is similar to a Chapter 14, but is coded for both drug and alcohol offenses. For example, separation for alcohol related offenses would be one code (Chapter 14a) and separation for drug related offenses would be another separate code (Chapter 14b). Utilization of these two codes alone could be monitored by garrison leadership as a barometer of risk. As the number of these actions exceeds a given threshold, commanders could use programs targeted to the specific need of the installation.

The commander should also have the flexibility to rehabilitate a Soldier. However, if a Soldier fails rehabilitation while in the program, commanders may use Chapter 9 to separate the Soldier from the Service. If the commander views drug abuse as due to misconduct, the commander should have the option of seeking to separate the Soldier under the proposed Chapter 14b.

Finally, the window for use of Chapter 9 should be extended to match the Army's recidivism period following successful rehab. This would increase the Chapter 9 threshold to rehab plus one year and combine Chapter 9 use for both rehab failure and recidivism.

CONCLUSIONS

- ★ When commanders believe their Soldiers have a drug or alcohol problem they must refer them to ASAP for clinical evaluation using DA Form 8003 (ASAP Enrollment). (page 63)
- ★ Use of DA Forms 8003 is not tracked and, therefore, there is no visibility of the number of command referrals. DAMIS data from FY 2009 indicate that while there were 7,907 Soldiers who tested positive for illicit drug use, only 4,111 were screened by ASAP. (page 63)
- ★ Army Regulation 600-85 directs commanders to initiate separation for Soldiers who test positive for illicit drug use. (page 64)
- ★ Soldiers who test positive for illicit drugs a **second** time or are convicted of driving while intoxicated a **second** time during their career, shall be administratively separated from the Service. (page 64)
- ★ Neither Chapter 9 nor 14 is ideally suited to respond to the Army's emerging drug use, high risk behavior and death trends. (page 65)
- ★ Use of Chapter 9 is at odds with how ASAP defines recidivism, which is an alcohol/drug relapse within one year of completing alcohol/drug rehab. On one hand the Army defines program failure as "recidivism" (rehab completion plus one year), while on the other, it brackets use of the chapter associated with program failure to the rehab program window only. (page 65)
- ★ Chapter 14 has become the catchall for a wide range of criminal activities, misconduct and disciplinary infractions; it masks the Army's ability to analyze and predict trends regarding drug use and the emerging high risk population (in covering everything, it signifies nothing). (page 66)
- ★ Chapter 9 is underutilized. Between FY 2001 – FY 2009 there was an average of 277 Chapter 9 separations per year compared to an average of 2,208 drug rehab failures in each year. (page 66)

(Continued)

RECOMMENDED ACTIONS

- ★ [HQDA] Revise policy to mandate use of DA Form 8003 for all drug/alcohol referrals; track utilization at garrison, IMCOM and HQDA level.
- ★ [HQDA] Track all Chapter initiations to differentiate between commander initiation and GO/separation board disposition. Ensure tracking closes the loop between chapter initiation and law enforcement/program visibility for final separation/disposition.
- ★ [HQDA] Create a new misconduct code (drug and alcohol misconduct) so that the levels of drug and alcohol abuse can be tracked within the force. This should be coded as a 14a (alcohol misconduct), 14b (drug misconduct) and 14c (other misconduct).
- ★ [HQDA] Expand Chapter 9 to include rehabilitation and recidivism period (rehabilitation plus one year). Additionally, add Other than Honorable as another option for characterization of service.
- ★ [HQDA] Direct research to assess the adequacy of Army's definition of "recidivism" as one year rather than the more widely used convention of five years.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 16 – Required Actions in Response to Illegal Activity

6. The Current Reality of the High Risk Population

Due to a change in operational requirements since the start of OEF/OIF, a subculture has been created that engages in high risk behavior. This population is every leader's concern. Tolerating high risk behavior for convenience and passing on the problem to the next commander is unacceptable. With the current operational tempo of the Army, it is essential that leaders step up and take responsibility for their Soldiers. Reporting is critical to maintaining situational awareness. Without reporting, it is difficult to assess newly assigned Soldiers among a transient population that exceeds 700,000 on active duty.

a. Separation for Entry Level Performance and Conduct

Under an unprecedented OPTEMPO, the number of entry-level performance separations (Chapter 11) has decreased dramatically (see Figure 18). This means we are retaining sub-standard trainees in the generating force and moving them quickly into the operating force. This movement into a high OPTEMPO environment makes it difficult to identify and differentiate this high risk cohort from other first term Soldiers.

Additionally, post entry-level separation actions (all other chapters) have decreased significantly over the same period. In fact, while the Army has increased by over 74,000 Soldiers between FY 2001 and FY 2009, data indicate there is an overall decrease in the total number of separations per year. This has likely resulted in the retention of over 25,283 Soldiers who would have otherwise been separated in previous years. Decreases in separation actions combined with current crime and alcohol/drug rates indicate an increase in tolerance, if not acceptance, of high risk behavior.

The intent of the entry-level separation is to remove individuals who do not represent Army standards of conduct or who are unlikely to be able to perform within the mission of the Army. With reduced Chapter 11 separations, one could argue that a larger number of individual Soldiers, who would otherwise have not been added to the ranks, have been retained due to the protracted conflict. The correct balance (between filling the ranks and a need to maintain a fit force) is one that can only be decided at the highest levels. At some point, the decision must be made either to accept the erosion of Army standards (entry and retentions) for the sake of manpower or enforce regulations to maintain order and discipline.

Separation of an unfit Soldier becomes more difficult as their time in service is allowed to continue. As these Soldiers transition from training to reporting to their first unit, the window of opportunity for a Chapter 11 has already closed. This means that unit commanders must use other separation chapters and criteria to remove a problematic entry-level Soldier. Chapter 14 (misconduct) represents the most frequently used administrative separation chapter for Soldiers who, in essence, have failed to adjust.

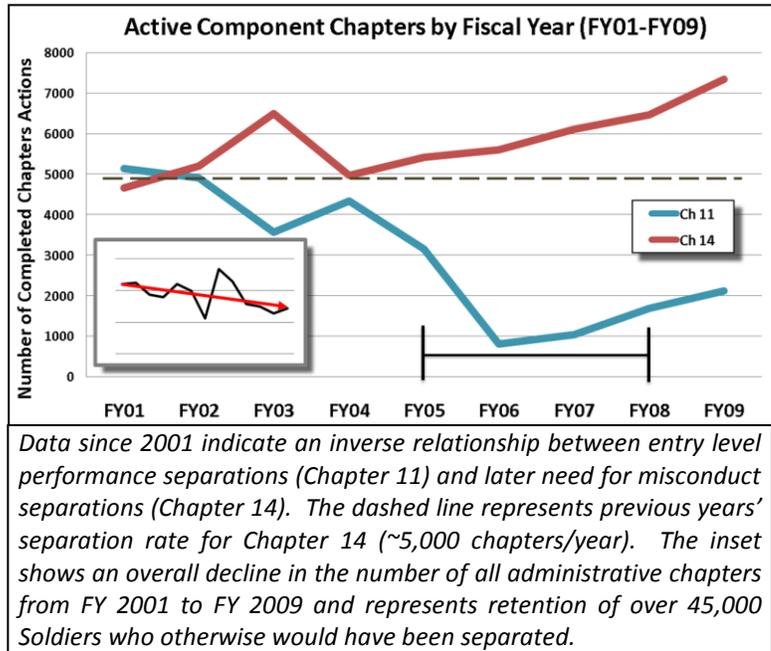


Figure 18 – Review of Active Component Chapters, FY01 -09

The graph in Figure 18 also indicates a recent effort to regain balance through an increasing number of later career chapter actions, by way of Chapter 14 (misconduct). While these chapter actions are on the rise the overall number of separations is in decline (Figure 18 inset). This means that there is still a population of Soldiers who would likely have been separated under Chapter 11 (consistent with historic pre-FY 2001 rates represented by the dashed line) who remain in the force today.

Simultaneous with the decreased rate of administrative separation of at-risk Soldiers, the Army brought in more Soldiers with waivers who are potentially at-risk. From FY 2006 – FY 2008 a significant number of waivers were granted to allow a larger number of recruits to enter the Army (see Figure 19). It stands to reason that these individuals were “waived in” because they did not meet the minimum standards for enlistment. While 80,403 entry-level waivers occurred from FY 2004 – FY 2009, the number of entry-level separations decreased dramatically. So the rate of entry for recruits with waivers increased while the rate of separation of potentially problematic Soldiers decreased (reductions in Chapter 11 actions). This, in essence, created a net gain of approximately 10,000 Soldiers (difference between Chapters 14 and 11 between FY 2004 and FY 2009) who might not have been eligible for entry into the Army before 2004.

Of the 80,403 waivers granted, 47,478 were granted to individuals with a history of drug, alcohol, misdemeanor crimes, or serious criminal misconduct (defined as a felony or United States Army Recruiting Command (USAREC) Misdemeanor).

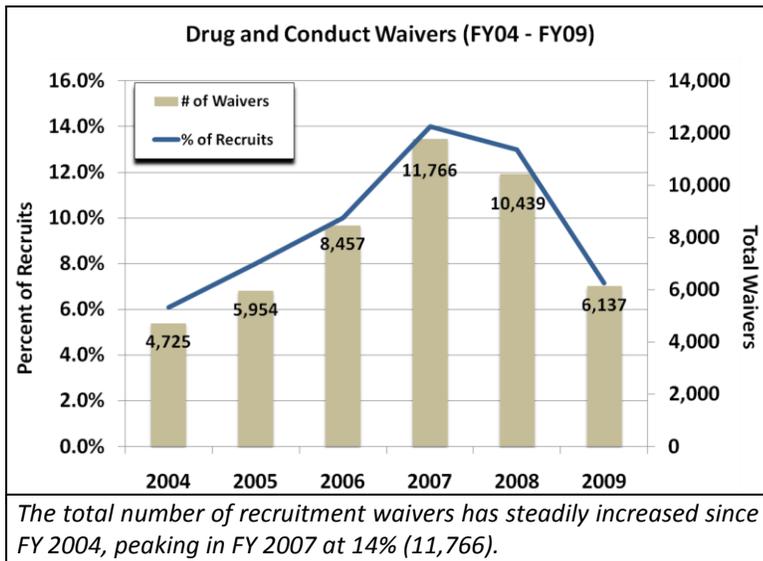


Figure 19 – Drug and Conduct Waivers, FY04-09

misdeemeanor offenses (counted as multiple offenses per case). This same year, there were 7,907 positive test results for illicit drug use, and 1,713 reports of attempted suicide.⁷⁵ In this example, of the 7,907 Soldiers who tested positive for drugs, 2,311 tested positive at least one more time in the same year. As outlined in the subsequent pages, allowing this high risk population to remain in the operating force has significant consequences.

b. ASAP Referrals for Illicit Drug Use and DUI

Alcohol and Drug Control Officers (ADCOs), who act as the directors of installation-level ASAPs, are required by regulation to monitor and evaluate the commander referral and the clinical evaluation rates, and to provide quarterly reports to commanders, installation and HQDA. Commanders are required to refer any Soldier who tests positive for illicit drug use or is involved in alcohol-related misconduct to the ASAP for clinical evaluation. In turn, the ASAP Clinical Director informs the ADCO of the commander’s non-compliance with referral action. The ADCO then follows up with commanders who do not refer Soldiers to the ASAP. This “check and balance” system is intended to ensure Soldiers who have drug or alcohol-related incidents receive required services. Simply put, this is not happening in every case.

Total DUIs	Ref to ASAP	Rate	Total UA Pos	Ref to ASAP	Rate	Total Rate
25,640	17,934	69.9%	61,912	37,627	60.7%	63.5%

AR 600-85 outlines procedures for referral to ASAP to evaluate potential drug or alcohol dependence. Any drug or alcohol related offense must result in an ASAP evaluation using DA Form 8003. The overall rate of referral to ASAP from FY 2001 to FY 2009 is only 63.5%.

Table 9 – ASAP Referral Rates, FY 01-09

Table 9 shows the number of referrals for total positive UAs and DUI citations results from FY 2001 – FY 2009. Of the total DUIs (25,640), only 17,934 were referred to ASAP (69.9%). Urinalysis positive referrals for the same time period were 60.7%. Once again, there appears to be a lack of consistent

It is difficult to know what effects the prolonged conflict has had on the individual Soldier. It is also unfair and impossible to directly correlate the current levels of high risk behavior solely on this matriculating population. We can however, look across the Army and identify specific trends, including those in suicide and high risk behavior (e.g., drug and alcohol use, criminality) which point to an institutional risk that can only be rectified by unit leaders with the appropriate institutional support. For example, in FY 2009, first term Soldiers account for the vast majority of the 74,646 felony and

⁷⁵ Reported suicide attempts that resulted in medical intervention in military or civilian treatment facilities.

enforcement of regulations with no oversight or consequence for non-referrals to the ASAP. As a result, these Soldiers will go unscreened and untreated and may continue down a path toward more severe consequences.

CONCLUSIONS

- ★ Since FY 2004, Chapter 11 separations have significantly decreased while entry waivers have increased from FY 2004 – FY 2007. (page 68)
- ★ While the Army increased by 74,000 Soldiers, the total number of separations (all chapters) has decreased since FY 2001, likely resulting in the retention of 25,283 Soldiers who would not have been retained in previous years. (page 68)
- ★ Drug and misconduct waivers increased steadily from FY 2004 and peaked in FY 2007 at 11,766; although waivers declined in FY 2009, 6,137 waivers were granted (Figure 18). (page 69)
- ★ In FY 2009, first term Soldiers account for the vast majority of the 74,646 criminal offenses, 7,907 positive urinalysis for illicit drug use, and 1,713 reports of attempted suicide. (page 70)
- ★ From FY 2001 – FY 2009, only 69.9% of all DUIs and 60.7% of all positive urinalysis were referred to ASAP for evaluation. (page 70)

RECOMMENDED ACTIONS

- ★ [CDRs] Enforce separation actions for high risk behavior (felony and multiple misconduct).
- ★ [HQDA] Revise policy to extend the amount of time during which a Soldier can be separated from the Army under Chapter 11 (from 6 months to 18 months).
- ★ [HQDA] Reduce drug and misconduct enlistment waivers to reduce accessions of high risk recruits to ensure more resilient applicants.
- ★ [HQDA] Direct research to assess the second and third order effects of increased waivers and relaxed separation standards in terms of crime and drug involvement and other high risk behavior.
- ★ [HQDA] Hold commanders and ADCOs accountable for referral compliance to ASAP.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 17 – Current Reality of the High Risk Population

7. Increased Crime

Crimes reflect the results, and in some cases, the cause of high risk behavior in the Army. This section discusses problems, conclusions and recommendations relating to risk associated with a variety of criminal offenses, from disciplinary infractions to misdemeanors to felonies. Although data for each of these categories reveal problems of risk, the recurring theme in this section is the Army's inability to assess that risk due to lack of visibility. This is caused by failures to use existing reporting procedures, gaps and seams in reporting policies and processes, and other deficiencies in information gathering that likely mask the scope of crime within the ranks.

a. Disciplinary Infractions

Suspected disciplinary infractions frequently trigger commanders' investigations under AR 15-6. There is no way to know how many AR 15-6 investigations were conducted over the last nine years, or how many commanders used this method of investigation to make determinations on serious misconduct. This is because there is no database to capture any elements of an AR 15-6 investigation. Only some of these investigations that indicate alleged crimes are referred to the appropriate agency (law enforcement, ASAP and/or FAP), which is responsible for documenting and tracking subsequent actions. There is a clear indication from existing data that commanders are not making all of the appropriate referrals to these agencies in accordance with policy.

b. Misdemeanor Crimes

An examination of all known misdemeanor offenses indicates a steady increase since 2004. In FY 2009 alone there were 50,523 misdemeanor offenses recorded in the COPS database. However, these numbers do not reflect the number of AR 15-6 investigations or subsequent disciplinary action taken by the commander.

FY 2009 misdemeanor data reveal that the primary offense was motor vehicle violations (MVs) including speeding, drunk driving, and motor vehicle fatalities. The second largest group includes absent without leave (AWOL), desertion, and missing movement. Since FY 2004, the number of MVs has increased by 166%. AWOL, desertion and missing movement has more than doubled (an increase of 234%).

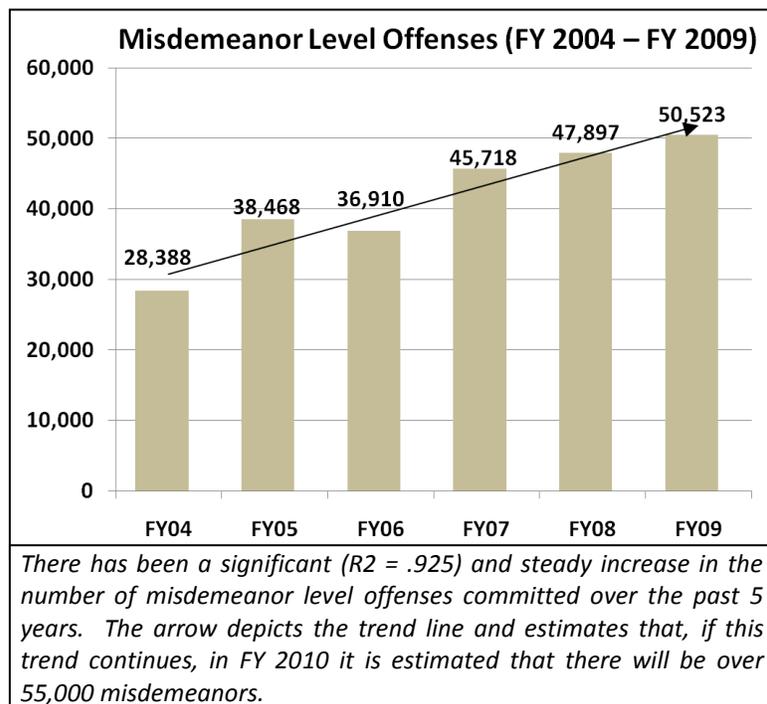


Figure 20 – Misdemeanor Level Offenses, FY04-09

While misdemeanor cases represent lesser crimes, the fact that they have been on the rise since FY 2004 at a rate of almost 5,000 per year indicates that good order and discipline are on the decline (see Figure 20). Like drug use, misdemeanors have a social component, often involving multiple subjects and often escalating to more serious crime. Additionally, this trend has a substantial collateral effect on the force in terms of victims and leader time and resources. Misdemeanors between FY 2004 – FY 2009, for example, negatively impacted 145,541 total victims when the government is included in the victim count. In terms of unit readiness and team cohesion, it affected 59,234 fellow Soldiers and Families.

c. Felony Crimes

Felonies represent the most serious offenses that can be committed in both the military and civilian sector. Of the 64,022 felony and death investigations between FY 2001 – FY 2009, 72% were drug related (see Figure 21). These 64,022 felony and death cases involved 68,028 subjects and 109,903 victims. The largest incidence of drug cases involved marijuana, which surpassed all other drugs combined. The second largest category of felonies was “All Others,” which includes burglary, fraud and larceny and accounted for just under 18% of all felonies during this period.

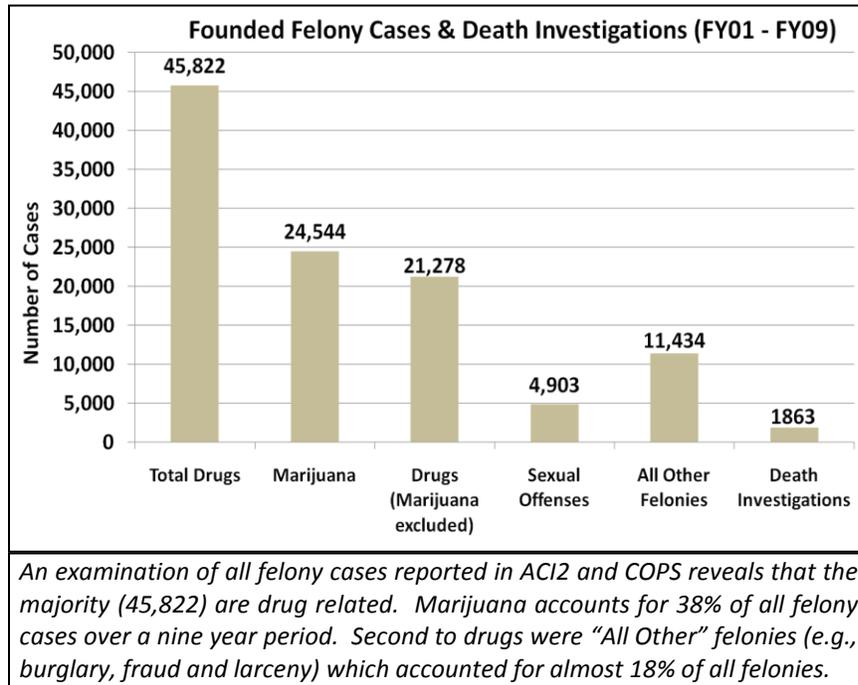


Figure 21 – Founded Felony Cases and Death Investigations (FY01-09)

(1) Felony Drug Crimes

Any possession or use (which implies possession) of illicit drugs constitutes a felony under the UCMJ. Unfortunately, the Army fails to account for and prosecute (or at least initiate administrative separation for) all cases of illicit drug use revealed by UA. Data on illicit use positives (reviewed earlier in this section), reveal that over 44,998 individual Soldiers were reported as drug positive in DAMIS between FY 2004 – FY 2009. A comparison of DAMIS and ACI2 data for illicit drug use last year (excluding marijuana use), demonstrates that 40% of the illicit use drug UA positives were never referred for felony investigation. The figures are far below the numbers expected given the quantity of positive UAs. This represents a gap between commander referrals and law enforcement investigations.

The COPS query in Table 10 reports the number of drug cases resulting in treatment referral. These data are significantly lower than the number of cases and referrals that result from UA positive tests. On average, the number of referrals to ASAP from UAs as reported in DAMIS is approximately 60% per year. Additionally, the number of drug cases being investigated is far below the number being referred to ASAP for positive illicit drug use (see Table 10). This means that even though these UAs represent illicit drug positives, the number of positive tests being referred to law enforcement from ASAP is

lacking. It is uncertain how many of the DAMIS referrals are also counted in the COPS data. Nonetheless, it speaks to gaps in silo'ed reporting and a failure in the ability to provide commanders with accurate and consistent information.

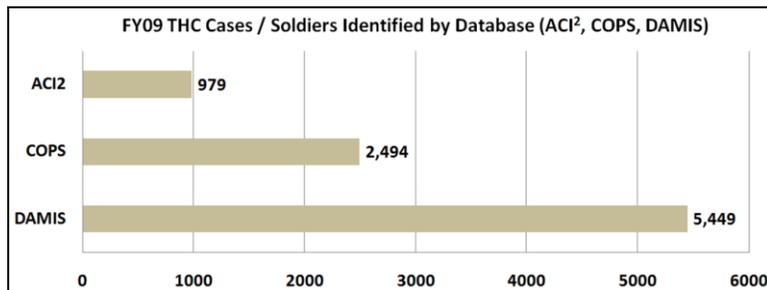
FY	COPS/ACI2 Data		?	DAMIS Data	
	Drug Subjects	Referred to ASAP		Total Positive for Street Drugs	Referred to ASAP
2004	6,391	468 (7%)		6,243	3,808 (61%)
2005	7,836	718 (9%)		7,381	4,059 (55%)
2006	7,681	1,204 (16%)		7,527	4,516 (60%)
2007	7,439	1,160 (16%)		8,080	5,575 (69%)
2008	7,874	1,123 (14%)		7,860	5,344 (68%)
2009	7,559	1,262 (17%)		7,907	4,111 (52%)

Drug referral rates to ASAP as a result of criminal drug activity remain low and have not improved much since a spate in 2006. By contrast, DAMIS data reflect a relatively high rate of referral to law enforcement. There also appears to be a serious gap in the number of referrals to ASAP triggered by law enforcement. While there has been improvement in referral rates, in FY 2009 a total of 6,297 law enforcement cases were never referred to ASAP for evaluation. Because these databases do not communicate, it is unclear how many of the above cases are represented in both databases.

Table 10 – Comparison of Law Enforcement and ASAP Referral Data (FY04-FY09)

As part of the annual law enforcement “drug report” for FY 2009, the total number of cases for marijuana in both COPS and ACI2 was dwarfed by the number of THC positives reported by ACSAP (see Figure 22). This finding is the result of commanders not referring allegations to law enforcement, failure of law enforcement to initiate a case or a combination of both. Consequently, this situation presents yet another example of discontinuity in processes harboring a population of potential high risk Soldiers within the Army.

One way to reduce this problem could be to reinstitute law enforcement awareness and crime prevention which has historically been successful among commands situated in garrison. Drug



An examination of CID ROIs, COPS MPRs and ACSAP positives for illegal use of THC indicate that there is a significant lack of cross reporting among the three agencies. There is an expectation that, at minimum, the number of cases reported in COPS and by CID should equal the number of drug positives reported by ACSAP.

Suppression Teams (DSTs) using sting operations could identify, trace and eliminate drug distribution rings on posts, camps and stations. DSTs, once relatively common prior to the increase in OPTEMPO, represent another example of tools available to unit commanders for combating illicit drug use. Additionally, commanders need to reacquaint themselves with crime prevention practices and not rely solely on UAs to detect illicit drug use.

Figure 22 – FY09 THC Cases/Soldiers Identified by Database

CONCLUSIONS

- ★ In FY 2009 alone there were 50,523 misdemeanor offenses committed by Soldiers. (page 72)
- ★ Misdemeanor crimes are on the rise since 2004 by almost 5,000 per year which indicates that good order and discipline are on the decline. (page 72)
- ★ In real terms of unit readiness and team cohesion misdemeanors affected over 59,000 fellow Soldiers and Families. (page 72)
- ★ There were 64,022 felony and death investigations conducted between FY 2001 – FY 2009, of which 72% were drug related. The 64,022 investigations involved 68,028 subjects and 109,903 victims. (page 73)
- ★ 40% of the illicit use drug UA positives were never referred for felony investigation. (page 73)
- ★ Gaps in silo'ed reporting prevent commanders from receiving accurate and timely information. (page 74)

RECOMMENDED ACTIONS

- ★ [OPMG] Activate and/or increase Drug Suppression Team operations at all installations.
- ★ [CDRs] Utilize military working dogs for health and welfare checks within the barracks and unit areas.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 18 – Disciplinary Infractions and Crimes

(2) Soldiers with Two, Three (or More) Felonies

Between FY 2001 – 2009 approximately 10,600 Soldiers were subjects of two or more felony cases (separate cases at different times). Unlike felony drug offenses (e.g., positive UA for an illicit or unauthorized use), no regulation requires separation action for a founded felony offense. A review of the disposition of these 10,648 felons revealed that 10% (1,054) remain on active duty, 50% were separated for misconduct, 13% were dropped from the rolls (DFR) and 7% were allowed to ETS under honorable conditions (see Figure 23).

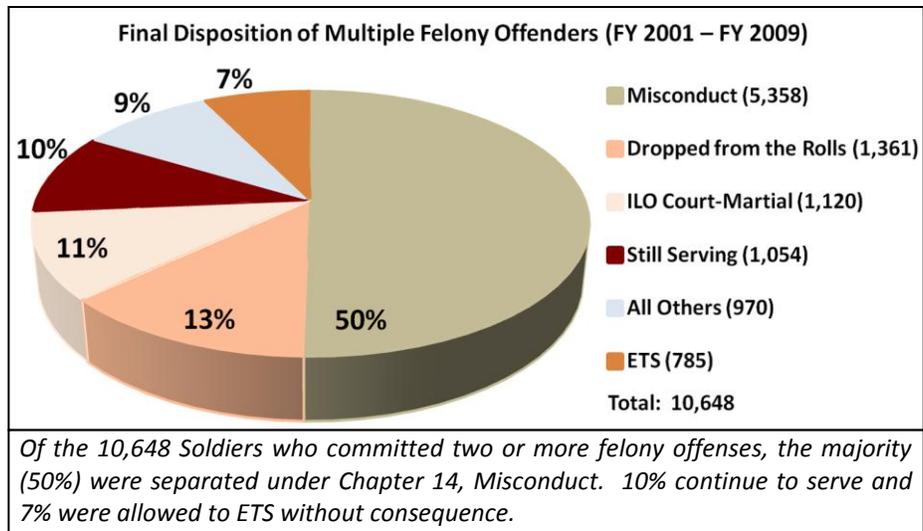


Figure 23 – Final Disposition of Multiple Felony Offenders

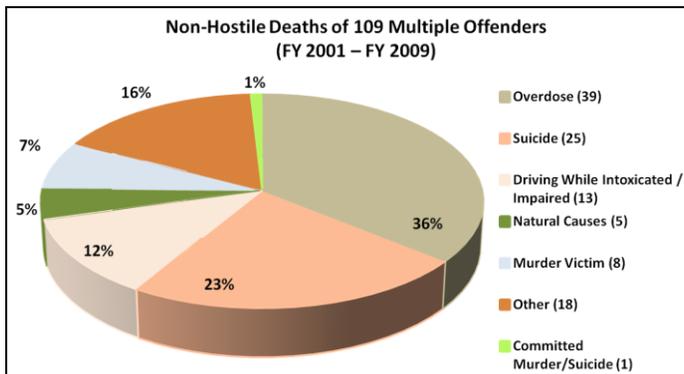
PATTERN OF CRIMINAL BEHAVIOR

A 30 year old Specialist was the subject of multiple criminal cases over a three year period. These included abusing his infant daughter (shaking her to the point of brain injury), injuring his three month old son, battering his wife and finally committing homicide (by killing his wife and then burning her car). He was charged with the homicide and the arson. While awaiting trial by civilian authorities for the homicide, he subsequently committed housing allowance fraud. He then remarried and was again accused of spousal abuse before ultimately killing himself.

- Early detection and appropriate adjudication can prevent serial offenders from negatively impacting Army readiness and prevents victimization.

Vignette 15 – Pattern of Criminal Behavior

Among the multiple (two) and serial (three or more) felony offenders from FY 2001 – FY 2009 there is a subset of 109 Soldiers who died while on active duty. Of these, 78% died as a direct result of high risk behavior. This includes 39 Soldiers who died from drug and/or alcohol overdose, 25 who committed suicide, 13 who died while driving intoxicated or impaired, eight who were victims of murder and one who committed murder and then suicide (see Figure 24). Of the 39 Soldiers who overdosed, 28 used prescription drugs. The toxicological examination of the 25 suicide victims determined 11 had drugs and/or alcohol in their systems. Of the eight murder victims, five Soldiers were stabbed and three were shot. In one murder case, four former Soldiers were suspected of the crime but never charged. In another, an intoxicated Soldier was shot after brandishing a firearm at a nightclub.



A total of 109 multiple offenders have died while on active duty as a result of non-hostile deaths. The majority (39) died by overdose with 72% of these deaths involving prescription drugs. Additionally, 25 committed suicide and eight became the victims of murder.

Figure 24 – Multiple Offender Non-Hostile Deaths, FY01-09

The Soldiers reflected in the 'Other' category died primarily from traffic accidents. However, six Soldiers were engaged in risky behavior at the time of their deaths. Examples include traveling with an intoxicated driver (3) and accidents involving firearms (3). Lastly, even two of the five Soldiers who died of natural causes were determined to have drugs and /or alcohol in their systems.

Soldiers who commit two or more felonies represent obvious disciplinary problems that if left unchecked, spiral toward serious negative outcomes. Leaders must recognize high risk behavior and intervene early through appropriate

discipline, referral and retention policies and processes. Similar to multiple illicit drug users, leaders must accurately report and record criminal offenses to ensure future adjudication is not conducted in the isolation of a single incident. Firm leadership Army wide will ensure Soldiers with multiple felonies are not retained, not allowed to move freely through the force or not able to adversely affect Soldier and unit readiness.

CONCLUSIONS

- ★ Between FY 2001 – FY 2009, approximately 10,600 Soldiers committed two or more felony offenses (separate cases at different times) with 1,054 remaining in the Army. (page 75)
- ★ Between FY 2001 – FY 2009, 109 multiple and serial felony offenders and drug abusers died while still serving. Of these, 77 died from overdose, suicide or DUI. (page 76)
- ★ Retaining multiple criminal offenders is an unacceptable liability to the Army, their potential victims and the offenders themselves. (page 76)

RECOMMENDED ACTIONS

- ★ [HQDA] Revise policy to ensure separation from the Army for all **second** felony criminal offenders.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 19 – Soldiers with Two, and Three (or More) Felonies

d. Multiple and Serial Illicit Drug Use

Given that illicit drug use is inconsistent with Army Values, one would not expect the presence of multiple and serial drug offenders in the Army. Data for FY 2001 – FY 2009 indicate otherwise.⁷⁶ Drug testing results reveal that of the total number of Soldiers tested, 3.5% (58,687 of 1,662,004) were positive for illicit drug use (see Table 7, page 50). That includes Soldiers who tested positive one, two or three or more times. When separated into these specific categories, 36,470 (62%) were first time positives, 11,828 (20%) were multiple, and 10,389 (18%) were serial offenders.

When the rates of first time, multiple or serial positives are charted by year, these data indicate that the multiple and serial positive rates fall far below the first time use rates (at about .03% of those tested, see Figure 25). Additionally, the figure indicates that while the overall rate of drug positives is not increasing, Soldiers who test positive a second time for illegal drug use are very likely to test positive again.

Even more concerning is the fact that it is impossible to know the disposition of these individuals. Even first time offenders who should be recommended for separation may not be going through the formal process, because there is no mechanism in place to

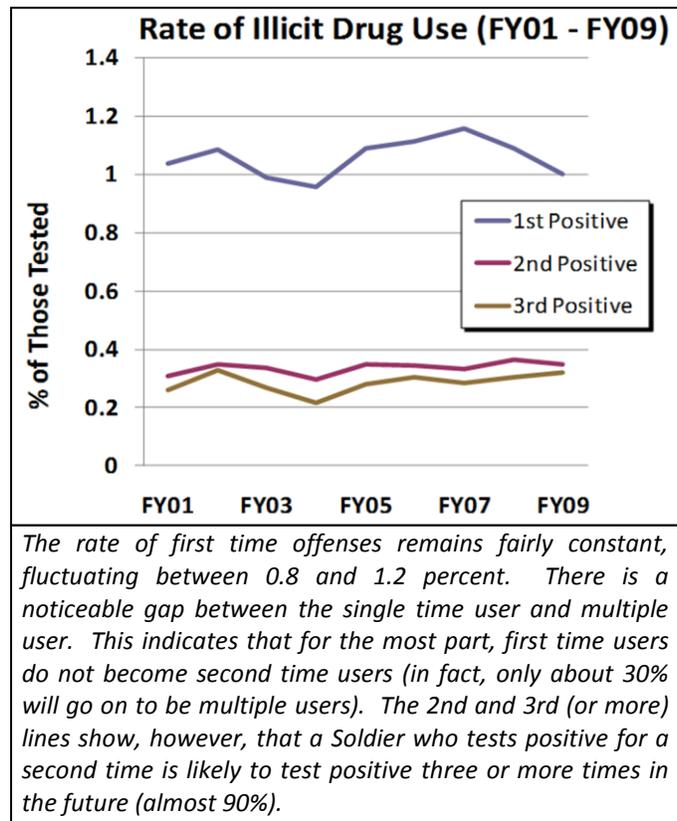


Figure 25 – Illicit Drug Use Rate, FY01-09

⁷⁶ AR 600-85, *Army Substance Abuse Program*, para. 1-7c(1).

determine if separation action has been initiated. Once again, failure to use DA Form 4833 creates blind spots in situational awareness. Until commanders report the disposition for separation of alcohol and drug offenders to ASAP and law enforcement, it is impossible to track separation actions for these specific offenses.

While the overall illicit drug use rate is holding constant, the number of MRO reviews is increasing (includes legitimate prescription drug use and positive UAs for other pharmaceutical drugs; see Figure 15, page 54). As previously noted, current policy governing prescription drug use may be masking illicit drug use due to open-ended prescriptions. Overall use of amphetamines (including both legal and illegal) is growing at a rate of 2.8 percent per year for all COMPOS. This means that by the end of next year it is expected that there will be over 5,000 MRO reviewable positive tests for amphetamines alone. Among the street drugs, marijuana is increasing significantly within the National Guard population. In fact, if we look at the rate of THC positives over the last four years, it is predicted that over 7,500 Guard Soldiers will test positive for THC this year. See Figure 69 in Annex E.

CONCLUSIONS

- ★ 58,687 Soldiers tested positive for illicit drug use between FY 2001 – FY 2009. 36,470 were first time positives, 11,828 were multiple and 10,389 were serial offenders. (page 77)
- ★ There is a 90% chance a Soldier who tests positive a second time will test positive three or more times. (page 77)
- ★ By the end of next year it is expected there will be over 5,000 positive tests for amphetamine which will require an MRO review. (page 78)
- ★ It is predicted over 7,500 Guard Soldiers will test positive for THC this year. (page 78)

RECOMMENDED ACTIONS

- ★ [HQDA] Revise Chapter 9 to extend the rehab window to include recidivism (drug rehab plus one year); revise Chapter 14 to provide specific data indicators for drug, alcohol use and other misconduct categories. Ensure separation code data is available at all levels of the Army.
- ★ [CDRs] Process second time offenders for separation from the Army.

Refer to Annex B for additional detail and supporting actions

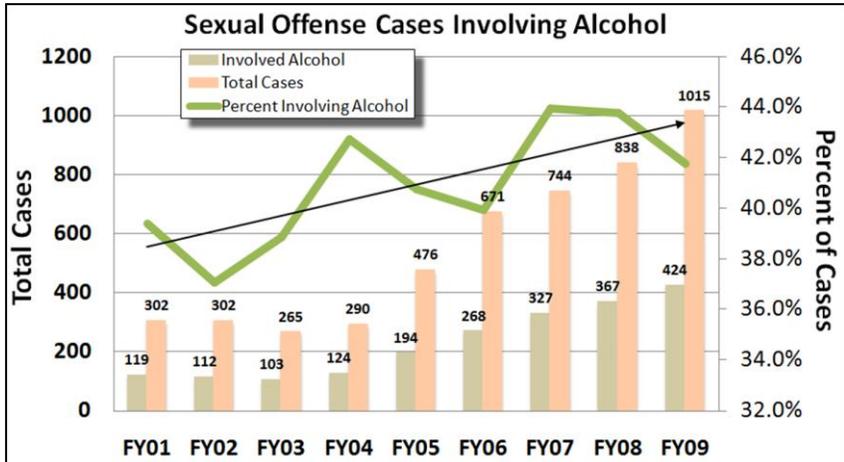
Conclusions & Recommendations 20 – Soldiers with Multiple Positive Drug Tests

e. Sexual Offenses

One of the more disturbing trends from FY 2001 – FY 2009 is a clear and steady rise in the number of sexual offenses, which have essentially tripled since FY 2003. This represents a specific increase from 265 cases in FY 2003 to a substantial 1,015 in FY 2009. In addition, there were 293 restricted reports in FY 2009 that are not reflected in these data. While these increases may be attributed to overall Army efforts to increase awareness, reporting and intervention, the steady rise is still cause for concern. It suggests that despite the Army's awareness campaign, there is still an indication that this high risk behavior will continue in the force.

In addition, potential involvement of drugs or alcohol (in both subject and victim) in sexual assault offenses is on the rise. Drugs and alcohol are historically significant “enablers” for sexual offenses, meaning that as the use of these substances increases, sexual assaults increase. What is not shown in the graph (Figure 26), however, is the fact that the rate of sexual assault is outpacing drug and alcohol involvement, indicating that these substances are not solely driving this behavior.

Approximately 41% of sexual crimes involved drug or alcohol use by the subject and/or victim. CID estimates this rate is actually closer to 60% based on an individual’s reluctance to admit to underage drinking or General Order #1 violations associated with the incident. Administrative shortcomings by CID, such as failing to document alcohol/drug involvement for each case, may also contribute.



The total number of Sexual Offenses (includes rape, incest and sodomy) have been steadily increasing since FY 2004. Rape alone is a major driver of these increases and has been escalating since 2004 at approximately 150 cases per year. Sexual offenses involving alcohol have also increased over this same time period, but to a lesser extent (about 30 cases per year).

Figure 26 – Sex Crimes Involving Drugs and Alcohol, FY01-09

CONCLUSIONS

- ★ There is a clear and steady rise in the number of reported sexual offenses from FY 2001 – FY 2009, tripling from a low point of 265 in FY 2003 to a substantial 1,015 in FY 2009. (page 78)
- ★ 41% of the FY 2004 – FY 2009 reported and founded sexual offense cases involved drug or alcohol use. CID estimates this rate is actually closer to 60% based on an individual’s reluctance to admit to underage drinking or General Order #1 violation associated with the incident. (page 79)

RECOMMENDED ACTIONS

- ★ [HQDA] Revise policy to separate first time sexual assault offenders from the Army.
- ★ [CDRs] Educate leaders and Soldiers on the relationship between drug/alcohol involvement and sexual offenses.
- ★ [HQDA] Coordinate policy revision to provide an opportunity for testimonial immunity of victims for violation of drug and alcohol policy in sexual assault cases.

Refer to Annex B for additional detail and supporting actions

f. Family Advocacy

The number of Soldiers who committed spouse abuse and child abuse/neglect in the last six years has increased by 177% (913 cases in FY 2004 vs. 1,625 in FY 2009). Of the 8,038 Soldiers who engaged in this high risk behavior between FY 2004 – FY 2009, only 1,022 (13%) were referred to FAP for counseling (as reported in the COPS database).

Additionally, much like other HQDA programs used to identify potential criminal behavior, there appears to be a gap in the referral of cases to law enforcement. HQDA FAP FY 2009 statistics show that 2,106 Soldiers were the subjects of substantiated spouse abuse cases and were referred for treatment/counseling. Unfortunately, only 1,129 spouse abuse cases were ever reported to law enforcement (as demonstrated by the number of cases entered in COPS). Some of this discrepancy, however, may be due to legal evidentiary thresholds for suspecting criminality. For example, FAP will refer Family members for treatment or counseling due to a perceived threat (e.g., verbal harassment/abuse). By contrast, data found in COPS require that there was credible information to title and subsequent probable cause to determine a founded offense. Additionally, law enforcement personnel may choose to enter the offense code for assault rather than for spouse abuse, administratively reducing the total number of reported cases to law enforcement. As a result, law enforcement may not have full situational awareness of domestic violence on the installation or how commanders are adjudicating these actions.

8. Death Cases

There is a slow but steady rise in the number of deaths from FY 2001 – FY 2009 as depicted at Figure 27. This is true for all manners of death except for murder rates, which have held somewhat constant over the nine-year period. This overall increase is almost fully accounted for by the rise in both suicide numbers and accidental deaths. Because accidental deaths can be considered the result of high risk behavior, these numbers speak to the fact that risk-seeking behavior is slowly increasing among Soldiers. When compared to FY 2001, the death rates of both suicide and accidental death have more than tripled. Additionally, there was a clear uptick in trends across all death categories between FY 2008 and FY 2009 (as demarcated by the dashed line).

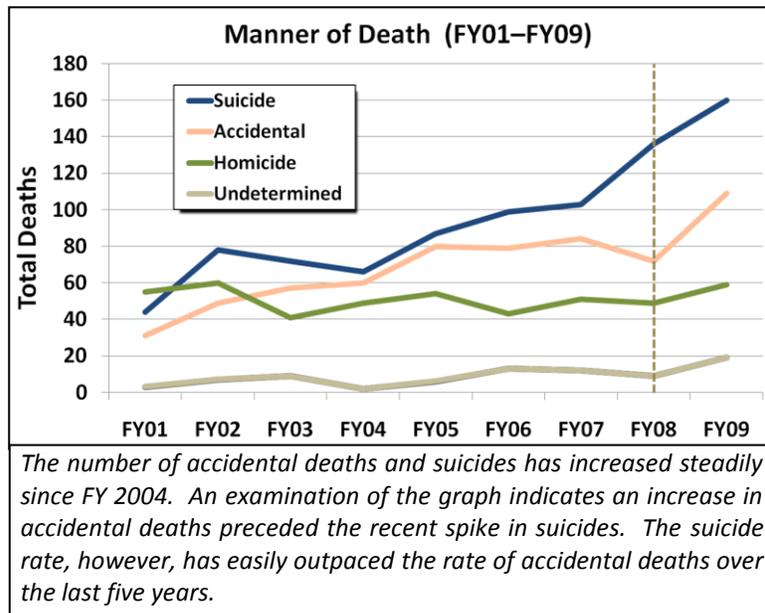


Figure 27 – Manner of Death, FY01-09

a. Criminal History and Suicide

A review of suicide victims from FY 2005 – FY 2009, illustrates a concerning level of criminal activity and drug/alcohol use. During this period, 25% of suicide victims were prior subjects of a founded misdemeanor or felony investigation and 29% of victims had drugs and/or alcohol in their systems at the time of death.

As displayed in Figure 28, 13% of suicides in FY 2009 involved drugs and/or alcohol. (This rate will likely increase when remaining FY 2009 toxicology reports are available). Approximately 31% of suicide victims were subjects of a prior law enforcement investigation. Their alleged offenses included DUI, rape, aggravated sexual assault, use of cocaine, etc.

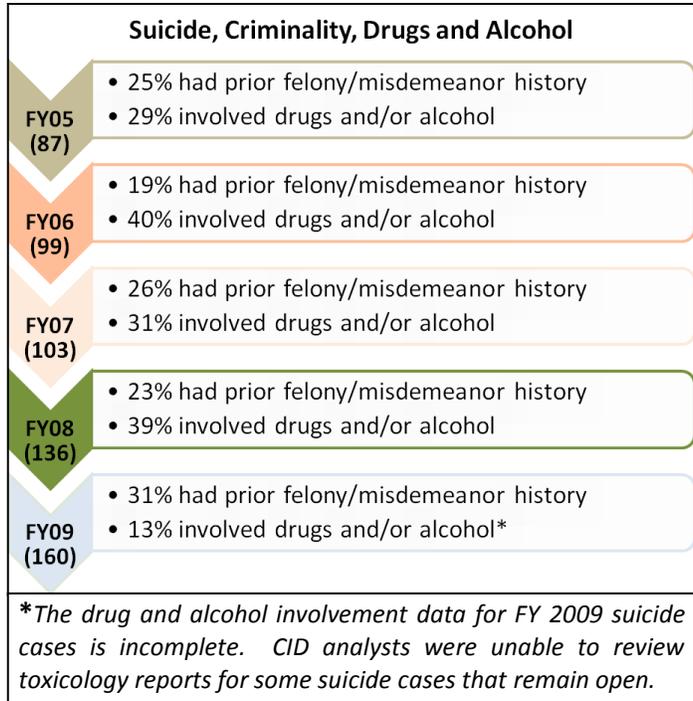


Figure 28 – Suicide, Criminality, Drugs and Alcohol, FY05-09

ALCOHOL & SUICIDE

A 45 year old, divorced Sergeant First Class who had never deployed and had a history of sexual misconduct was facing a Special Court-Martial. He was also recently charged with DUI. The command referred him to ASAP and behavioral health. The unit was persistent in ensuring he received professional help. When he was late for duty, unit members went to his off-post apartment where he had been drinking heavily. He met them outside and began to argue. He returned to his apartment and shot himself.

- Potential career ending events place senior Soldiers at higher risk. Drug or alcohol abuse further erodes judgment and coping skills.

Vignette 16 – Alcohol and Suicide

CONCLUSIONS

- ★ Law enforcement personnel may enter the offense code for assault rather than for spouse abuse, administratively reducing the total number of reported cases to law enforcement. (page 80)
- ★ There is a slow but steady rise in the number of non-combat Soldier deaths from FY 2001 – FY 2009. This increase is almost fully accounted for by the rise in both suicide numbers and accidental deaths. (page 80)
- ★ 25% of FY 2005 – FY 2009 suicide victims were prior subjects of a founded misdemeanor or felony investigation. 29% of FY 2005 – FY 2009 victims had drugs and/or alcohol in their systems at the time of death. (page 81)

(Continued)

RECOMMENDED ACTIONS

- ★ [OPMG] Prevent double reporting in COPS by making the "Referred to CID" field a mandatory populated field.
- ★ [OPMG] Ensure assaults in cases of spouse abuse are coded appropriately for spouse abuse to provide accurate and consistent data reporting.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 22 – Death Cases

9. Consequences of Inaction

When known criminals are not removed from the force, it sends a message to the rest of the Soldiers in the unit that high risk behavior, such as drug use, is acceptable. Soldiers know the members of their unit who are using, distributing and trafficking drugs. Allowing high risk individuals to persist in the force calls into question the readiness of the command. As command climate erodes, the Soldiers who are prone to practice high risk behavior have little reason to question consequence, as they see there will likely be none. While some commanders may use alternative methods (besides separation) in an attempt to initially rehabilitate a Soldier, frequently these actions are not documented in any database that is accessible by future commanders. Reporting, documenting and acting on high risk behavior are the only means to reduce future serious and dangerous outcomes. This section discusses the negative outcomes of inaction.

“This is the intersection of individual-level problems that tended to focus around unrecognized and untreated post-traumatic stress problems and depression and some other behavioral health problems; alcohol or drug use that was not addressed properly and treated successfully; and misconduct that began as nonviolent, non-serious crimes but were not recognized and not dealt with aggressively by the leadership.”

– LTG Eric B. Schoomaker, *The Surgeon General, Army*
“Wounded Platoon,” PBS Frontline, 15 March 2010

Quote 8 – LTG Eric Schoomaker, 15 Mar 10

a. Impact of Low Referrals to ASAP

These data show that, potentially, 30-40% of the Soldiers who received a DUI citation or were positive for illicit drug use were never referred to the ASAP for a clinical evaluation. This rate is steady from FY 2001 – FY 2009 (see Table 29 in Annex E), as reported by substance abuse counselors worldwide. Essentially, there is a population of Soldiers (over 9,000 in nine years) exhibiting high risk behavior that has never seen an ASAP counselor for an evaluation to determine abuse or dependence. Consequently, commanders are unsure of the readiness, fitness, health and wellness of their Soldiers. Drug and alcohol abuse can also be a sign of behavioral health problems. By not referring Soldiers to ASAP, we are potentially missing contact opportunities to provide program/service intervention.

b. Prescription Drug Referrals

The Army’s medical leadership needs to address a troubling concern: prescription medication abuse may be inadvertently masked by current prescribing practices, and therefore may be more prevalent

than indicated by ASAP UA testing. Specifically, a physician may authorize a Soldier to use a medication on an “as needed” basis, but without setting a time limit for approved use. As a result, the Soldier may use, abuse or distribute the drug long after the medical condition for which the drug was prescribed has resolved. For example, if in 2001 a Soldier incurred a minor back injury and was prescribed 30 pills of oxycodone for use “as needed,” the Soldier could potentially test positive on a UA test 30 times for oxycodone and be exonerated by MRO review each time over the ensuing years. The number of pills the Soldier actually took over this period from this prescription or from other sources (for authorized or illicit purposes) would be unknown. Simply put, this Soldier could be taking high doses of oxycodone daily with no means for detection or intervention.

There is no policy governing the length of “as needed” prescriptions. These open-ended prescriptions create another policy and process gap that harbors illicit use. This may also account for the leveling off of drug use in the Army as Soldiers transfer from street drugs to illicit use of pharmaceuticals. It may even foster illegal distribution because a Soldier with an “as needed” prescription could buy and sell the drug to other Soldiers with impunity.

In a recent briefing, the Army Surgeon General estimated that almost 14% (76,463) of the force were prescribed some form of an opiate drug. Of those, 95% (72,764) were taking oxycodone. In addition, almost 34% (25,761) had two or more active prescriptions. The number of prescriptions per year in the Army has increased. This means, the number of pharmaceutical drugs in the force has gone up (by an unknown amount) because there is no expiration for some prescriptions. This is illustrated by the increasing number of MRO reviews required year over year. This increase in reviews, coupled with an increase in the overall authorized use rate for these pharmaceutical drugs, speaks to the permissive climate of prescription medication use in the Army. Consequently, the overall increase in authorized use severely dampens surveillance and detection of any potential illicit drug use.

From the commander’s perspective, there is no way to detect the masked abuse of “as needed” prescription drugs. Therefore, commanders can neither measure nor mitigate this potentially deadly risk to their Soldiers. The Army’s medical leadership can remedy this problem by placing appropriate time limits on the legitimate use of prescription drugs, particularly for oxycodone and other opiates/ drugs with addictive qualities or a high propensity for abuse.

CONCLUSIONS

- ★ There were over 9,000 Soldiers (in the last nine years) who demonstrated substance abuse issues that were not referred to ASAP for evaluation. Drug and alcohol abuse can also be a sign of behavioral health problems. By not referring Soldiers to ASAP, we are potentially missing contact opportunities to provide program/service intervention. (page 82)
- ★ Current prescription medication policies may be masking abuse problems across the force. (page 83)

RECOMMENDED ACTIONS

- ★ [HQDA] Limit prescription duration so a script is not considered valid after one year without provider reevaluation and renewal.
- ★ [IMCOM] Monthly reporting of ASAP referral rates to garrison commanders and higher headquarters to ensure compliance to existing policy.

Refer to Annex B for additional detail and supporting actions

c. Impact of Delinquent DA Forms 4833 on the Force

Failure to forward DA Forms 4833 to commanders results in a lack of command visibility of criminal and high risk behavior. This limits the commander’s ability to get the “whole picture” when adjudicating a course of action on an individual Soldier. If commanders do not know the number of criminal offenses occurring in their unit and cannot weigh that with previous criminal history (which is provided by program databases), they cannot make informed decisions. If the commander in turn subsequently fails to take action or fails to return the DA Form 4833 to law enforcement with adjudication results, they place future commanders of these Soldiers in the same predicament. This enables these Soldiers to continue high risk behavior without leader intervention. This impacts the Soldier, unit and the Army at large.

The general lack of DA Form 4833 reporting also negatively impacts law enforcement agencies. Without a DA Form 4833 they are unable to officially close the criminal case and report adjudication to DoD and national databases in accordance with regulations. Also, law enforcement agencies are unable to record and analyze actions taken by commanders to develop installation-wide risk assessments. This means that commanders lose visibility of the extent of high risk behavior at each echelon, from small units to HQDA.

d. Impact of Retaining Soldiers with Multiple and Serial Positive UAs

Serial drug abuse contradicts Army values. The large number of Soldiers who have three or more positive drug tests demonstrates that the Army by its inattention is condoning high risk behavior, such as illicit drug use. If the rates within the last few years continue, we can expect over 3,000 Soldiers will test positive for multiple or serial offenses at some time during FY 2010.

One should question the fitness and readiness of a Soldier who has been identified as a serial drug abuser. A positive drug test only shows activity at or near the time of the test. There is no way to be certain of the number of times a Soldier, especially a serial abuser, used a particular drug before getting “caught.” For that reason, the numbers of actual drug users may be underestimated. Since serial abusers may be under the influence of drugs nearly all the time, not just at the time of the urinalysis, the Army assumes a level of risk when it maintains serial drug users in its ranks.

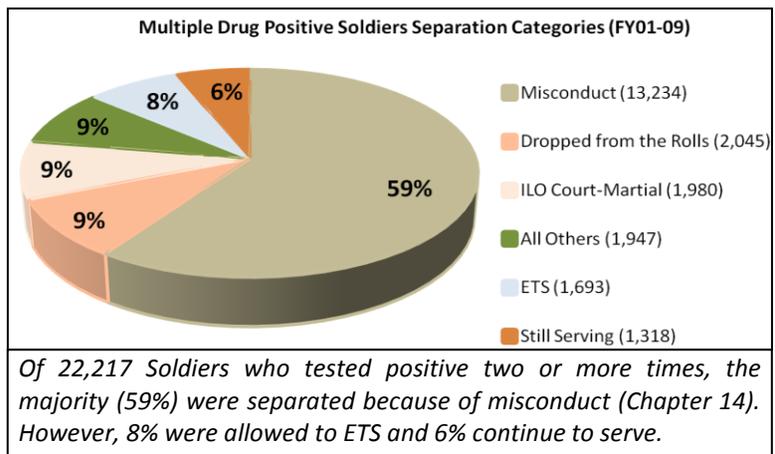


Figure 29 – Separation Categories for Multiple Drug Positive Soldiers

Compounding this risk is the scope of the serial abuse problem across the Army. The Soldiers who tested positive multiple or serial times (1,643 and 1,512 last year respectively) represent potentially more than 3,000 Soldiers who were candidates for discharge from the Army. The estimated number of such Soldiers over a nine year period would exceed 20,000.

Soldiers who abuse drugs indicate a larger problem such as drug distribution. When the number of Soldiers titled by CID for distribution was compared to the number of Soldiers who had tested positive on a drug screen for illicit use, 1,801 of the total 4,469 Soldiers (40%) had tested positive at least once in their career. In one unique case, a Soldier who had been the subject of a founded offense for distribution had also tested positive for illicit use 17 times. Therefore, leaders who fail to take proper steps to administratively separate serial abusers increase the risk of not only drug use, but also the likelihood of drug distribution within the ranks.

SERIAL DRUG ABUSE

A Sergeant tested positive for cocaine and marijuana three weeks prior to a December 2007 OIF deployment. He tested positive for cocaine again following his November 2008 R&R leave and then a third time after redeploying in February 2009. Criminal information indicated he was also cited for five moving violations to include two traffic accidents resulting in damage to private property. He was separated (Chapter 10) in May 2010.

- Drug abuse, like other crimes, can have a deleterious effect on fellow Soldiers, their unit and the community at large.

Vignette 17 – Serial Drug Abuser

Even though most of the separation actions taken in both the multiple and serial illicit positive cases were Misconduct (Chapter 14), there is no way of knowing if the separation was a direct result of the UA positive or if it was a result of a subsequent high risk behavior. Again, because there is no mechanism for tracking drug or alcohol specific separation actions, analysis of data could not determine the appropriateness of many Chapter 14 separations when drugs or alcohol were involved.

In addition, factors linked with drug use include criminal activity, spouse abuse and financial strain, to name a few. The drive to feed a drug habit fuels criminal activity and tension during social interactions. When cross-referencing the 10,389 SSNs of alleged serial drug users with the 2,405 SSNs of alleged serial criminal offenders from FY 2001 – FY 2009, data showed 1,675 Soldiers are common to both lists. While drug activity represents 75% of their crimes, these high risk offenders have also committed offenses such as murder, rape, arson, burglary and fraud, and thus had a devastating impact on other Soldiers and Families.

CONCLUSIONS

- ★ Failure to forward DA Forms 4833 to commanders results in a lack of command visibility of criminal and high risk behavior. This limits the commander's ability to get the "whole picture" when adjudicating a course of action on an individual Soldier. (page 84)
- ★ We can expect that over 3,000 Soldiers will test positive for multiple or serial offenses at some time next year. (page 84)
- ★ A positive drug test only shows activity at or near the time of the test. There is no way to be certain of the number of times a Soldier, especially a serial abuser, used a particular drug before getting "caught." (page 84)
- ★ The Soldiers who tested positive multiple or serial times (1,643 and 1,512 last year respectively) represent potentially more than 3,000 Soldiers who were candidates for discharge from the Army. The estimated number of such Soldiers over a nine year period would exceed 20,000. (page 84)

(Continued)

- ★ When cross-referencing the 10,389 SSNs of alleged serial drug users with the 2,405 SSNs of alleged serial criminal offenders from FY 2001 – FY 2009, data show 1,675 Soldiers are common to both lists. (page 85)

RECOMMENDED ACTIONS

- ★ [HQDA] Revise policies to separate all Soldiers who commit two or more felony offenses, including drug and alcohol related offenses.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 24 – Soldiers with Multiple and Serial Positives



e. Impact of Retaining Soldiers with Multiple Felony Offenses

Retaining multiple offenders erodes Army wellbeing. The collateral impact of their criminal conduct impacts Soldier, Family and unit readiness. Further, it allows Soldiers to spiral into the high risk behavior continuum, thereby permitting them to become a greater risk to others and themselves. Multiple offenders impacted a total of 50,472 victims. Specifically:

- 12,093 two-time offenders impacted a total of 34,002 victims,
- 2,681 three-time offenders impacted a total of 11,028 victims,
- 700 four-time offenders impacted a total of 3,916 victims and
- 197 five-time or more offenders impacted a total of 1,526 victims.

THE POTENTIAL COSTS OF RETAINING MULTIPLE OFFENDERS

A Private tested positive for marijuana in August 2003 and January 2004. He was referred to the Army Substance Abuse Program (ASAP) in February 2004 but not enrolled. He tested positive for marijuana twice in May 2005. The Private completed his term of service and was honorably discharged in June 2005. He enlisted again and returned to duty in February 2006. He was enrolled in ASAP in 2008 for alcohol misuse and tested positive for marijuana a fifth time in February 2009. After consuming several drinks of tequila and arguing with his wife in March 2010, he sexually assaulted her. Despite her attempts to prevent it, he then hanged himself.

- Appropriate administrative separation prevents the re-introduction of high risk behavior in the Army and may prevent the compounding effect of mixing high risk behavior with military related stress.

Vignette 18 – The Potential Costs of Retaining Multiple Offenders

10. Summary

None of these data reviewed in this section, when viewed in isolation, directly address the Army’s suicide problem. However, the Army’s current suicide problem is exacerbated by an acceptance of high risk behavior, amply demonstrated by the consequences of, in part, lapses in leadership in the garrison environment. Consistent with the VCSA’s direction to widen the aperture to look at high risk behavior, this report documents that the suicide problem can only be solved when all aspects of risk management are addressed by commanders, leaders and program/service providers. It is clear certain high risk

behaviors have been trending up since FY 2004. Additionally, these data suggest either commanders lack awareness of these increasing problems or they are ignoring risk factors to retain Soldiers to maintain unit deployment strength. In either case, the results are tragic. If we are going to affect the health of the force, we must provide leaders with the appropriate information so they can lead effectively. In turn we must expect them to use that information and lead.

A review of FY 2010 CID investigations indicates high risk behavior continues to trend upward. Of 283 death cases reviewed, 222 (78%) were the result of high risk behavior (i.e., murder, suicide, accidents or of an undetermined manner). Of these 222 deaths, at least 92 (41%) involved drugs or alcohol use at the time of death. At least 50 (23%) were solely due to drug or alcohol overdoses. These statistics indicating an upward trend will likely continue once CID analysts are able to review toxicology reports for those cases that remain open.

Additionally, FY 2010 drug testing data (through the third quarter) indicate prescription drug use remains a threat to the force. While the illicit use rate has seemingly dropped (from 1.67% in FY 2009 to 1.25%), a review of the MRO review process indicates that the total number of Soldiers illicitly using prescription drugs is on the rise. The number of MRO evaluations in the first three quarters alone surpassed the FY 2009 total with a projected total of 11,288 in FY 2010 (compared to 8,390 in FY 2009). This means if the unauthorized use rate continues through the fourth quarter at 20.1%, 2,370 Soldiers will be identified as illicit users of prescription drugs vice 1,727 in FY 2009. However, given the increase of open ended prescriptions in 2010 the true rate of illicit use still remains unknown. More concerning is that with an increase in open ended prescriptions and an increase in availability of prescription drugs, the gap in surveillance and detection is undoubtedly masking the overall illicit use rate.

Information about the status of Soldiers must be readily available to commanders. Loopholes in information processing and sharing need to be closed. Policy directs specific actions be taken (referral to ASAP, separation initiation, final adjudication of disciplinary cases, etc.), so those actions should be readily verifiable. What gets checked gets done. A review of FY 2010 data thru 30 June 2010 suggests the Army is making some improvements. For example, the FY 2010 ASAP referral rates for DUIs and positive UAs are higher than the FY 2001 – FY 2009 average. However, with only 75% of DUIs and 66% of positive UAs being referred in FY 2010, potentially 25% of these Soldiers are not being rehabilitated. Again, the current gap in surveillance and detection, which masks the overall illicit use rate, may mean the number of Soldiers requiring rehabilitation for dependency/illicit use is even greater.

Statistics presented here represent the result of inaction. Leaders at all levels (e.g., commanders, staffs, program/service providers, medical, law enforcement and judge advocates) must act if the Army is to be successful in reversing these trends. At all points in the Soldier life cycle, leaders need to ensure they are aware of the stressors their Soldiers face, the risks they take and the mitigation required.

Next: The Composite Life Cycle



IV – The Composite Life Cycle

“Soldiers today live a lifetime in their first 6 years of service; [they] experience more during their first enlistment than most of their civilian peers will in a lifetime.”

– GEN Pete Chiarelli, Vice Chief of Staff, Army
ASPTF, 30 April 2010

Quote 9 – GEN Pete Chiarelli, 30 Apr 10

1. Transitions, Major Life Events and Stress

Army Soldiers and Families are familiar with transitions. In many respects, transitions represent the military way of life. The Army’s recognition and minimization of the impact of transitions on units, Soldiers and Families is critical to wellbeing at all levels. In fact, an entire field of study, Transitional Psychology, is dedicated to transitions and their impact as a part of Life Stage Theory. Transitional Psychology recognizes and seeks to better understand the relationship between transitions and personal, career and life stress. According to Dai Williams, “Most transitions are associated with significant life events – changes to the individual’s role or environment.”⁷⁷ These transitions have been recognized by Hopson and others as a primary cause of life stress.⁷⁸ These significant life events (e.g., starting school, graduating high school, entering the Army, death of a loved one, PCS, deploying, etc.) are unavoidable and recurrent. For most, they are experienced either sequentially or concurrently, and may occur infrequently or in compressed cycles. The superposing of the military way of life leads to more frequent and concurrent transitions, which for members of the Army, can lead to greater stress.

In a landmark study, Holmes and Rahe recognized the timing between major life events and major illness and developed a scale to measure this relationship.⁷⁹ Their scale is a weighted list of major “stressful” life events that range in severity from more serious events (such as death of a spouse, divorce, marital separation, etc.) to less serious events (such as change in schools, residence, and work hours/conditions). As these events begin to cluster, there is an accumulation of stress based on individual factors, including: (1) severity of the major life event, (2) number and compression of major life events, (3) personal resiliency, (4) personal coping skills, (5) personal inclination toward help-seeking behavior and (6) access to external intervention. At best, transition may be experienced as a learning or maturing event. At worst, as Williams observed, “Multiple transitions can produce a cumulative deterioration in wellbeing if the individual is unable to recover before another change.”⁸⁰

⁷⁷ Williams, Dai, “Life Events and Career Change: Transition Psychology in Practice,” British Psychological Society Occupational Psychology Conference, January 1999.

⁷⁸ Adams, J., Hayes, J. and Hopson, B., *Transition - Understanding and Managing Personal Change*, London: Martin Robertson, 1976.

⁷⁹ Holmes, T. H. and Rahe, R. H., “The Social Readjustment Rating Scale,” *J. Psychosom. Res.*, 11(2), August, 1967, p. 213-218.

⁸⁰ Williams, op. cit.

“Home is where the Army sends me.”

– Anonymous Army Spouse

Quote 10 – Anonymous Army Spouse, No Date

This section focuses on unit, Soldier and Family transitions. Although transitions can be viewed as positive or negative, they are an essential part of the military culture (e.g., deployment, PCS, promotion, key leadership billets, etc.). For units, Soldiers and Families, any transition can represent a stressful period of change, uncertainty and isolation. The outcome of a transition can either enhance wellbeing through personal and team growth or degrade wellbeing and quality of life through acute, recurring or cumulative stress. Army leaders must amplify the first and mitigate the second.

CONCLUSIONS

- ★ Transitions within the Army are unavoidable and recurrent, representing extensive life stressors that affect the wellbeing of the units, Soldiers and Families. (page 89)
- ★ Compared to civilians, Soldiers experience multiple and more frequent transitions throughout their careers. (page 89)
 - These multiple transitions can produce a cumulative deterioration in Soldiers’ health, wellbeing and ability to recover before another transition. (page 89)
- ★ While stressful transitions are inevitable, their outcomes can enhance Soldier and Family wellbeing or degrade quality of life through acute, recurring or cumulative stress. (page 90)

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 25 – Transitions, Major Life Events and Stress

2. The Composite Life Cycle Model

Following the Army’s installation assessment, the Army Suicide Prevention Task Force (ASPTF) recognized early that in order to address suicide prevention, the Army must widen the aperture from a singular focus on the act itself to a more holistic view of Soldier and Family wellbeing. The VCSA remarked in his media engagement on 29 March 2009 that, “The Army’s charter is more about improving the physical, mental and spiritual health of our Soldiers and their Families than it is about suicide prevention. If we do the first, we are convinced that the second will happen.” The ASPTF’s chartered course broadened the Army’s perspective and prompted the development of a holistic model with the intent of promoting a general awareness of stressors impacting the force.

The *Composite Life Cycle Model* was developed to provide a framework to better view, understand and mitigate the effects of stress during transitions. It is a holistic model that looks beyond the military unit to focus on the whole person through a composite view of three separate strands: the Unit

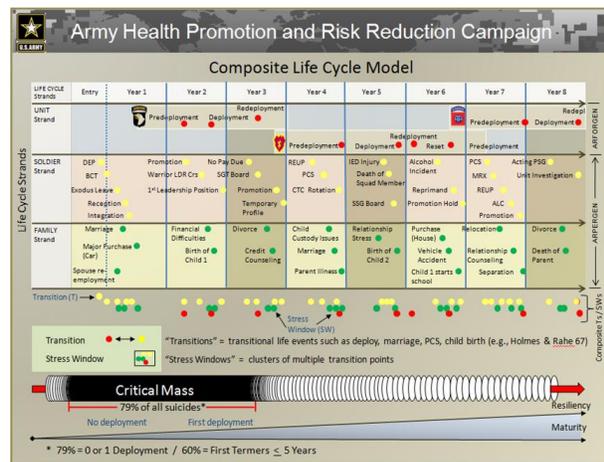


Figure 30 – Composite Life Cycle Model

Life Cycle, the Soldier Life Cycle and the Family Life Cycle. Each strand contributes a unique set of transitions associated with a person’s role as a unit member, an individual Soldier and a Family member. These transitions and associated stressors often occur within the narrow context of a single life cycle strand but also accumulate across the broader context of all three strands. In other words, the total stress on an individual is the composite of unit stress, career stress and Family stress. It is the full appreciation of this accumulation that widens the lens on how we view the whole person. This perspective will help to better frame and focus the Army’s HP/RR/SP programs and services across both the “Event Cycle” (see page 144) and the “Care Continuum” (see page 145).

The following discussion outlines the *Composite Life Cycle Model*. The model at Figure 30 is constructed sequentially by strands, which are depicted as separate figures, to focus the discussion on each life cycle strand. The sequential build across figures, highlights each strand while demonstrating the accumulative impact of transitions on individual stress. The section concludes with a general discussion of the relationship between transitions and stress as well as the development of personal resiliency and maturity.

CONCLUSION

- ★ The *Composite Life Cycle Model* is a holistic model that looks beyond the military unit to focus on the whole person through a composite view of three separate strands: the Unit Life Cycle, the Soldier Life Cycle and the Family Life Cycle. (pages 90-91)
- ★ Transitions and major life stressors often occur within a single life cycle strand. However, transitions and their associated stressors can accumulate across all three strands. (page 91)

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 26 – The Composite Life Cycle Model

a. The Unit Life Cycle Strand

The first life cycle strand, that of the Unit, is depicted in Figure 31. The Army clearly recognizes stressors associated with unit rhythms incorporated in the the Army Force Generation (ARFORGEN) model. Normal unit rhythms of predeployment, deployment, (e.g., first 100 days in theater), redeployment, reintegration/reset (e.g., first 100 days home), etc., are among examples of discrete transitions. Highlighted as red dots, these occur throughout the life cycle of the unit. Each dot represents a point of transition which may have some impact on individual stress. The red dots within the figure represent transitions during individual unit deployment cycles. The dots below the Unit Strand represent the overall stress points that will carry over to the next two strands. These transitions add stress to the Soldier and Family as recurring stress points, or as cumulative stress, over time.



Figure 31 – Unit Life Cycle Strand



Over most of the last decade, units have routinely deployed as the Army continued to adjust the ARFORGEN model to increase rest periods between deployments. Additional structure was added to the force, other Services provided additional assets and Forces Command (FORSCOM) developed systems to improve equity among deploying units (e.g., Red/Amber/Green Cycles, In-Lieu-Of units, additional reliance on the RC, etc.). Nevertheless, the Army continues to experience an unprecedented operational tempo along multiple fronts supporting overseas contingency operations and Army Transformation.

The Unit Life Cycle is not always a predictable rhythm. Unit ARFORGEN cycles may be disrupted by unexpected events, compressed deployment cycles, or extensions in theater (as was the case for units and Soldiers during the OIF surge). The ARFORGEN model, in general, may not apply to functional units with inadequate structure to accommodate a complete cycle. Consequently, the rhythm of transitions during deployments and redeployments can become compressed or unpredictable, adding even more stress on the unit, Soldier and Family. Unit transitions are not always aligned with deployments.

(1) Factors Destabilizing ARFORGEN

Base Closure and Realignment (BRAC): BRAC is a transition mandated by law that has added untold stress on units, Soldiers, Civilian employees and Families. BRAC, when coupled with deployment and transformation, can result in orphaned Families and fractured Soldier support networks with potentially disastrous results. As a result, some units deploy only to find upon their return that their home station no longer exists.

UNIT TRANSITIONS

In July 2004, the 2nd Brigade, 2nd Infantry Division began an odyssey that included: a rapid deployment from the Korean DMZ into the Iraqi Theater of Operations (ITO), redeployment to Fort Carson as part of BRAC and the Army transformation process, and a quick turnaround back into the ITO for combat operations during the OIF Surge. The unit redeployed back to Fort Carson and began preparations for a third deployment. This 70-month period included 27 months of combat operations, the restructuring from a legacy to a transformed BCT, a reflagging of the brigade and reflagging of two of the infantry battalions three times. The net result of the numerous transitions and increase in operational tempo was extremely disruptive to unit cohesion. The constant state of change impacted leaders, Soldiers and Families and severely degraded unit focus, good order and discipline. A series of subsequent outbreaks of violence associated with the unit became the focus of an Army Epidemiological Consultation (EPICON) conducted at Fort Carson from Nov 08 to May 09.

Source: Army Suicide Prevention Task Force

Vignette 19 – Unit Transitions

Natural Disasters: Army contingency planning for natural disasters can also create transitions. Natural disasters divert units and Soldiers from home station or pre-deployment activities in order to respond worldwide to earthquakes, tsunamis or drought-induced famine. Closer to home, U.S. Northern Command (USNORTHCOM) contingencies can further test unit transitions when responding to national security emergencies, forest fires, floods and hurricanes.

Worldwide Individual Augmentation System (WIAS): Soldiers often deploy via the WIAS. This system fills critical requirements not satisfied by unit deployments. These requirements include critical

staff positions on corps or division staffs, task force staffing or specialty functions on transition teams. The WIAS exacerbates the transition to theater because it often provides late notice to deploying Soldiers, separates Soldiers from their unit or current work environment, requires an additional transition – sort of a transition within a transition – through a combat readiness center, and requires Soldiers to integrate into a new unit in theater. All of this creates some level of uncertainty within the individual, much like the first day at a new school. To add to this uncertainty, Soldiers filling the WIAS must often perform duties outside their occupational skill set including mentoring governance, developing rule of law or serving in a special-focus task force (e.g., detainee operations, biometrics).

Similarly, PCS cycles compound stress. Soldiers who are moving to a new installation end up “PCSing” from one unit’s life cycle into another. Soldier PCSs are not aligned or synchronized with unit life cycles. For instance, a Soldier may return from deployment only to PCS into a new unit preparing to deploy. Although there are provisions to preclude violations of a 12-month dwell, Soldiers may feel compelled to support the new unit, even at a high cost of additional personal and Family stressors. Additionally, many Army functional units or providers may have a high operational tempo between deployments, including military police, medical, medical service and chaplains who provide critical garrison services while at home station.

(2) Impact of Dwell Time on Unit Readiness

Information on Soldier dwell time and Soldier behavioral health wellbeing was gathered during the Iraq Mental Health Advisory Team (MHAT) survey from February to March 2009.⁸¹ These data indicate

that within maneuver units, less dwell time is strongly correlated with reported symptoms of depression, anxiety and/or acute stress. They found that overall behavioral health does not return to “baseline” (10% or less of the unit reporting behavioral health symptoms) until 24-36 months after the deployment. This may mean Soldiers and, perhaps, Families who experience shortened dwell cycles or other compressed transitions may continue to experience elevated stress levels for extended – if not for indefinite – periods of time. This finding is significant in that it demonstrates the cumulative impact of stress that can continue to build when Soldiers and Families are unable to recover before the next transition. An Army G-1 analysis of Active Component (AC) “Boots on the Ground” (BOG) and Dwell times accumulated from September 2001 through September 2009 reveal the average median BOG to Dwell ratio for all grades is just below 1:2.⁸² While the Army’s “current” target is a 1:2 ratio for the AC, the optimum recovery time as depicted at Table 11 is closer to 36 months or a 1:3 ratio.

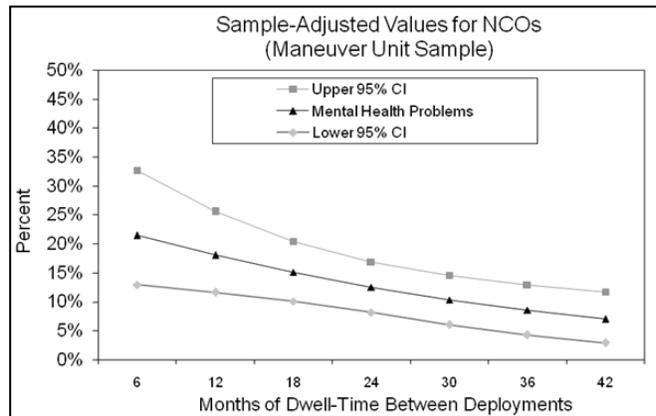


Table 11 – Dwell Time and Behavioral Health with 95% Confidence Intervals (CI)

⁸¹ “Individual Dwell Time” is the time a Soldier spends at home station after returning from combat deployment (e.g., OIF, OEF); operational deployment (e.g., peacekeeping, domestic civil, humanitarian international, etc.); or dependent-restricted tours (e.g., Korea). Source: G-1 ALARACT 253/2007, Subject: Individual Dwell Time (IDT) Deployment Policy, DTG: 072213z NOV 07.

⁸² Source: G-1, Strength Analysis and Forecasting Division.



CONCLUSION

- ★ Unit Strand transitions (e.g., pre-deployment, deployment, redeployment, reintegration and reset) recur and accumulate stress on Soldiers and Families over time. (page 91)
- ★ Stress upon units, Soldiers and Families will remain high as the Army continues to experience a high operational tempo. (page 92)
- ★ ARFORGEN is destabilized by BRAC, disaster responses, WIAS taskers and PCS; these can add stressors to the Unit Strand. (page 92)
- ★ Soldiers may incur additional stress as they PCS from one unit's life cycle into another. (page 93)
- ★ While a 1:3 BOG:Dwell ratio is optimum to restore overall behavioral health, the current median BOG:Dwell ratio for all grades is just below 1:2. (page 93)
- ★ Since behavioral health wellbeing does not return to "baseline" until 24-36 months after a deployment, Soldiers and Families who experience shortened dwell cycles or other compressed transitions may continue to experience elevated stress levels for extended, if not indefinite, periods. (page 93)

RECOMMENDED ACTION

- ★ [HQDA] Direct research to determine the optimum time for BOG:Dwell ratios to reduce stress levels and return Soldiers' and Families' overall behavioral health back to baseline.
- ★ [HQDA] Direct research to examine the unique stressors associated with WIAS taskings (e.g., Soldiers deployed in isolation, double transition of integrating into a unit in a theater, etc.).
- ★ [CDRs] Target HP/RR/SP programs and services in synchronization with major unit transitions (FAP during pre-deployment, ASAP during deployment, etc.).

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 27 – Unit Life Cycle Strand**b. The Soldier Life Cycle Strand**

The second life cycle strand, that of the Soldier, is depicted below the Unit strand in Figure 32. The Soldier Strand highlights another set of transitional events, which focus on the professional yet personal transitions common to all Soldiers. The Soldier Strand and the Unit Strand by their very nature are not mutually exclusive. Events in the Unit Strand can drive events in the Soldier Strand and vice versa. Therefore these two strands work in concert either to elevate or amplify the amount of stress felt by the individual Soldier. Unlike the Unit Strand that is regulated by the ARFORGEN model, the Soldier Strand is less predictable. Although Soldier events affecting personal or career goals are not as regularly timed as ARFORGEN events, there is a rhythm of expectations in a Soldier's life that should be taken into account. A proposed Army Personnel Generation (ARPERGEN) Model (described throughout this report) would recognize this cyclical pattern of personal and career goals and measure holistic individual readiness (ARPERGEN) against unit readiness (ARFORGEN). The ARFORGEN and the ARPERGEN, when considered in tandem, ensure that Soldier professional and personal transitions are synchronized to promote both the growth of the individual and the health of the unit.

The figure depicts the sequence and rhythm of those expected transitions affecting Soldiers, which may include leaving home, recruitment and accession, attending a Service Academy, and so on. The Soldier Strand may continue until retirement or even continue in post-retirement through participation with military associations or services provided by Veterans Affairs, military veteran service organizations, or a second career affiliated with continued service.

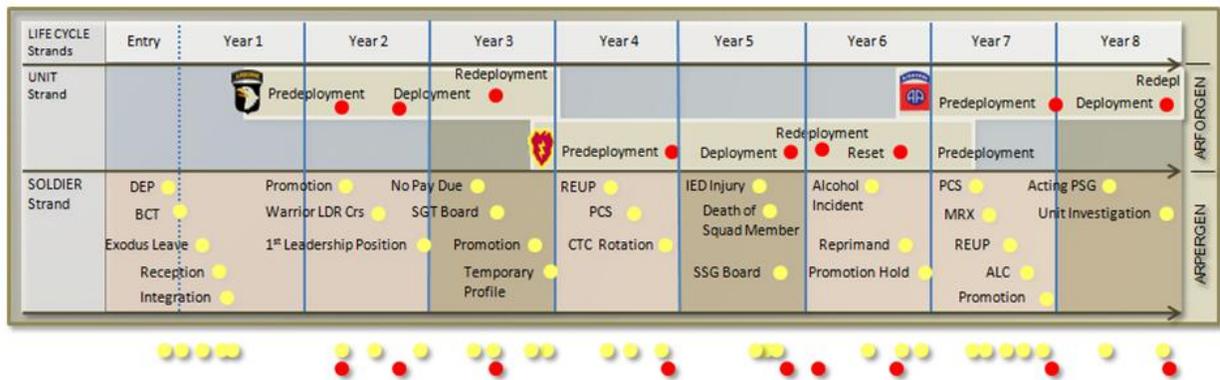


Figure 32 – The Soldier Life Cycle Strand

Transitions in the Soldier Strand are highlighted in yellow and represent events that are not uncommon in the life and career of a Soldier in today's Army. Regardless of whether a transition is seen as positive or negative, research has found that the events are often associated with stress.⁸³ Even a positive event, such as a promotion or reenlistment, can be linked to stressors. For instance, a promotion could mean a PCS, change in jobs, increased responsibility, change in work relationships, or higher expectations for productivity. Other transitional events are more obviously linked with stress such as leaving home, basic training, medical issues, disciplinary actions or professional boards.

The combination of the Soldier and Unit Life Cycle Strands illustrated in Figure 32 results in a larger set of transition points that need to be viewed from both an ARFORGEN and ARPERGEN cycle perspective. Just the addition of a single strand demonstrates how the complexity of transitions can rapidly accumulate. This is due to the independent but interdependent nature of the Unit and Soldier Strands. The stressors associated with the Soldier are additive to those stressors associated with the unit. Taken together, the unit and Soldier transitions add more events and associated stressors affecting the individual by either compressing the time between transitions or by combining the stressful effects of transitions at any single point in time. For example, the unit's pending deployment [Unit Strand] can be stressful to a new Soldier, but the fact that it is the Soldier's first deployment [Soldier Strand], and coincides with the Soldier's recent PCS [Soldier Strand], means that the Soldier is transitioning to the Army and a new unit while transitioning to combat. It is unlikely that these stressors are merely additive (Unit Strand + [Soldier Strand X 2] = 3 stress units). It is more likely that as the time between these events compresses, one plus two really equals five. Combined with additional stressors including a disciplinary action or promotion to a new job that requires new skills, this scenario can become complex, stressful, and for some Soldiers, overwhelming.

⁸³ Holmes, T. H. and Rahe, R. H., "The Social Readjustment Rating Scale," *J. Psychosom. Res.*, 11(2), August, 1967, p. 213-218.

SURVEILLANCE SYSTEMS AND TRANSITIONAL STRESS

A 19 year old, married Private (**Army transition**) at his first duty station (**unit transition**) was living in an on-post trailer. In Jan 09, the Soldier was medicated for back pain with tramadol (side effects include anxiety and confusion) (**health transition**). On 12 Jul he was pending UCMJ action for motorcycle theft and distribution of drugs (**disciplinary transition**). He tested positive for Ecstasy on 20 Jul (**disciplinary transition**). A subsequent counseling revealed two previous suicide attempts (drug overdose and hanging) which were not reported to the chain of command. The provider sent the Soldier with an escort for urgent inpatient care. He was not deemed a suicide risk and was released the same day with instructions to return to the ER if he experienced suicidal thoughts (**health transition**). The next day he was seen at the TMC for a sleep disorder and received a prescription for Ambien (**health transition**) with a warning not to mix with alcohol. On 31 July he was reported AWOL from his unit. On 20 Aug he was found dead in his trailer by his roommate.

- Multiple systems failed to connect individual risk factors and transitional stress. Stressors may compound with fatal consequences.

Source: Army Suicide Prevention Task Force.

Vignette 20 – Transitional Stress

CONCLUSION

- ★ The Unit Strand (ARFORGEN) is not synchronized with the Soldier Strand (ARPERGEN) and fails to accommodate normal Soldier life expectations, personal and/or career goals. (page 94)
- ★ The combination of Soldier and Unit Strand transitions can result in the rapid accumulation of stress that adversely impacts the unit, Soldier and Family. (page 95)
- ★ It is unlikely that these stressors are merely additive (Unit Strand + [Soldier Strand X 2] = 3 stress units). It is more likely that as the time between these events compresses, one plus two really equals five. (page 95)

RECOMMENDED ACTION

- ★ [HQDA] Use ARFORGEN and ARPERGEN in tandem to synchronize Soldier professional and personal transitions to ensure both the growth of the individual and the health of the unit.
- ★ [CDRs] Conduct periodic informal assessments of Soldiers' wellbeing. Events seemingly "acceptable" to most may be overwhelming to some Soldiers (e.g., PCS, promotion, PME).

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 28 – Soldier Life Cycle

c. The Family Life Cycle Strand

The third life cycle strand, that of the Family, is depicted with the Unit and Soldier Strands at Figure 33. It is similar to the Unit and Soldier life cycles but is included as a separate strand for several practical reasons: (1) to highlight the Army's commitment to the Family (symbolized by its capitalization of the word "Family"); (2) to recognize that Families experience a unique set of transitions and requirements that are not necessarily addressed by Army programs and services; (3) to demonstrate that the Army must have visibility and the capability to penetrate each tier of the *Composite Life Cycle Model* from Unit

to Family; and (4) to ensure the Army develops, implements, measures and assesses solutions to optimize all three life cycles both independently and interdependently.

The figure depicts the sequence and rhythm of transitions affecting the Family, which may include marriage, birth of a child, marital discord, aging parents, school cycles, etc. The Family Life Cycle Strand is appropriately positioned in the model, certainly not last, but in the sequential order of the Army’s

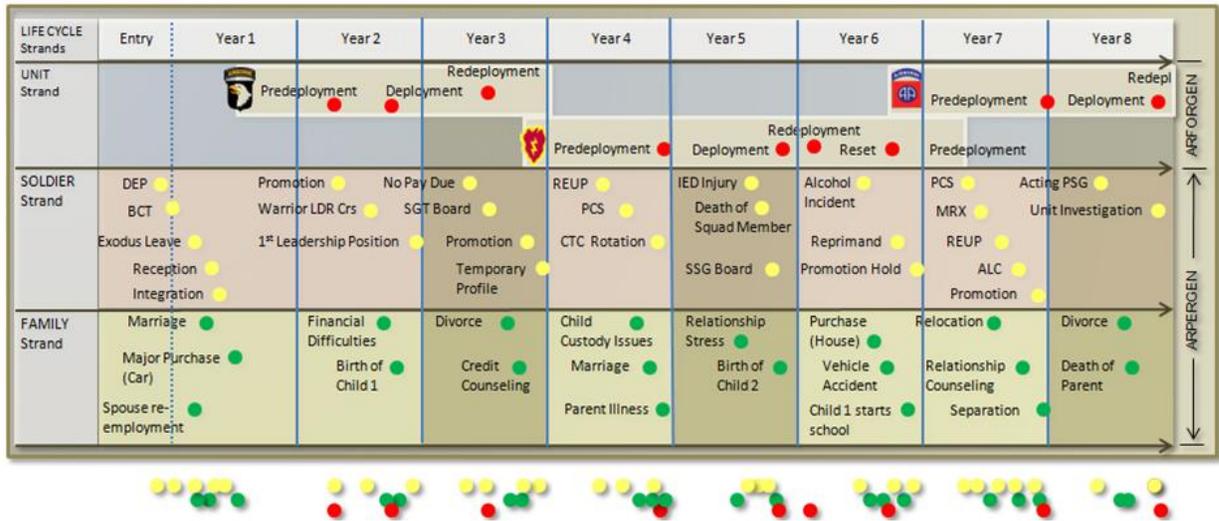


Figure 33 – Family Life Cycle Strand

hierarchical view from unit, to Soldier and then to Family. Family transitional events, depicted in the figure as green dots, are often generated by unit and Soldier transitions. A unit deployment or Soldier PCS may create transitions that impact the Family. Family relocation during a deployment or a PCS means transitions to new jobs, neighborhoods and schools. Unit and Soldier transitions also may exacerbate naturally occurring transitions experienced by every Family including: parenting, marital discord, financial problems and taking care of aging parents. Add these issues now to transition points from the other strands and one quickly appreciates the cumulative stressors associated with military life.

The Family Life Cycle Strand is equally relevant to single Soldiers and single-parent Soldiers. Family composition has evolved well beyond the nuclear Family. Soldier “Families” now include extended Families that consist of grandparents, aunts, uncles and other relatives; “adopted” Families that Soldiers assimilate as their “own”; single-parent Families; and even single Soldiers who are attached to a beloved pet. Although these Families may not be formally recognized as “Army Families,” they provide Soldiers nurturing and financial support; stability and refuge; enjoyment and escape. They, too, should be considered in this *Composite Life Cycle Model* when gauging mitigation efforts in policy and program (services and products) as they can also be a source of stress as a result of transitional events.⁸⁴

⁸⁴ Some Army-sanctioned programs and services (e.g. Strong Bonds, Family Readiness Groups, family housing) accommodate or include, for example, child care providers (live-in nannies and non-dependent relatives) or unmarried Soldier partners (fiancés).

(1) Factors Affecting the Army Family

Again, by adding the Family Life Cycle Strand, the composite picture now more holistically depicts for Army leaders and program/service providers the cumulative set of potential transition stressors across all three life cycles. Moving from unit, to Soldier, to Family down the chart at a single time and point, one can see specific sets of transitions, clustered as red, amber and green dots at the bottom of Figure 33. Taken as a whole across the entire composite life cycle, the variable spread of these clusters illustrates the complexity of transitional sets impacting units, Soldiers and their Families. Although similar in many respects to clusters one might find for individuals in any society, the operational tempo of the Army causes an increase in frequency of these transitions due to both the Army's institutional and expeditionary requirements. This complexity strikes at the heart of Family transitions. In many respects, the Army Family has become an expeditionary element of the Soldier and unit. This realization means that unit leaders and Soldiers must incorporate Family transition planning considerations into their pending deployment or separation. Although the Army is working hard to accommodate critical aspects of separation preparation via Family Care Plans, Family Readiness Groups (FRG), Family Readiness Support Assistants (FRSA), the Soldier Readiness Program, etc., current policies and programs do not penetrate the Family Life Cycle to address all aspects of Family transitions.

“The effects of these deployments are cumulative. Twelve months at home isn't long enough ... for families to reintegrate. So the stress doesn't just go away when the deployment is over.”

– Sheila Casey, Army Spouse
Family Matters Blog, 8 October 2009

Quote 11 – Sheila Casey, 8 Oct 09

Family, friends and fellow Soldiers who provide surrogate parenting through mandated Family Care Plans are poor substitutes for deployed parents. The surrogate parent is not compensated, so dual-military and single-parent Soldiers must rely on the goodwill and unconditional love of Family and friends. Over time, this can lead to feelings of guilt due to the pressures of repeatedly “drawing from the same well.” In some cases, this can lead to relationship stress between the Soldier and the care-providers who may be fatigued or unavailable to assist again. Relations become strained with both the children left behind and with those who care for them. Because these child-care arrangements are temporary, these care providers are not wedded to the Army culture. For ease of personal transition as a surrogate parent, many elect to assimilate military children into their own way of life which may further alienate the child from “Army society” and their normal neighborhoods, schools and friends.

According to a recent *NewsWeek* article, Jessica Ramirez wrote that a number of children who are experiencing the repeated absence of their parents are displaying “clinically significant” mental and behavioral health problems.⁸⁵ Colonel Kris Peterson, a child and adolescent psychiatry consultant to The Surgeon General of the Army, stated that he is “seeing a range of problems requiring intervention; from attention issues and heightened aggression, to anxiety and depression.” His concerns are echoed by Dr. Shelley MacDermid Wadsworth, the director of the Military Family Research Institute, who says “the signs of trouble among the troops' children appear to be growing.”⁸⁶

⁸⁵ Ramirez, Jessica, “Children of Conflict,” retrieved from www.newsweek.com/id/200864, June 15, 2009.

⁸⁶ Ibid.

CONTINUOUS PARTIAL ATTENTION

Communication is at the center of the concept of Continuous Partial Attention or CPA, published by Linda Stone.⁸⁷ CPA is a result of segmenting one's attention in order to satisfy one's desire to be connected and to stay connected to multiple sources of information. According to Stone, "It is an always-on, anywhere, anytime, anyplace behavior that involves an artificial sense of constant crisis. We are always in high alert when we pay continuous partial attention." This is because we are constantly vigilant of any and all incoming signals which may represent an opportunity to "connect." This phenomenon may describe or, at a minimum, complicate some people's inability to fully transition from one state to another (e.g., from home to a forward theater) due to the fact that they focus their attention across too many fronts (i.e., home front, theater front, beyond the front, etc.). This continuous hyper alertness creates stress and real risk for Soldiers deployed to combat zones, geographically separated or assigned to isolated locales or units. Hence, CPA may explain the transfer or buildup of stress among Soldiers or Families who continuously and actively engage in managing multiple fronts. Soldiers experiencing CPA, for instance, may attempt to manage their Families from forward theater rather than rely on pre-deployment transitional preparation – in effect "living" both the home front and the theater front.

Source: Army Suicide Prevention Task Force.

Vignette 21 – Continuous Partial Attention

When the Family or care provider is not part of the Army's expeditionary set (e.g., appropriately informed, integrated and prepared), they seek answers and express concerns during a transition to the only person who understands the process: the Soldier. This, in turn, places additional stress on Soldiers who must attempt to mitigate Family transitions and stressors while deployed or separated from the Family. This situation creates an even stronger pull on Soldiers' attention, time and commitment to remain integrated with their Families. While electronic media and technological advances in communication networks makes connectivity feasible, too much connectivity and personal involvement with Families may distract and disrupt personal focus and team cohesion among deployed units. Prolonged or intense Family distractions may divide Soldiers who attempt to live two lives, straddling the expeditionary arch between home and the deployed location.

The Family Life Cycle Strand at Figure 33 portrays subsequent transitions and sequential periods of Soldier and Family separation across an eight year period, but implies a continuation of separations throughout a Soldier's service years in conjunction with other new and recurring transitions. The figure illustrates a cycle of deployments, for example, that may coincide with the birth of a child or a child starting school, transferring to another school, or graduating from high school. Each transition is unique and important to Soldiers and Families. Pressure to reduce stress associated with Family transitions can often result in hard choices for Soldiers and their spouses. Does the Soldier sacrifice the Family to make the transition easier or does he/she implement other options (e.g., ETS, retire, voluntary hardship tour)?

⁸⁷ Stone, Linda, "Continuous Partial Attention – Not the Same as Multi-Tasking," retrieved from www.businessweek.com/business_at_work/time_management/archives/2008/07/continuous_part.html, July 24, 2008.

TRANSITIONS, DEPLOYMENTS AND FAMILY CONCERNS

A 23 year old Private First Class received an Article 15 for punching a hole in the wall in Jul 09. He was married in Oct 09 and deployed in Nov 09. He was providing financial assistance to his wife's parents and was in daily communication with his wife via telephone and text messaging. Just before he committed suicide, he argued with his wife about finances. He asked her to communicate with him on instant messenger via internet webcam. Once the connection was established, he informed his wife he planned to kill himself. She attempted to talk him out of harming himself, but was unsuccessful.

- The impact of transitions and associated stress (family separation) can seem overwhelming for some Soldiers.

Source: Army Suicide Prevention Task Force.

Vignette 22 – Transitions, Deployments and Family Concerns**IV****CONCLUSION**

- ★ Current HP/RR/SP policies and programs do not take into account critical aspects of Family separations/transitions within the Family Life Cycle. (pages 96-97)
- ★ Family transitional events are often generated by unit and Soldier transitions. Unit and Soldier transitions may also exacerbate naturally occurring Family transitions such as parenting and marital discord. (page 97)
- ★ The Family Life Cycle Strand is as relevant to single Soldiers and single-parent Soldiers as it is to Soldiers with Families since they receive nurturing and support from extended and "adopted" Families. (page 97)
- ★ Critical aspects of unit separation preparation (e.g., Family Care Plans, Family Readiness Groups) do not fully penetrate the Family Life Cycle to address all aspects of Family transitions. (page 98)
- ★ Some children who are experiencing the repeated absence of their parents are displaying "clinically significant" mental and behavioral health problems. This, in turn, places additional stress on Soldiers trying to mitigate Family transitions. (page 98)
- ★ While electronic media and technological advances in communication networks makes connectivity feasible, too much connectivity and personal involvement with Families may distract and disrupt personal focus and team cohesion among deployed units. Prolonged or intense Family distractions may divide Soldiers who attempt to live two lives, straddling the expeditionary arch between home and the deployed location. (page 99)

RECOMMENDED ACTION

- ★ [HQDA] Initiate an ARPERGEN forum to synchronize Soldier and Family life cycles with the ARFORGEN unit life cycle.
- ★ [HQDA] Develop, measure and assess programs and services that take into account all three life cycles, both independently and interdependently.

(Continued)

- ★ [HQDA] Direct program evaluation to determine the efficacy of existing policies, programs and structure (e.g., Family Care Plans, Soldier Readiness Program, Family Readiness Groups, and Family Readiness Support Assistants) in addressing aspects of Family transitions.
- ★ [HQDA] Develop programs capable of building resiliency in Families; place special emphasis on children.
- ★ [HQDA] Direct research to explore resiliency, coping skills and help-seeking behavior required by Soldiers and Families.
- ★ [CDRs] Unit leaders and Soldiers must incorporate Family transition planning considerations into their pending deployment or separation planning. Incorporate those Families who do not intend to remain in the area.
- ★ [CDRs] Include single Soldiers and single-parent Soldiers in the *Composite Life Cycle Model* when gauging Family transition mitigation efforts in policy and programs.
- ★ [All] Incorporate the risks associated with communications technology (Continuous Partial Attention) in pre-deployment programs and services (e.g., FAP, FRGs, FRSAs, etc.).

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 29 – Family Life Cycle

3. The Impact of Transitions on Soldiers and Families

The sum of transition points associated with major events and accompanying stressors is illustrated as the clustering of red, green, and amber dots at the top of Figure 34. The dots, and clusters of dots, symbolize transition points for the three different strands across time. Although notionally positioned in this diagram, these transitions logically represent an average scenario impacting units, Soldiers and Families. Again, major events may occur singularly as a “transition,” or at close intervals as a cluster of transitions. For obvious reasons these clusters are recognized as “stress windows.” Regardless, the series of transitions continues unabated in an endless cycle throughout a Soldier’s career and beyond.

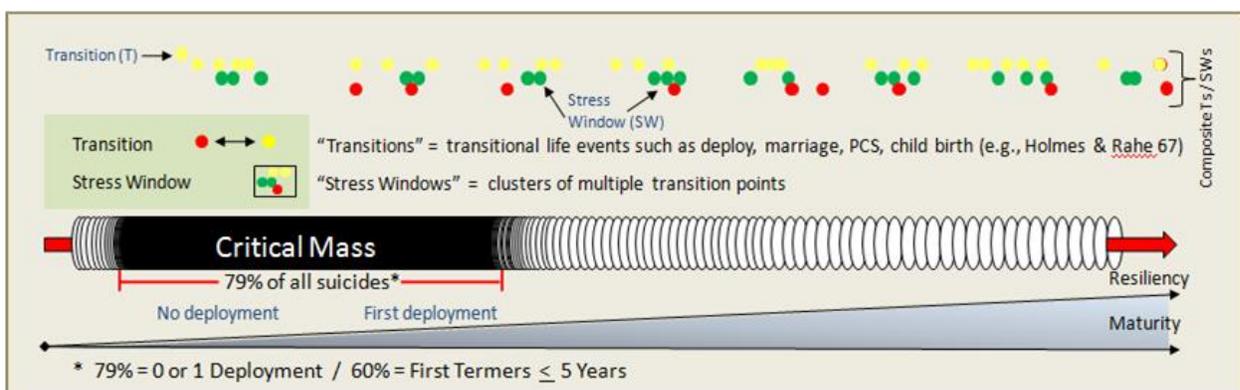


Figure 34 – Relationship between Transitional Stressors and Resiliency/Maturity

While the clustering of transitions into stress windows becomes apparent in the *Composite Life Cycle Model*, in reality identifying these individual transitions and stress windows is much more difficult. Army leaders do not currently have a method for looking across all strands of a Soldier’s life and identifying potential stress windows. Even the Army’s development of policies and programs which are

designed to assist leaders in implementing HP/RR/SP programs and services do not effectively penetrate all three life cycle strands to provide visibility of Soldier and Family requirements. For instance, while leaders normally have complete visibility of unit transitions via ARFORGEN (e.g., deployment cycles, CTC rotations, etc.), they may have less visibility of Soldier transitions (e.g., Soldiers “TDY en route” or PCS late into the unit, Soldier pay issues, etc.), and may have even lesser visibility of Family transitions (e.g., parent illnesses, a child starting school, spousal employment termination). What has become apparent, however, is that there is a critical window early in a Soldier’s career that seems to make them more susceptible to the stress of transitions.

The coil across the bottom of Figure 34 illustrates the effect of transitions on units, Soldiers and Families. It represents the Soldier or Family’s *resiliency* or ability to cope with transitions. The early onset of Army-associated transitions may have an acute effect on young or entry level Soldiers. Young or new Soldiers may not have the resiliency or life experience [maturity] to ward off or cope with the stress associated with a compressed cycle of transitions. The number of transitions in the first two years (leaving home, entering basic training, integrating into a first unit and deploying for the first time) can cause significant stress across the other strands. A lack of resiliency and maturity among “first termers” may make this population exceptionally vulnerable to the stress of first term transitions. This may account for why Soldiers within the first two years of their enlistment display the majority of high risk behaviors and account for the majority of the Army’s suicides. These two facts are echoed in the overall suicide data. According to the 2009 Center for Health Promotion and Preventive Medicine (CHPPM) report, 36% of Soldiers who committed suicide had never deployed, 43% had only one deployment; the remaining 21% fell into the more seasoned population with multiple deployments.

RESILIENCY AND SOLDIERS WITH BREAKS IN SERVICE

Of the 120 FY 2010 active duty (AD) suicides thru 30 June 2010, 71 involved Soldiers within their first five years of service. Of the remaining 49, at least five Soldiers had breaks in service before returning to the Army and ultimately committing suicide. The breaks in service ranged from eight to 30 months. The Soldiers were back on AD for an average of 3.2 years before taking their own lives.

- Soldiers returning to the Army may face transitional stress similar to first-termers. Leaders should not assume that prior service experience compensates for early transitional stress.

Source: Army Suicide Prevention Task Force.

Vignette 23 – Resiliency and Soldiers with Breaks in Service

The coil figuratively represents the relationship between recurring transitions and a Soldier’s growing resiliency and maturity over time. Simply stated, stressors associated with change can create overwhelming personal tension among less resilient and less life-experienced Soldiers. The coil becomes more compressed with the increase in stress as new Soldiers and Families experience an early onslaught of transitions (e.g., entering the Army, first PCS, new unit, first deployment, etc). The coil’s compression during these times may reach critical mass that can lead to high risk or suicidal behaviors. As Soldiers and Families become experienced or more mature, the impact of transitional stressors is reduced as depicted by the relaxed compression of the coil. Simply put, Soldiers and Families become more practiced or experienced in coping with transitions and, thereby, less subject to the stresses associated with each recurring transition as their abilities to cope have grown. The second or third PCS, like the second or third deployment, may not have the same stress associated with the novelty of the first iteration of such a major life event. Soldiers and Families also may have developed experientially

through establishment of support networks, experience as leaders, or help-seeking behaviors that prompted use of Army programs or services. This concept is reflected in certain models in the field of Transitional Psychology.

Holmes and Rahe have proposed a “Social Readjustment Rating Scale” that includes major life events such as changes in residence, schools, work hours, and work conditions. Each major life event is given an “event severity” score which impacts the individual. The application of this model may have relevance for new or young Soldiers and Families, but may lose its relevance over time as Soldiers and Families adjust to frequent service moves (i.e., transient population). However, more severe life events such as death of a loved one, jail [disciplinary actions], being fired [relieved for cause], or retirement may have particularly enduring effects. As illustrated by the transition indicators in Figure 34, there is no promise of a slowdown in military transitions across a full military career. Perhaps even comparisons of Transitional Psychology models such as The Social Readjustment Rating Scale understate the recurring cycle of life events in a military versus civilian social model.



“... it’s stress on the force. It’s not just the ones who are deployed ... it’s those who are preparing to deploy and it’s the Soldiers left behind ... coming home from deployment, packing up the Family and moving ... the impact of the economy from trying to sell a house...”

– Kenneth O. Preston, Sergeant Major of the Army
Army News Service, 5 March 2009

Quote 12 – SMA Kenneth Preston, 5 Mar 09

The impact of transitions/life events can be offset by increased personal maturity and resiliency (see the Comprehensive Soldier Fitness discussion in Section II of this report, “*The Reality of Suicide.*”) This “hardening” may occur as Soldiers and Families become adjusted to change and these events become more routine. Additionally, Soldiers and Families develop more sophisticated coping mechanisms or develop help-seeking behavior associated with use of Army HP/RR/SP programs and services. Consequently, a more mature Soldier and Family are resilient to the same transitional stressors that may have negatively impacted them early in their career. Even when impacted by major life events later in their career (e.g., loss of parents, medical disability, etc.), mature Soldiers and Families typically have more sophisticated coping skills to overcome challenges and reduce associated stressors.

CONCLUSIONS

- ★ It is difficult to gain visibility of all Soldier and Family transitions. Army leaders do not have a systematic method for anticipating or identifying potential transition clusters across all three strands of their Soldiers’ lives. (page 102)
- ★ While the series of life cycle transitions continues unabated throughout a Soldier’s career and beyond, resiliency and maturity are often effective counterbalances. (page 102)
- ★ The lack of resiliency and maturity among “first termers” makes this population exceptionally vulnerable to the stress of initial transitions and may account for high risk behavior. First term Soldiers account for approximately 60% of Army suicides in FY 2009 – FY 2010. Of all Army suicides in FY 2009, 79% had one or no deployment. (page 102)
- ★ Soldiers and Families become more resilient/mature as well as more practiced/experienced in coping with transitions and less stressed with each recurring transition. (page 103)

RECOMMENDED ACTIONS

- ★ [HQDA] Develop a comprehensive first term Soldier integration program to reduce the onslaught of stressors associated with first term transitions including, entering the Army, first unit, first deployment; and typical transitions associated with young men and women (marriage, first child, etc.).
- ★ [HQDA] Examine first term Soldier suicides to identify common causes (i.e., stressors) and high risk behavior. Tailor strategies to reduce suicides within this vulnerable population.
- ★ [HQDA] Develop an integrated portal/dashboard to enhance Army and leader situational awareness of stress windows.
- ★ [HQDA] Synchronize and target HP/RR/SP programs and service delivery with recurring stress windows.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 30 – Impact of Transitions on Soldiers & Families

IV

4. Application of the Composite Life Cycle Model

“Keeping track of the dwell of an inanimate object like a [unit] flag means nothing. It's the individual that's key and critical.”

– GEN Pete Chiarelli, Vice Chief of Staff, Army

Senate Armed Services Subcommittee on Readiness and Management Support, 14 April 2010

Quote 13 – GEN Pete Chiarelli, 14 Apr 10

In lieu of universally recognized predictive indicators of risk-taking behaviors, the *Composite Life Cycle Model* provides a conceptual framework that has utility in how the Army can identify and target transitions or stress windows during each stage of the Event Cycle and phase of the Care Continuum. It can be used to inform Army readiness and personnel policies, filter program evaluations and shape commanders' philosophy and guidance in implementing HP/RR/SP programs. The model codifies what the Army already appreciates, but does not effectively apply in program design and delivery, which is, transitions occur across three life cycle strands of Unit, Soldier, and Family. While the Army currently weights the effort on the Unit Strand as part of its ARFORGEN cycle, it must rebalance its efforts to accommodate and engage Soldier and Family transitions as part of an ARPERGEN cycle. Each strand has its own set of transitions but the current focus on unit life cycles only gauges the tip of the iceberg. Beneath the surface, complex combinations of transitional events compound the effects of change, uncertainty and isolation.

Creation of an ARPERGEN forum based upon the proposed Army enterprise-based business transformation model, as part of a collaborative cross-functional advisory body, elevates the importance of “generating personnel” readiness to that of “generating force” readiness to better sustain the Army's campaign capability and provide a voice for the other two life cycle strands. It would synchronize transitions within the Unit, Soldier and Family Strands as part of a holistic approach to Army wellness. This ARPERGEN forum comprised of key Army Secretariat, ARSTAF and command stakeholders would ensure a multi disciplinary approach focused on rebalancing readiness from an exclusively unit perspective to include other critical Soldier and Family stressors and complementary policy, program and resource components. The ARPERGEN forum, for example, might focus on developing and

synchronizing the expeditionary capabilities of the *HP/RR/SP Program Portfolio* to enhance Soldier and Family readiness. In this example, ARPERGEN proponents could develop an expeditionary capability in FAP, ASAP, SHARP and other programs/services to promote health and reduce risk among deployed units/Soldiers. This would entail the programmed delivery of FAP, ASAP and SHARP services to deployed theaters to provide continuity between garrison and theater. This recognition would ensure the Army can reduce gaps in its surveillance and detection programs and, consequently, reduce gaps in Soldier and Family treatment. Such emphasis on ARPERGEN could provide timely preventive education regarding Family Advocacy issues rather than waiting until redeployment and reintegration, identify and treat drug dependency in theater and identify Reserve Component Soldiers at-risk during the mobilization processes.

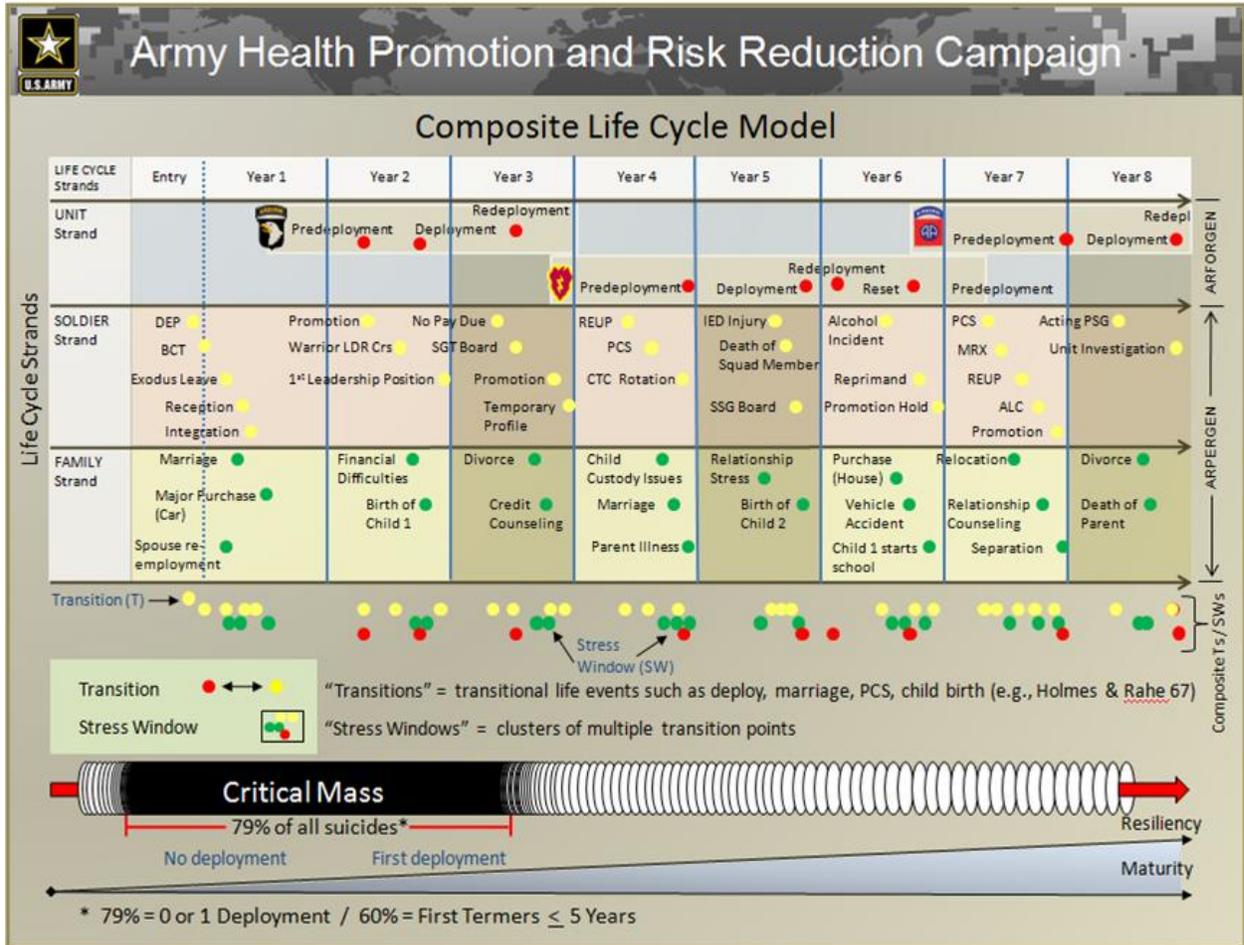


Figure 35 – The Composite Life Cycle Model

From an institutional perspective, Army leaders must intuitively recognize transitional events that occur across time (left to right) as well as transitional events that occur simultaneously across all three life cycle strands (top to bottom) to fully understand the Composite Life Cycle. This composite view of stressors will allow leaders to improve prevention programs and services along the Care Continuum within the “recruit, separate and awareness/resiliency” phases, while timing service and intervention programs along the Care Continuum within the “assess, educate/train, intervene and treat” phases.



As a practical point, the Army may not be able to effectively reduce the operational tempo of ARFORGEN or ARPERGEN transitions; however, it can develop policy and programs that mitigate those transitions and potential stressors now captured as part of the Composite Life Cycle. Policy, for instance, can synchronize discrete ARFORGEN and ARPERGEN transitions by —

- Establishing unit integration criteria that focus on the Soldier and Family;
- Developing effective unit integration programs for new Soldiers with emphasis on first termers;
- Timing leader command team transitions to accommodate both critical unit cycles and leadership continuity and awareness of Soldier/Family issues;
- Synchronizing unit fill with delivery of HP/RR/SP programs and services during pre-deployment cycles and delivery of HP/RR/SP programs and services with post-deployment cycles;
- Maintaining unit integrity during deployment reintegration/reset including command team, key leaders and buddy team cohorts;
- Developing targeting criteria to align program access and delivery to critical transition windows (e.g., provide FAP training with Soldiers and Families prior to deployment);
- Focusing surveillance, detection and intervention programs with a 360 degree view of high risk Soldiers;
- Ensuring Soldiers complete intervention programs or disciplinary actions before deployment, PCS and TDY; and
- Providing critical respites during major Soldier or Family life events (i.e., similar to maternity leave or high school senior stabilization).

Aligning program and service access and delivery to transitions is a fundamental aspect of the *Composite Life Cycle Model*. Rather than just focusing on general awareness of HP/RR/SP, the Army can design and implement programs and services that target critical Soldier and Family transitions, build resiliency (e.g., Comprehensive Soldier Fitness), instill coping skills, increase help-seeking behavior and reduce stigma associated with seeking behavioral health care.

OLDER RECRUITS

A 42 year old Specialist with eight years of service and one deployment to Iraq was married with four children. Two of his four children were diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and another with Oppositional Defiant Disorder (ODD). The Specialist fractured his ankle; after surgery and therapy he was still unable to perform cardio training. A Medical Evaluation Board deemed him unfit for continued service as an infantryman. He was reclassified to Finance and was awaiting training. His neighbors reported he was under stress trying to take care of his Family on a single salary. In December 2006 and February 2007, the Specialist was seen by the Family Advocacy Clinic and Social Work Services for parent/child problems and possible child neglect. In April 2009, he told his provider that he only averaged four hours of sleep a night and was concerned about his memory, concentration and finances. His provider recommended he get tested for ADHD; there is no record he was ever tested. In January 2010, the Specialist and his wife argued about taxes. Approximately 15 minutes later his 14 year old son found him hanging in the garage.

- Older recruits may enter the Service with significant prior life stressors that may be compounded by Army life cycles.

Source: Army Suicide Prevention Task Force.

Vignette 24 – Older Recruits

The Army must immediately target and address strategic gaps in policy, process and program coverage. Army policy must rescope Service entrance standards to assess and vet Soldiers who demonstrate resiliency or maturity to withstand the transitions associated with their first term of service. Too many Soldiers may be entering on behavioral health, medical, disciplinary or education waivers (see *“The Lost Art of Leadership in Garrison”* starting on page 35). Also, older recruits entering the Service may be encumbered by negative life experiences. Once accessed, the Army must focus on new Soldiers negotiating the wave of early transitions that may build to “critical mass” during vulnerable periods in the initial enlistment term. Effective policies, process and programs could inoculate “first termers” against the trials and tribulations associated with integrating into the Army, their first unit, or their first deployment.

Commanders, at all levels, must be sensitive to key transition points during ARFORGEN cycles that have an acute, recurring and cumulative impact on ARPERGEN. Commanders must understand the importance of unit integration, which simply might be defined as a “planned transition.” Unit integration is paramount among the innumerable tasks associated with team building and ensures that Soldiers and Families achieve an immediate sense of purpose, worth and belonging upon arriving at a new unit or in preparation for pre-deployment and post-deployment phases. For a commander, each of the life cycle strands must be considered in relationship with the other across time and measured against the maturity and resiliency of the Soldier. A commander who elects not to command-refer a Soldier for a positive urinalysis (Soldier Life Cycle Strand) in order to ensure the Soldier’s availability for deployment (Unit Life Cycle Strand) is in fact, contributing to the potential of adding stress to the unit, Soldier and Family, particularly if the Soldier’s high risk behavior continues.

The use of the colored dots in the *Composite Life Cycle Model* must not belie the complexity of transitional events. Each one of those dots has an Army policy or program connection that when neglected, singularly or collectively, by the Army, unit, Soldier or Family can escalate to crisis, or worse.

CONCLUSION

- ★ The *Composite Life Cycle Model* provides a holistic view of transitional events occurring over time and simultaneously across the three life cycle strands. It is a critical tool to improve HP/RR/SP program/service access and delivery. (page 104)
- ★ The Army currently weighs efforts on the Unit Strand as part of its ARFORGEN cycle. However, the Army fails to balance efforts to accommodate and engage Soldier and Family transitions as part of an ARPERGEN cycle. (page 104)
- ★ Army policy does not scope service entrance standards to assess Soldiers who demonstrate resiliency or maturity to withstand the transitions associated with their first term of service. (page 107)
- ★ Statistics suggest too many Soldiers entered the service on waivers. These Soldiers may be among a critical mass that engages in high risk behavior and may commit suicide. (page 107)
- ★ Unit integration is critical in ensuring Soldiers and Families achieve an immediate sense of purpose, worth and belonging upon arriving at a new unit or in preparation for pre-deployment and post-deployment. (page 107)
- ★ A commander who elects not to command-refer a Soldier for a positive urinalysis (Soldier Life Cycle Strand) in order to ensure the Soldier’s availability for deployment (Unit Life Cycle Strand) is in fact, contributing to the potential of adding stress to the unit, Soldier and Family, particularly if the Soldier’s high risk behavior continues. (page 107)

(Continued)

RECOMMENDED ACTIONS

- ★ [HQDA] Use the *Composite Life Cycle Model* to inform Army readiness and personnel policies, filter program evaluations and shape commanders' philosophy and guidance in implementing HP/RR/SP programs.
- ★ [HQDA] Anticipate and facilitate Soldier and Family transitions as part of an ARPERGEN cycle and rebalance efforts between ARFORGEN and ARPERGEN.
- ★ [HQDA] Create an ARPERGEN forum to elevate the importance of "generating personnel" readiness to that of "generating force" readiness to sustain campaign capabilities and provide a voice for Soldier and Family Life Cycle Strands.
- ★ [HQDA] Prompt HP/RR/SP programs and services to target critical Soldier and Family transitions, build resiliency, instill coping skills, increase help-seeking behavior and reduce stigma associated with behavioral health care.
- ★ [HQDA] Army policy must re-scope Service entrance standards to assess and vet Soldiers who demonstrate resiliency or maturity to withstand the transitions associated with their first term of service. Conduct research to identify recruit characteristics associated with early resilience and maturity.
- ★ [CDRs] Commanders must consider each of the life cycle strands in relationship with the other along the time continuum and measured against the maturity and resiliency of the Soldier to mitigate risk to the Soldier, Family and unit.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 31 – The Composite Life Cycle

5. Summary



"What we are trying to do is identify skills that we can give to our Soldiers – intellectual, physical, spiritual – to build those skills into someone from the time they raise their hand, so that when stress hits, they are armed to deal with it."

– General Martin E. Dempsey, TRADOC Commander "Mission: Suicide Prevention," Fort Jackson Leader, 27 March 2009

Quote 14 – GEN Martin Dempsey, 27 Mar 09

The total stress on an individual Soldier is the composite of unit stress, career stress and Family stress. Leaders must fully appreciate the accumulation of stress that burdens our Soldiers. Each strand and its related stressors need to be identified and tracked. ARFORGEN, the principal driver in the Unit Life Cycle, is an ambitious model levied on a tired force but it can be further exacerbated with unforeseen natural disaster responses, BRAC, or the disruptions of leader/Soldier departures due to WIAS or PCS requirements. Creation of a complementary ARPERGEN forum could help generate Soldier and Family readiness with a net increase on unit/ARFORGEN readiness. Transitions in the career of a Soldier such as promotions and reductions, school attendance or non-selections, PCS moves and job changes all add an element of stress distinctly separate from the Unit Life Cycle. Families live a life cycle that, depending on the Families' perspective, is either married to or held hostage by the Unit and Soldier Life Cycles. The common elements in all three strands are Soldiers and the strength they derive from their unit camaraderie and loving Family, or the stresses they shoulder because of isolation from the unit and conflict in the Family.

The *Composite Life Cycle Model* serves as an awareness tool for surveillance, detection and mitigation of acute, recurring and cumulative stressors represented by each strand. Leadership at all levels, Soldiers, their Families and care/service providers can better plan and approach transitional “stress windows” with eyes wide open and take measures to mitigate potential stressors before they occur. Planning for or enhancing defenses in anticipation of potential transitional stressors can mitigate the actual stress. Planned transitions, stress mitigation and successful intervention actually build resiliency. The model accounts for experiential development through the acknowledgement of the rites of passage and time. The coil at the bottom of Figure 35 represents the expected tension due to the rapid transitions a new Soldier experiences. As Soldiers develop resiliency and maturity over time, they are better armed for continued growth through new challenges and Service life.

CONCLUSIONS

- ★ The *Composite Life Cycle Model* serves as an awareness tool for surveillance, detection and mitigation of acute, recurring and cumulative stressors represented by each strand. (page 108)
- ★ As Soldiers and Families develop resiliency and maturity over time, they are better armed for continued growth through new challenges. (page 109)

RECOMMENDED ACTIONS

- ★ [HQDA] Create a complementary ARPERGEN forum to generate Soldier and Family readiness and produce a net increase on unit/ARFORGEN readiness.
- ★ [CDRs] Identify and track the stressors related to all strands of the *Composite Life Cycle Model*, to understand their affect on Soldiers and Families.
- ★ [CDRs/Garrisons] Plan for and approach “stress windows” systematically. Take measures to mitigate potential stressors before they occur.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 32 – Summary of the Composite Life Cycle

Next: Army Suicide Prevention Campaign

V – The Army Suicide Prevention Campaign

1. Army Campaign Plan for HP/RR/SP | March 2009-Present

Army suicide data in May 2008 revealed a continuing escalation in the number of Soldier suicides (see Figure 36) and generated a full-scale, concerted effort by the Army leadership to understand and mitigate this trend.⁸⁸ Intervention programs such as ASIST and ACE along with training products such as *Beyond the Front* and *Shoulder to Shoulder* were developed, produced and distributed across the force.⁸⁹ The Secretary of the Army (SecArmy) tasked the Army Science Board (ASB)⁹⁰ to conduct an “Army Suicide Mitigation” study that included immediate recommendations for changes to Army policies, programs and processes. Additionally, the Army entered into a long-term research agreement with the National Institute of Mental Health (NIMH).⁹¹

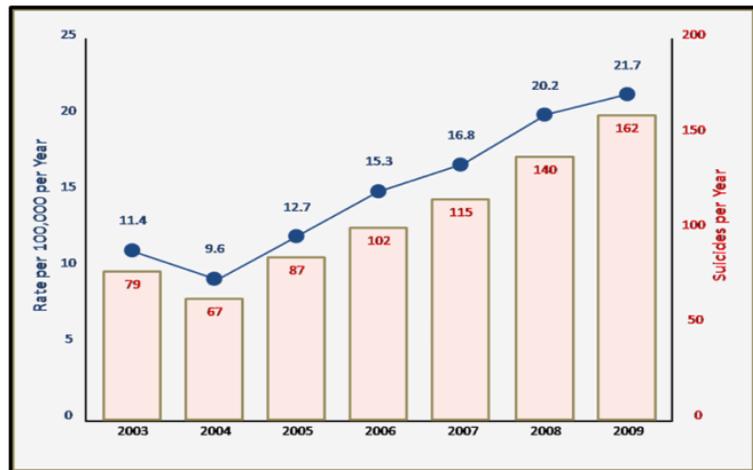


Figure 36 – Active Duty Suicide Rate by Calendar Year, 2003-2009

⁸⁸ Figure 36 depicts the Army active-duty calendar year suicide rate from 2003-2009. The official suicide rate is calculated by the Mortality Surveillance Division (MSD), Armed Forces Medical Examiner System, Armed Forces Institute of Pathology. Because MSD has not yet released the official calendar year 2009 suicide rate, the depicted rate (21.7) is estimated.

⁸⁹ The *Applied Suicide Intervention Skills Training (ASIST)* program trains Army leaders, chaplains and chaplain assistants, substance abuse counselors, family advocacy program providers, medical and dental-health professionals, and other care providers in a range of suicide-prevention and intervention skills.

ACE—Ask, Care, Escort is an intervention developed by the Army Center for Health Promotion and Preventive Medicine (CHPPM) to provide Soldiers tools to prevent a suicide event. Topics include: suicide awareness, suicide warning signs, suicidal thinking/behavior and intervention skill development. ACE is recognized by the American Foundation for Suicide Prevention as a national “best practice” for suicide prevention.

Beyond the Front is an interactive video developed by Lincoln University, in partnership with WILL Interactive, using new behavior-modification VEILS technology. The DVD allows Soldiers to practice how they would aid potential suicide victims. The DVD features realistic video vignettes.

Shoulder-to-Shoulder, No Soldier Stands Alone is a video intended to augment the Army suicide prevention video *Beyond the Front* with a more deliberate and intimate approach to training conducted by small unit leaders and first line supervisors for Soldiers and Department of the Army Civilians within their area of responsibility.

⁹⁰ The Army Science Board’s mission is to provide the Army with independent and unbiased advice on issues that are strategic in nature and important to large segments of the Army. It is one of the Army’s senior scientific advisory body.

⁹¹ The agreement with NIMH was to conduct a comprehensive assessment of Army suicides to assist in identifying risk factors and possible solution sets. Further discussion of the agreement is in the “Future Research” section.

The preliminary findings of the ASB study were briefed to the SecArmy in December 2008 and included recommendations that suicide prevention roles and responsibilities be clearly defined and assigned within the Army, and that current programs and policies be evaluated. The need for urgent reform became more apparent as the suicide rate continued to increase through 2008 into early 2009.

The alarming and continued rise in the Army suicide rate into 2009 commanded a more focused and directive stand against this trend. After the all time high of 20 suicides in a single month (January 2009) the Army mandated an unprecedented Army-wide stand-down followed by a deliberate chain teaching program focused on suicide prevention.⁹² The SecArmy and Chief of Staff of the Army (CSA) appointed the Vice Chief of Staff of the Army (VCSA) to lead the effort to reduce the trend of suicides in the Army.



“The numbers represent tragedies that have taken place across our Army...We felt it was necessary to have a central figure at the top ranks of the Army to reach across those components and bring about the kind of progress we hope to achieve.”

– Honorable Pete Geren, (Former) Secretary of the Army
Army Addresses Rising Suicide Rate, Army News Service, 29 January 2009

Quote 15 – Former SA Pete Geren, 29 Jan 09

2. Campaign Phase I – Production

After a second consecutive month of 20 suicides in February 2009, the Army created a suicide prevention task force to accelerate and focus an Army-level review to rapidly execute required changes in policies and programs. The immediate objective was to provide commanders with the programs, services and resources required to reduce Army suicides.

a. Creation of the Task Force

The VCSA formed the Army Suicide Prevention Task Force (ASPTF) as an interim organization designed to integrate, synchronize and implement a multidisciplinary approach to suicide prevention. The Task Force was activated to encapsulate and expedite the Army Staff (ARSTAF) process for an immediate impact on suicide reduction. The ARSTAF offices with equities in health promotion, risk reduction and suicide prevention were represented on the Task Force and organized into two elements; a primary staff and coordinating staff.

The VCSA directed ARSTAF principals and other key Army stakeholders to provide personnel to form the primary staff of the Task Force with full time commitment to Task Force duties. The members included both policy and technical experts with extensive operational experience.⁹³ The coordinating staff worked from their designated ARSTAF offices but provided immediate and dedicated support to the Task Force. Together, the primary and coordinating staffs were responsible for the development

⁹² February 2009 the Army directed an Army-wide stand down (all COMPOs) to conduct suicide prevention training. The training was conducted in three phases for all Soldiers, DA Civilians and Family members to increase awareness of suicide risk factors and warning signs and to encourage intervention for at-risk Soldiers. See ALARACT DTG: 060010Z Feb 09.

⁹³ The Task Force primary staff included, for example, a practicing Army civilian psychologist, a military police battalion commander and the Suicide Prevention Program Manager for the Army National Guard.

and publication of the Army Suicide Prevention Task Force Charter and the Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention (HP/RR/SP).

The Army Suicide Prevention Task Force Charter was signed 30 days after the task force was assembled. The content of the Campaign Plan was informed and developed by three concurrent efforts – (1) the collection of suicide data and research, (2) the comprehensive review of existing policy, doctrine and all known HP/RR/SP related documents from HQDA and across DoD, and (3) the VCSA-led installation-level assessment of HP/RR/SP problems and solutions from the perspective of commanders, Soldiers and Families.

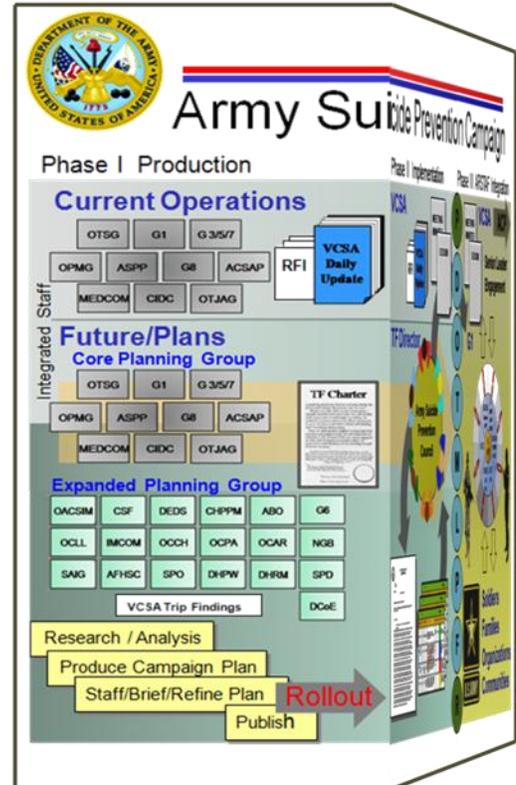
b. Collection of Suicide Data

The Task Force immediately developed a suicide event collection report, comprised of data fields to be filled out by the Field Army. The report provided Army leadership with instant, actionable information on each individual Army suicide within approximately 72 hours of CID’s initial response. The report, which dramatically expanded information requirements, was also intended to inform future research beyond the routinely reported demographic information. Following notification of a death through established Army channels or by receipt of the suicide collection report, the Task Force CID representative could directly contact the unit, military or civilian law enforcement agencies or other investigative organizations to seek additional information. All information regarding the suicide event was examined by the Task Force to determine if there were any policy, program or resource shortcomings that could have contributed to or prevented the suicide.

c. Task Force Comprehensive Review

The Task Force conducted a thorough and comprehensive review of the Army’s suicide prevention policy—a recommendation from the ASB report. The review quickly revealed that the focus on suicide prevention was too narrow and the aperture needed to widen to a more comprehensive review to include all Soldier and Family risk reduction and wellness programs. Informed by the daily suicide data, the Task Force recognized a correlation between risk-taking behavior (often amplified by the current operational tempo) and suicide behavior. Consequently, the Task Force expanded its efforts in a more holistic review to incorporate all facets of HP/RR/SP. This review was conducted over the course of six weeks and consisted of a systematic review and analysis of hundreds of documents including Army, DoD and external agency regulations, policy memoranda, studies and suicide reports that were directly or indirectly associated with HP/RR/SP.

The review quickly revealed that the focus on suicide prevention was too narrow and the aperture needed to widen ...



Dedicated to task organization and production of the TF Charter and Campaign Plan.

Figure 37 – Campaign Plan Phase I, Production



d. VCSA Installation-Level Assessment

While the Task Force's primary staff was collecting suicide data and conducting a thorough document review, other members of the Task Force along with other external subject-matter experts accompanied the VCSA to six installations for an installation-level assessment of suicide prevention programs and services. From 23 to 30 March 2009, two assessment teams led by the VCSA and Task Force Director met with leaders, Soldiers, Families and staff at Forts Jackson, Bragg, Campbell, Lewis, Hood and Drum.⁹⁴

The VCSA team focused on local leader engagements as part of an HQDA fact-finding mission to inform the Campaign Plan. This team conducted sensing sessions to provide leaders, Soldiers, Civilians and Families the opportunity to influence the Campaign Plan. The second team focused on a review of all command and staff, agency, and program integration, roles and responsibilities, processes and resources to identify gaps, seams and redundancies, as well as best practices in HP/RR/SP.

The two teams would compare findings and conclusions each day to cross reference gaps and redundancies in programs and processes. Unremarkably, the two teams came away with similar findings and conclusions obtained from two disparate survey groups — those who used or referred others to programs and services and those who provided or administered the programs and services. What was remarkable, however, was that the traveling team and the Task Force at the Pentagon came to near simultaneous discovery that a more comprehensive, holistic campaign approach was going to be required to effectively address the suicide trend.

e. Campaign Plan Development

The VCSA's subsequent trip report, based on discussions with leaders, Soldiers and Families, validated that a holistic approach to Soldier wellness (promoting the physical, mental and spiritual health of the force) was required to address the problem. This confirmed the Task Force's approach to HP/RR/SP and was incorporated into the expanded Campaign Plan.

Analysis of the findings of both the trip report and Task Force's holistic review revealed a number of key themes supported by numerous discrete findings. The key themes from the trip report are outlined below. Each key theme is followed by an example of some of the findings.

(1) Key Themes

- **Army Transformation.** Transformation created tension between the generating and operating force. It reduced access and delivery of program/service providers (e.g., medical, chaplains, military police (MP), etc.). New manpower modeling/templates did not address all units or appropriate echelons. Also, the transition to a brigade-centric Army, which imbedded service providers into the brigade structure, reduced the pool of assets available to centralized community management and, therefore, the general population.
- **High Risk Population.** There is an increase in the high risk population of Soldiers when measured by the cumulative impact of negative trends and indicators including: positive urinalysis (UA), multiple positives, lack of Army Substance Abuse Program (ASAP) referrals,

⁹⁴ The assessment team's scheduled visit to Fort Carson was cancelled due to inclement weather.

continuity of treatment and rehab failures; crimes, repeat offenders and socialization of crimes (e.g., drug distribution, multiple subjects); disciplinary actions and administrative separations; and commanders' disciplinary reporting. Additionally, the team found that the size and scope of the Warrior Transition Unit (WTU) was comparable to an Army "long-term health care" plan; Soldiers may be in the system for years.

- **Fragmented HP/RR/SP Efforts.** Policy, programs and processes were fragmented by too many silos, home grown programs and independent processes. Garrisons lacked standardization, common performance metrics and unity among HP/RR/SP programs and services. Additionally, HP/RR/SP efforts were not transferable to the Reserve Component (RC) or to the Army Service Component Commands (ASCCs) to export to forward deployed locations.
- **Situational Awareness.** HP/RR/SP databases were not integrated across the medico-legal, law enforcement and program/service systems. Data sharing and retrieval were hampered by lack of integrated methodology, disjointed reporting, information gaps, misperceptions of privileged information (law enforcement, ASAP and FAP confidentiality, Health Insurance Portability and Accountability Act (HIPAA), AR 15-6 findings, etc.) and parallel systems without appropriate intersections to provide automatic data feed, consolidation, analysis and visibility. Also collaborative forums for HP/RR/SP decision makers were often ad hoc and informal.
- **Force End Strength.** Teams identified numerous critical shortages of care providers including behavioral health, chaplains, investigators, counselors and program staffs/service providers (e.g., substance abuse counselors). In fact, the VCSA sensing sessions documented a recurring recommendation among leaders, Soldiers and Families to "grow the Army."

(2) Findings

(a) Transformation:

- The Army needed to adjust force modeling/templates to support increase/surge in generating force requirements that support an expeditionary Army with a campaign capability.
- The Army needed to improve continuity and stability during redeployment and reintegration periods (Changes of Command, Professional Filler System (PROFIS) Doctors, Military Family Life Consultant (MFLC), Chaplains, etc.).
- There was a lack of integration of brigade combat team (BCT) and installation HP/RR/SP care providers (medical, legal, MP, Chaplains, etc.).
- Outdated policy reflected a pre-Transformation Army (e.g., DA PAM 600-24, *Health Promotion, Risk Reduction, and Suicide Prevention*, was over 20 years old).

(b) High Risk Population:

- The Army was experiencing an increase in alcohol/substance abuse (illicit use of prescription medication, use of illegal street drugs and alcohol-related incidents).
- The Army was experiencing an increase in crime incidents and retaining Soldiers with multiple offenses.
- The ASAP had gaps in reported positive UA, referrals, enrollment completion and administrative actions regarding positives, multiple positives, rehab failures, and recidivism.
- The effect of polypharmacy was a significant risk factor (the provision of multiple medications from one or more providers to a single patient).
- The Army needed to establish standards for drug offenses and hold Soldiers accountable.

- WTUs had become the equivalent of an Army “long-term health care” system.
- Only 15% of the WTU population had combat-related injuries or illnesses.
- The team found that WTU cadre needed to be hand-picked; the mission was so challenging that cadre selection criteria needed to ensure that these officers/NCOs had the right training, leadership credentials and motivation.
- Soldiers frequently sought high adrenaline activities following deployments which led to risk-seeking and high risk behaviors (alcohol, drugs, law enforcement encounters, etc.).

(c) Fragmented HP/RR/SP Efforts:

- Health promotion policy was fragmented and uncoordinated.
- There were too many unsynchronized, uncoordinated and home grown programs.
- There was a lack of communication among care providers due to perception of privileged information.
- Insufficient coordination resulted in protocols for caregivers (medical, behavioral health and chaplains) that were silo’ed and lacked unity of effort.
- National Guard and Army Reserve units were not provided the full spectrum of programs/services.
- There was a proliferation of home grown programs without charters and dedicated funding.
- There was not a centralized forum to identify and bench mark best practices.

(d) Situational Awareness:

- There was no single database to track program and service contact for HP/RR/SP intervention.
- There was no central, standard system to track multiple offenders (crimes/drugs), high risk behavior and indiscipline.

(e) Force End Strength:

- There was a requirement for additional uniformed care providers.
- The Army was critically short of behavioral health (BH) counselors.
- Army Chaplains had a critical staffing shortage for both units and communities. Additionally the emerging role for early behavioral detection and referral created additional requirements well above their traditional pastoral roles and training/education.
- The Army was experiencing compassion fatigue among professional care providers to include medical, chaplains and law enforcement.
- The Army needed to expand the MFLC program.

All significant findings were subsequently incorporated into the *HP/RR/SP Synchronization Matrix (Sync Matrix)* for an aggregate 242 specific actionable tasks. The Policy-DOTMLPF-Resource domain set was used as a technique to categorize the tasks.⁹⁵ Once a task was categorized into a specific domain, it was cross-walked against the other domains to address sequential P-DOTMLPF-R requirements. For

⁹⁵ P-DOTMLPF-R is the acronym for the conceptual model used by the Task Force to conduct the holistic analysis of HP/RR/SP processes and systems. A P-DOTMLPF-R analysis considers policy, doctrine, organization, training, materiel, leadership and education, personnel, facilities and resources. DOTMLPF is a recognized DoD term. See JP 1-02, *DoD Dictionary of Military and Associated Terms*, 31 October 2009.

instance, a discrete task categorized under “policy” might generate new requirements in “doctrine, organization and training.” Examples of significant tasks from across the domain set that were generated from the Task Force review include:

- **Policy** – Develop and distribute policy guidance to direct more conservative use of psychiatric medications for conditions that are generally expected to resolve within six months and for which psychotherapy may be a more appropriate option.
- **Doctrine** – Establish procedures and protocols for Military OneSource to be promoted as a crisis intervention hot line. Allow trained professionals to assist with crisis intervention and immediate referral as well as location-specific emergency points of contacts at installations.
- **Organization** – Establish a Suicide Prevention Program Manager (SPPM) at the installation/ Operational & Functional Command or Regional Readiness Support Command/State Joint Forces Headquarters.
- **Training** – Integrate resiliency training into the Deployment Cycle Support task list from the Army National Guard (ARNG) for broader application as best practices within the Army.
- **Materiel** – Develop IMCOM protocols for collection, reporting and data-basing of suicide information (fatality review board) into the Army Behavioral Health Integrated Data Environment (ABHIDE).
- **Leadership** – Issue "VCSA Sends" or ALARACT emphasizing the requirement for commanders to refer Soldiers to ASAP whenever a commander learns that a Soldier has tested positive for illicit drugs or engaged in alcohol-related misconduct.
- **Personnel** – Revise policies and procedures to improve the Civilian Human Resources Agency (CHRA) ability to effectively support the hiring of medical professionals and support staff in a timely manner.
- **Facilities** – Collocate behavioral health and primary care providers within medical service facilities to combat stigma. Physically dovetailing these services will help to allay Soldiers' concerns about being seen by peers as they enter behavioral health, encourage informal communication between behavioral health and medical service providers and improve Soldier access to behavioral health care.
- **Resources** – Proportionally increase the number of hours of free child-care at the Child Development Center (pre-deployment, during the deployment and post-deployment) based on the length of a Soldier's deployment.

CONCLUSIONS

- ★ The Army HP/RR/SP Campaign Plan was informed and developed by three concurrent efforts – (1) the collection of suicide data and research, (2) the comprehensive review of existing policy, doctrine, and all known HP/RR/SP related documents from HQDA and across DoD, and (3) the VCSA-led installation assessment of HP/RR/SP problems and solutions from the perspective of commanders, Soldiers, and Families. (page 113)
- ★ The Army's focus on suicide prevention up until 2009 was too narrow; the aperture needed to widen to a more comprehensive review to include all Soldier and Family risk reduction and wellness programs. (page 113)
- ★ There is a correlation between risk-taking behavior and suicide behavior. Risk-taking behavior is often overlooked within the Army due to the current operational tempo. (page 113)

(Continued)

- ★ Army Transformation created tension between the generating and operating force, resulting in the reduction of access and delivery of program/service providers to installations. (page 114)
- ★ There is an increase in the high risk population of Soldiers as evidenced by street and illicit drug use, criminal activity and higher levels of risk tolerance. (pages 114-115)
- ★ HP/RR/SP policy, programs and processes are fragmented and have not been effectively transferred to the Reserve Component or exported to ASCCs for bridging to deployed locations. Home grown programs and independent processes have proliferated as a result. (page 115)
- ★ HP/RR/SP databases are not integrated across the medico-legal, law enforcement and program/service systems and as a result do not provide adequate situational awareness to commanders. (page 115)
- ★ Critical shortages of care providers exist in the Army including behavioral health providers, chaplains, investigators, counselors and program staffs/service providers. (page 115)

RECOMMENDED ACTIONS

- ★ [HQDA] Continue to utilize the P-DOTMLPF-R construct to evaluate the tasks associated with changes to Army HP/RR/SP.
- ★ [HQDA] Analyze and implement this report’s conclusions and recommendations into the Campaign Plan *HP/RR/SP Sync Matrix*.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 33 – Campaign Plan Phase I

3. Campaign Phase II – Implementation

The Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention was approved on 16 April 2009, just three weeks after the Task Force Charter and the installation-level assessment. This plan – published with HP/RR/SP tools for HQDA and garrison leaders as annexes – was the result of the effort of Task Force members who worked six (and sometimes seven) days a week from March to mid-April 2009. The rapid development of the Campaign Plan is a testament to both the Army’s focused dedication and the urgent need to combat the increasing number of Soldier suicides. Consistent with the directive to implement immediate and enduring change, the Campaign Plan contained two essential components: (1) an ARSTAF plan incorporated into the body of the Campaign Plan and supported by a comprehensive *HP/RR/SP Sync Matrix*, and (2) a message directly from the VCSA speaking directly to commanders which was also in the body of the Campaign Plan and supported by an *Installation/Garrison/Medical Treatment Facility Commanders’ Plan* written as Annex D. This

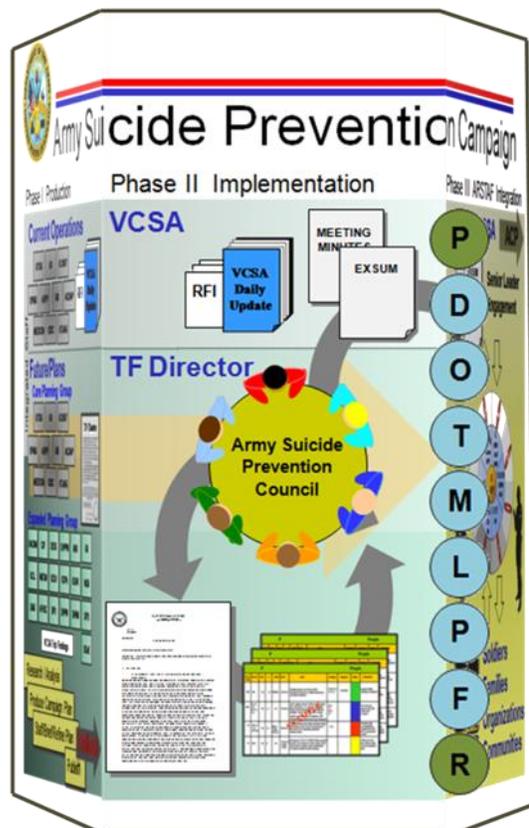


Figure 38 – Campaign Plan Phase II, Implementation

campaign plan construct was innovative in that it simultaneously directed two communities—HQDA and Field Army Leaders—to operate in tandem and in a complementary manner to accelerate immediate change. This was not going to be “business as usual.”

The second phase of the Campaign Plan (Figure 38) was initiated immediately. This phase focused on the implementation and integration of the P-DOTMLPF-R solutions by the Army Suicide Prevention Council (ASPC). The Council was established as an interim HQDA-level organization chartered under VCSA authority and was mandated to expedite solutions from HQDA through appropriate commands, staffs and agencies to the commanders at all levels. Its purpose was to initiate change, provide multidisciplinary integration, validate/nominate new tasks and verify implementation of completed (retired) tasks for HP/RR/SP-related policies, structure and processes. All new and completed tasks were personally approved by the VCSA.

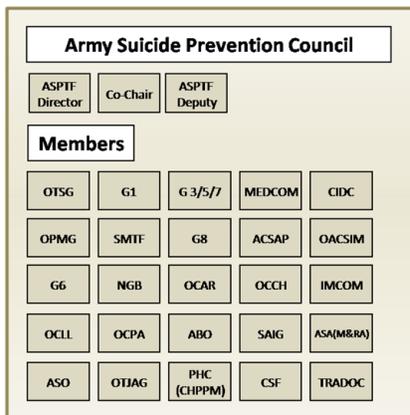


Figure 39 – Army Suicide Prevention Council Members

The Council membership (Figure 39) consisted of O6-level representatives from each ARSTAF office and other Army stakeholders, co-chaired by the Task Force Director and a senior Civilian official (Flag Officer level). The Field Army was also represented through the findings in the trip report and by direct communications to the Task Force. Some members represented multiple agencies; others a single agency. Each Council meeting was attended by an average of 28 individual representatives. The Council concept was to operate as an expedited and truncated replica of the standard ARSTAF process by creating a senior-level interdisciplinary forum that would meet regularly to adjudicate issues without routine staffing delays. The Council integrated all staff, agency, external partners and field command efforts through execution of the *HP/RR/SP Sync Matrix*.

a. The HP/RR/SP Sync Matrix

The *HP/RR/SP Sync Matrix*, which contained the 242 tasks generated from the Task Force review, installation-level assessment and ongoing research and analysis, was the centerpiece of the Campaign Plan. The *HP/RR/SP Sync Matrix* was the tool for coordinating, expediting and monitoring the implementation of each task. The *HP/RR/SP Sync Matrix* not only served as a tracking mechanism to show progress but also was updated continuously as new tasks were added and others were approved for retirement.⁹⁶ Each task on the matrix was assigned to a specific Office of Primary Responsibility supported by an Office of Coordinating Responsibility for completion by a designated suspense date; biweekly meetings were conducted to monitor their status. During each meeting, the status of each task due for completion was reviewed and discussed by the Council and updated accordingly.

An example *HP/RR/SP Sync Matrix* task is depicted at Figure 40. The matrix columns are designed to capture all information required to expedite task completion:

- Bin and Number columns depict the task’s P-DOTMLPF-R domain set and task number within that domain set.

⁹⁶ The *HP/RR/SP Sync Matrix* was included as Annex B to the Campaign Plan. It is important to note that the *HP/RR/SP Sync Matrix* is not a static document – it is dynamic and incorporates new and modified tasks over time.

- Office of Primary Responsibility (OPR) column shows the Council office responsible for completing the task.
- Office of Coordinating Responsibility (OCR) column depicts required coordination with Council offices. Tasks can be closed only with the concurrence of assigned OCRs.
- Topic column contains a description of the task (after the "(T)" indicator) as well the desired outcome of task completion (after the "(O)" indicator).
- Suspense Date column contains the assigned completion date for the task.
- Status column depicts the current status of the task. Each task on the Sync Matrix is color-coded to reflect its status: blue (new), green (on schedule), yellow (overdue), red (frustrated) or black (completed). Some Tasks included a white "V" in the status column indicating it is a task derived directly from the installation visits.
- Linkages column shows connections between the task and other interrelated Sync Matrix tasks.

Leadership										
Bin	#	OPR	OCR	Task	Source (title, para, page, date)	Deliverable	Suspense	Status	Linkage(s)	Comments
L	5.4.5	G1		(T) Encourage CDRs at all levels to comply with regulatory guidance to Administratively Separate Soldiers for misconduct to include serious drug / alcohol or multiple drug / alcohol incidents. Clarify policy to provide clear guidance and reduce additional administrative requirements to simplify and expedite CDR actions. (O) An Army-wide reduction in high-risk Soldiers and influencers to a growing high-risk Soldier population, and an increase in Soldier / unit readiness. NOTE: This policy change will not impact or otherwise influence CDR's discretion in dealing with the criminal aspects of illicit drug use.	AR 600-85, 2FEB09, para 2-32k, p4	VCSA SENDS	20-May-09		Po1.3.7 Po1.3.8 Po1.6.1 T4.3.1 T4.5.2 R7.4.4 R7.3.2 T4.5.3	Generally CDRs are retaining Soldiers with multiple instances of drug / Alcohol incidents above historical levels. Retention of these Soldiers - medical conditions notwithstanding - negatively impacts good order and discipline of units. These Soldiers are often prone to engaging in high-risk behavior and may influence misconduct in other Soldiers resulting in a growing population of high-risk Soldiers. In the final analysis, this growing population of high-risk Soldiers may cause CDRs to retain them against unit requirements for readiness / deployments. Accepted as "Black" task by co-chairs at 06 May 09 ASPC.

Figure 40 – Synchronization Matrix Task Example

The Campaign Plan was designed to be an expedited version of the routine staffing process. It was therefore necessary to establish and maintain transparency of the plan to accomplish each task. The Council utilized a standardized template, the "Task Action Plan" (TAP), for this purpose. The task OPR prepared and presented the TAP to brief the task to the Council.

Bin	#	OPR	OCR	Topic	Suspense	Status	Comments
L	5.4.5	ASPTF	G1 ACSAP	Administrative Separation for serious or multiple drug (UA's) / alcohol incidents	23 Mar 09 thru 20 May 09		
Findings: Generally CDRs are retaining Soldiers with multiple instances of drug / alcohol incidents above historical levels. Retention of these Soldiers - medical conditions notwithstanding - negatively impacts good order and discipline of units. These Soldiers are often prone to engaging in high-risk behavior and may influence misconduct in other Soldiers resulting in a growing population of high-risk Soldiers. In the final analysis, this growing population of high-risk Soldiers may cause CDRs to retain them against unit requirements for readiness / deployments.							
Task / Outcome: (T) Encourage CDRs at all levels to comply with regulatory guidance to Administratively Separate Soldiers for misconduct to include serious drug / alcohol or multiple drug / alcohol incidents. Clarify policy to provide clear guidance and reduce additional administrative requirements to simplify and expedite CDR actions. (O) An Army-wide reduction in high-risk Soldiers and influencers to a growing high-risk Soldier population, and an increase in Soldier / unit readiness.							
OPR Suspense Sub-Tasks							
ASPTF		23-30 Mar 09 VCSA visited six installations to assess impact Army transformation on Soldiers, Health Promotion programs, ASAP, WtUs, personnel resourcing, medical assets, and to assess best practices.					
ASPTF		1 May 09 Publish a VCSA SENDS emphasizing administrative separation requirements IAW AR 600-85 and mandatory reporting using DA Form 4833 CDR's Disciplinary Action, IAW AR 190-45.					
Constraints: *VCSA SENDS must be concise to preclude appearance of undue command influence *Scheduling new / additional POI requirements at Army and Branch POCs for refresher training for incoming commanders							
Follow-up: *This task is incorporated into the ACPHP Sync Matrix for follow-up assessment by the Army Suicide Prevention Council *G1 will bench current rates and track changes in Administrative Separation rates to brief VCSA monthly *Alcohol/Drug information and corresponding separations will be incorporated into USR reporting starting July 2009 *Refresher training on referral requirements and separations will be incorporated into Commander and Rear-Detachment Commander training programs							

Figure 41 – Task Action Plan (TAP)

However, the publication of this report will generate additional tasks.

The Task Force was responsible for providing both administrative and substantive support to the Council. Each biweekly Council meeting required Task Force members to spend approximately 24 hours

After each task was briefed, the co-chairs would either accept or modify the proposed plan and task status. Subsequent to each Council meeting, the Task Force Director would brief and obtain approval/feedback from the VCSA for new, frustrated and completed tasks.

The initial meeting of the Council was conducted by the VCSA on 17 April 2009. Over the course of the year, each of the 242 action tasks were repeatedly briefed, coordinated and worked to effect immediate and rapid change. As of 30 June 2010, after 15 months of effort, the Council had completed 87% of the tasks, with only 31

developing the slide presentation, conducting a preparatory drill, and pre-briefing the Council co-chairs prior to each meeting. A week prior to each meeting, Task Force members collected folders for those tasks to be briefed at the meeting. All tasks nominated for completed status required a legal review. Immediately following each meeting, Task Force members met with their respective Council members to discuss council guidance for accuracy and clarification as required. Extensive Council meeting minutes and an EXSUM were produced for the VCSA within 72 hours. Once the VCSA approved all tasks presented for retirement, post-meeting products were sent to Council members. The Task Force maintained archives of all completed tasks for continuity and historical purposes.

Vignette 25 – The Sync Matrix in Action

THE SYNC MATRIX IN ACTION

One personnel practice impacting HP/RR/SP identified by both the Task Force comprehensive review and the installation-level assessment was that medical and behavioral health personnel assigned to redeploying units were rotating out of the unit soon after re-integration back home. A task

Personnel									
Bin	/#	OPR	OCR	Task	Source (title, para, page, date)	Deliverable	Suspense	Status	Linkage(s)
Pe	6.1.7	G1 OTSG	ASPTF	(T) Review and revise Army and MEDCOM policies (including AR 601-142) policies to retain medical personnel in redeploying units for 90-120 days during the reset phase to ensure continuity of care, cognizant-mitigation of unit and Soldiers stressors, and sufficient treatment “handoff” to incoming medical personnel. (O) Continuity of medical and behavioral health care in units is maintained for 90-120 days post-deployment, mitigating development of high-risk factors through medical reset plans / processes.	VCSA Installation Visit	Policy change. Published ALARACT guidance reflecting a minimum 90-day post-deployment stabilization period (with allowances for individual waiver for extenuating circumstances) for behavioral health professionals.	12-Aug-09		D2.2.7

was created and assigned to DCS, G-1, and OTSG to review and revise Army/MEDCOM policies to retain medical and behavioral health personnel in redeploying units for 90-120 days during the reset phase to ensure continuity of care, cognizant-mitigation of unit and Soldier stressors and sufficient treatment “handoff” to incoming medical personnel. The task was classified as a Personnel task on the P-DOTMLPF-R spectrum and added to the Sync Matrix for tracking and management by the Council.

The Task Force requires that a Task Action Plan (TAP) be completed for every Sync Matrix task. It identifies sub-tasks that must be completed to retire the task (see figure below). By implementing these tasks, the Army maintains continuity of medical and behavioral health care in units for 90-120 days post-deployment, mitigating development of high risk factors through medical reset plans/ processes. The DCS, G-1 was given primary task responsibility, with OTSG as a coordinating office. The “deliverable,” or proof of task completion, was a policy revision. Following the policy revision, an ALARACT was published that required a minimum 90-day post-deployment stabilization period (with allowances for individual waivers) for behavioral health professionals.

(Continued)



THE SYNC MATRIX IN ACTION

Bin	Task #	OPR	OCR	Topic	Suspense	Status	Linkages															
Pe	6.1.7	G1	OTSG	MEDCOM policy for assignment of Health Professionals to deploying units	(1 Aug 09) 12 Aug 09	V																
<p>Findings: Medical personnel assigned to deployed units often immediately or quickly rotate out of the unit upon redeployment back to installations, which can degrade continuity of health care to at-risk Soldiers during the high-stress phase associated with unit reintegration and reset. Treatment providers who saw the Soldier during deployment are prepared to mitigate stressors affecting the Soldier (e.g., adrenaline surge, ongoing disciplinary / separation actions, family strife, physical and mental trauma, team dispersion and isolation, etc.). Rapid rotations of deployed treatment providers also reduces opportunities for medical personnel to prepare for treatment "handoff" to incoming treatment providers. In short, disruption of continuity of medical care during reintegration may increase the danger to Soldiers of developing suicide risk factors.</p> <p>Task / Outcome: (T) Review and revise Army and MEDCOM policies (including AR 601-142) policies to retain medical personnel in redeploying units for 90-120 days during the reset phase to ensure continuity of care, cognizant-mitigation of unit and Soldiers stressors, and sufficient treatment "handoff" to incoming medical personnel. (O) Continuity of medical and behavioral health care in units is maintained for 90-120 days post-deployment.</p> <p>Deliverable: Publish ALARACT guidance reflecting a minimum 90-day post-deployment stabilization period (with allowances for individual waivers for extenuating circumstances) for behavioral health professionals.</p>																						
<table border="1"> <thead> <tr> <th>OPR</th> <th>Suspense</th> <th>Sub-Tasks</th> </tr> </thead> <tbody> <tr> <td>OTSG</td> <td>10 Jul 09</td> <td>Finalize ALARACT to provide guidance to MTF, RMC, and commands; ALARACT will specify affected units, AOCs, and effective date similar to 180-day ALARACT. (i.e. SM deploying on or after XX date will be affected; current deployed are grandfathered under existing MC/FC MOU with risk mitigated by developing a detailed process b/w current and gaining provider at home station to ensure continuity of patient care)</td> </tr> <tr> <td>OTSG</td> <td>15 Jul 09</td> <td>Revise existing MEDCOM/FORSCOM MOU (Guidance for the utilization of MEDCOM PROFIS/IA in FC units for contingency and deployment operations) to reflect 90-120 day post deployment requirement and continuity of care procedures. This is an enhancement but is not critical to achieving TF objective of stabilizing PROFIS personnel.</td> </tr> <tr> <td>G-1</td> <td>15 Jul 09</td> <td>Revise SL/SM ALARACT (076/2009) to authorize extension of TCS orders for health professionals assigned via PROFIS to deploying/contingency units for the period of deployment plus a minimum of 90 days.</td> </tr> <tr> <td>G-1</td> <td>12 Aug 09</td> <td>Revise Master ALARACT (077/2009) and Stabilization MILPER 06-232 to require AMEDD personnel assigned to deploying units to be stabilized at home station with their unit for a minimum of 90 days post deployment with allowances for individual waiver for extenuating circumstances.</td> </tr> </tbody> </table>								OPR	Suspense	Sub-Tasks	OTSG	10 Jul 09	Finalize ALARACT to provide guidance to MTF, RMC, and commands; ALARACT will specify affected units, AOCs, and effective date similar to 180-day ALARACT. (i.e. SM deploying on or after XX date will be affected; current deployed are grandfathered under existing MC/FC MOU with risk mitigated by developing a detailed process b/w current and gaining provider at home station to ensure continuity of patient care)	OTSG	15 Jul 09	Revise existing MEDCOM/FORSCOM MOU (Guidance for the utilization of MEDCOM PROFIS/IA in FC units for contingency and deployment operations) to reflect 90-120 day post deployment requirement and continuity of care procedures. This is an enhancement but is not critical to achieving TF objective of stabilizing PROFIS personnel.	G-1	15 Jul 09	Revise SL/SM ALARACT (076/2009) to authorize extension of TCS orders for health professionals assigned via PROFIS to deploying/contingency units for the period of deployment plus a minimum of 90 days.	G-1	12 Aug 09	Revise Master ALARACT (077/2009) and Stabilization MILPER 06-232 to require AMEDD personnel assigned to deploying units to be stabilized at home station with their unit for a minimum of 90 days post deployment with allowances for individual waiver for extenuating circumstances.
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<p>Constraints / Resourcing: Nothing in AR 601-142 specifies the period of attachment to deploying units for health professionals on TCS orders in support of operations in theater. No changes are required to this regulation. HRC assignment policy change will ensure that support personnel remain with returning deployers to provide continuity and care in the transition from the stress of theater operations.</p> <p>Follow Up: MEDCOM will monitor and report impact of policy on functions of installation MTFs, accessions of skilled medical professionals, and the wellbeing of medical care providers. G-1 ALARACTs defining additional stabilization requirements for PROFIS personnel were released 04 August 09.</p>																						

The status changed to black (*completed to meet the intent of the task*) by taking the following steps:

- At the 29 July 2009 Council meeting, a G-1 representative briefed that the ALARACTs associated with this task were completed but not yet ready for release and requested an extension. The Council co-chairs approved a suspense date change from 01 August to 12 August 2009.
- On 12 August 2009, the G-1 representative reported to the Council that the G-1 ALARACTs and OTSG MILPER message had been released in tandem to establish a 90-day minimum post-deployment stabilization period for behavioral health and medical professionals. The co-chairs recommended that the G-1 request to retire the task be approved.
- On 4 September 2009, the VCSA approved the status change to Completed (black).

Source: Army Suicide Prevention Task Force

CONCLUSIONS

- ★ The development of a synchronization matrix became the centerpiece of the Campaign Plan. As of 30 Jun 2010, 87% of the 242 tasks were complete. (page 120)
- ★ This report will generate additional tasks for incorporation into the Synchronization Matrix. (page 120)

RECOMMENDED ACTIONS

- ★ [HQDA] Continue to utilize the P-DOTMLPF-R construct to evaluate the tasks associated with this report's conclusions and recommendations for integration in the HP/RR/SP Sync Matrix.

Refer to Annex B for additional detail and supporting actions

b. Commanders' Plan

The second part of the Campaign Plan consisted of VCSA guidance directly to installation, garrison and medical treatment facility (MTF) commanders to set the conditions for strategic change as part of the Sync Matrix. He communicated the immediate requirement for commanders to standardize programs and processes and optimize current resources in preparation for additional HQDA guidance in the Commanders' Plan (Annex D to the Campaign Plan), which consisted of *HP/RR/SP Sync Matrix* tasks that were immediately actionable at the installation level. The Commanders' Plan reflected the Army leadership's intent to synchronize HP/RR/SP efforts at all levels across the Army.

“Commanders... I have identified actions/tasks at Annex D that must be implemented immediately by you at every camp, post, and station and in every MTF to maximize the effects of your Health Promotion, Risk Reduction and Suicide Prevention-related Programs; optimize your policy, programs, and resources; and set conditions for new and supplemental Army programmatic solutions and resources.”

– General Peter W. Chiarelli, Vice Chief of Staff, Army Campaign Plan, April 2009

Quote 16 – GEN Pete Chiarelli, Apr 09

The guidance contained in the Commander's Plan was well-received in the field. The Task Force Director received numerous positive comments from a variety of commanders.⁹⁷ Annex D was designed to help commanders identify opportunities for improving their existing HP/RR/SP programs/services and was not intended to serve as a “report card” that HQDA or other higher headquarters would use to evaluate the commanders. Examples of guidance contained in the Commanders' Plan included:

- Program/Service Integration – e.g., do the HP/RR/SP programs, councils, and committees under your purview have a comprehensive charter document?
- Specific Programs/Staffs – e.g., do you have adequate staffing for behavioral health programs to provide timely support to Soldiers and Families?
- Primary and Behavioral Health Care – e.g., are medical/clinic operating hours convenient for Soldier/Family care access and maximum facility usage?
- Family/Friends Participation – e.g., do you include Families in reintegration training?
- Reducing High Risk Behavior – e.g., do your commanders refer Soldiers to ASAP who have either a positive urinalysis or a drug/alcohol related incident?

c. Task Force Ongoing Efforts

Phase II of the Campaign Plan is ongoing and will conclude with the publication of this report. The primary focus of the Task Force during Phase II was to provide responsive support to Army leadership on all HP/RR/SP matters and to act as action officers for the Council during the implementation of the Sync Matrix. In November 2009, the Task Force issued an update (fragmentary order) to the Campaign Plan, directing a comprehensive review of HP/RR/SP programs. This review ultimately supported the development of the “*Managing the HP/RR/SP Program Portfolio*” section of this report.

⁹⁷ For example, positive feedback and comments were received from the MTF commander at Ft. Campbell, the garrison commander at Ft. Lewis and the Senior Commander at Ft. Drum.

The operational tempo for the Task Force during the early stages of Phase II was extremely high. Task Force operations were classified along four major lines of operation: Research and Assessment, Implementation and Effects, Training and Education and Communications and Promotion:

(1) Research and Assessment

- Reviewed all relevant informing documents for possible incorporation into the *HP/RR/SP Sync Matrix*.
- Monitored and supported several study and research initiatives to include the National Institute for Mental Health (NIMH) for the Army Study to Assess Risk and Resilience in Service Members (Army STARRS) and 10 other research grants through Medical Research and Materiel Command.
- Consulted with the NIMH, ASB, RAND, TRICARE Management Activity Online Counseling Network, Veteran's Administration/Veteran's Service Organization, Tragedy Assistance Program for Survivors (TAPS) and Research Triangle Institute (RTI).
- Responded (and continued to respond) to numerous inquiries from individuals with specialized expertise (psychics, scientists, psychologists, musicians and authors) who offered assistance to the Army in its HP/RR/SP efforts.
- The Task Force conducted extensive statistical reviews on suicide data. Data have been analyzed on every available demographic (e.g., rank, component status, race, age, marital status, number of deployments and suicide by home station, to mention a few) in a Suicide Data and Analysis Report provided weekly to the VCSA, the Sergeant Major of the Army (SMA) and the co-chairs of the Council. Concurrently, the Army Suicide Prevention Program (ASPP) continues to track suicides with comprehensive demographics.
- Report packets to the VCSA, co-chairs of the Council, and SMA were developed in April 2009 and are generated daily. All military and civilian law enforcement agencies directly and indirectly involved in a suicide case have been feeding information directly to the Task Force to provide background information. The VCSA read every packet and sent questions back to the Task Force for follow up. Each packet took approximately eight hours to complete and contained:
 - A detailed 37 line report completed by CID on every suicide. To generate this report, the CID representative contacted many local police officers, CID agents, etc.
 - A year-to-date summary of current suicide statistics, cases of interest, monthly suicide statistics, current operations, future operations and VCSA tasks.
 - Rolling statistics on CY Active Duty, non-Active Duty and Family member suicides.
- Weekly report packets, developed in March 2009, continue to be provided to the VCSA. These packets contain noteworthy events that have taken place during the week pertaining to HP/RR/SP. In addition, weekly suicide data and analysis charts as well as the HQDA Balcony Brief charts (extensive breakdown of suicide data provided by the ASPP) are included.

(2) Implementation and Effects

- Task Force members conduct biweekly Measures of Effectiveness (MOE) Meetings with the ASPP to determine the efficacy and provide input into the ASPP's efforts in increasing health promotion and risk reduction. Task Force input is used to update the VCSA's monthly report.
- The Task Force and Council continue to monitor the data management working group efforts to enable shared data across HP/RR/SP proponents and to support Army STARRS research requirements.

- Six months after the Campaign Plan was released, the Task Force began an assessment of completed (black) tasks. Completed tasks were reviewed and implementation status verified at installation level to ensure compliance. The Task Force developed a standardized tracking tool to collect complete information from the field (an ongoing assessment). This ongoing audit is necessary to ensure policy is fully implemented, in compliance and measured for effectiveness.

(3) Training and Education

- The VCSA chairs the monthly suicide Senior Review Group (SRG), established in March 2009. The SRG involves senior commanders from affected commands across the Army and reviews 15 to 20 suicide cases each month. The cases are discussed to glean lessons learned and identify trends and themes. Prior to each meeting, the Task Force spends three and a half weeks preparing pertinent material and coordinating with commands. In addition to preparing the specific cases for discussion, the Task Force provides significant substantive support for the SRG, including preparation of meeting minutes; development of executive summary and lessons learned for each case; and preparation of a post-meeting “Themes and Trends” document for Army-wide dissemination.

(4) Communications and Promotion

- Strategic communication (STRATCOM) meetings take place every two weeks and involve individuals from various ARSTAF agencies. The ASPP spends approximately eight hours every other week to prepare for this meeting. A master STRATCOM matrix is updated monthly which captures all conferences, councils, summits, campaigns and symposia supporting HP/RR/SP efforts.
- The Task Force prepared and provided monthly suicide reports for Congressional and Army-wide dissemination through the Office of Chief of Public Affairs (OCPA).

d. Army Accomplishments

The unique governance, policy, structure and process of the Task Force and Council greatly expedited implementation of many strategic changes over the past 15 months. A notable accomplishment was the Task Force’s re-write of DA PAM 600-24, *Health Promotion, Risk Reduction, and Suicide Prevention*. This document, last revised in 1988, contained obsolete information. The Task Force spent six intense weeks rewriting the document. The Task Force cross-referenced every task on the Sync Matrix and incorporated 66 tasks (in some form) into the revised DA PAM. Additionally, all guidance in Annex D of the Campaign Plan was cross-referenced and examined for inclusion into the DA PAM. The Task Force contacted subject matter experts to verify the efficacy of programs introduced and outlined in the new DA PAM. This revised policy established the Community Health Promotion Council (CHPC) as the responsible activity to integrate efforts involving HP/RR/SP; set protocols for establishing an Army Suicide Prevention Task Force (ASPTF) at installations and field organizations; devoted an entire chapter on geographically-dispersed Soldiers; and added chapters covering deployment, Family member suicide prevention and database and information sharing as they relate to HP/RR/SP.

The following examples demonstrate how the Task Force and Council were able to accelerate the change process. The accomplishments below are categorized by the Unit, Soldier and Family Strands of the *Composite Life Cycle Model*, discussed in depth at Section IV of this report.

(1) Support to Units

- June 2009, accessions waivers were reduced for adult felony (major misconduct) convictions; and drug/alcohol positive tests; misconduct (misdemeanor)/major misconduct for drug use; possession; or drug paraphernalia, to include marijuana. This means over 4,000 recruits were not accepted into the Army compared to 2008.
- Revised legacy protocols for investigating and reporting suicide.
- Standardized a council at every post, camp and station to integrate all aspects of health promotion, risk reduction and suicide prevention into the community.
- Revised AR 600-63, *Army Health Promotion Program* which modernizes garrison programs to align with the transformed Army.
- Rewrote DA PAM 600-24, *Health Promotion, Risk Reduction, and Suicide Prevention* for synchronization of the *HP/RR/SP Program Portfolio*.
- Improved integration of Primary Care and Behavioral Health services through the RESPECT-Mil training program.
- Implemented HP/RR/SP training across all leadership programs.
- Developed requirements for the Army Behavioral Health Integrated Data Environment (ABHIDE), a Center for Health Promotion and Preventive Medicine (CHPPM) Suicide Registry, to obtain data on suicides/serious events for the purpose of categorizing and analyzing data. This effort is discussed in Section IX, *“Information Sharing and Retrieval,”* beginning on page 201.
- Created a HQDA-level, multi-disciplinary response team (Suicide Specialized Augmentation Response Team) of subject matter experts to assist commanders (as needed) in the event of suicide clusters.
- Reinforced the commander’s authority to manage Soldiers with drug and alcohol incidents by revising AR 600-85, *The Army Substance Abuse Program*.
- Mitigated risk associated with transitions by revising policies across all components to stabilize unit leadership (e.g., chaplains, medical personnel and the ARNG and USAR command teams) for 90-120 days after redeployment.

(2) Support to Soldiers

- Increased access to Primary Care and Behavioral Health services, both within the military health system and in the TRICARE network.
- Initiated the Army’s mild Traumatic Brain Injury (mTBI) Campaign Plan and pilot project to improve early identification and treatment.
- Expanded post-deployment behavioral health screening with “face-to-face” and tele-behavioral health screening pilot projects.
- Optimized the operation of the ASAP by reintegrating the non-clinical and clinical components of the program into one entity.
- Expanded credentialing requirements and improved on-hand fill of ASAP counselors for improved access to care for Soldiers seeking assistance.
- Increased access to the full range of suicide prevention efforts by building enduring funding requirements into the Program Budget Review for the FY 2011 – FY 2015 program.
- Created and authorized the fill of 72 chaplains across the Army.
- Infused the requirement for suicide prevention training during “transition windows” (crucial points) for Soldiers during the deployment cycle.

- Coordinated efforts of all stakeholders involved in the Confidential Alcohol Treatment and Education Program (CATEP) to accelerate the pilot test at three major installations which has now expanded to six total installations.
- Reduced the stigma associated with counseling services and maintained continuity of care by requiring all Soldiers to in- and out-process through Behavioral Health (BH), Social Work Services and ASAP.
- Expedited the implementation of suicide prevention efforts for posts, camps, and stations with the highest risk via a fully funded and enduring Suicide Prevention Program Manager (SPPM) position.
- Improved opportunities for developing the necessary skill sets by modifying the tuition assistance policy to provide funding for up to 18 hours of college credit for all Soldiers, regardless of their educational background.

(3) Support to Soldiers and Families

- Developed a comprehensive tele-behavioral health campaign plan to improve identification of at-risk Soldiers and Families.
- Expanded access to non-emergency BH services for Soldiers and Families, thus allowing use of services after normal duty hours.
- Programmed additional funding to expand the Strong Bonds program.
- Revised policy and protocols to extend free child care based on length of deployments.
- Made significant upgrades to MilitaryOneSource for Soldier and Family awareness and intervention.
- Updated various new training videos to add Family vignettes.



“I think educating our leaders, Soldiers and Families on what to look for in suicidal behaviors has made our people more sensitive and aware.”

– MG Douglas Carver, Chief of Chaplains “Suicide Prevention: Watch out for Your Buddy,” *Army News Service*, 10 September 2007

Quote 17 – MG Douglas Carver, 10 Sep 07



4. Campaign Phase III – ARSTAF Integration

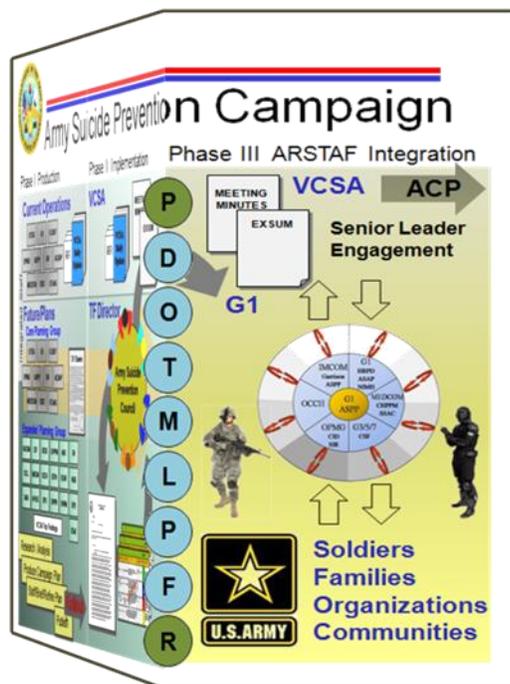


Figure 42 – Original Campaign Plan Phase III, ARSTAF Integration

as part of continuous process improvement. The outcomes of these efforts may not be fully realized for several years. The Army needs to remain dedicated and flexible to respond to evolving requirements through a formal process that expeditiously communicates requirements directly to senior Army leadership and uses a deliberate holistic process to institute corrective change. The Campaign Plan administered through the Council provided for unprecedented and holistic change in HP/RR/SP policy and programs.

Phase I of the Campaign Plan was initiated at the direction of Army Senior Leadership to mitigate the increasing trend of Soldier suicides by implementing immediate and enduring changes in policies and programs from HQDA to the installation level. The Task Force – a group of multidisciplinary representatives from across the ARSTAF – informed the development of the Campaign Plan through a comprehensive review of all relevant documents, including policies, programs and suicide reports. The other informing means for the Campaign Plan was the installation level assessment, which obtained input from commanders, Soldiers and Families and reviewed programs and processes at the installation level. From these two sources, the Task Force identified 242 actionable tasks, which were incorporated into the *HP/RR/SP Sync Matrix* for implementation.

Phase II of the Campaign began with the issuance of the Campaign Plan in April 2009. The Campaign Plan had two principal components – the ARSTAF Plan and the Commanders’ Plan. The ARSTAF plan utilized the council system to validate the tasks on the Sync Matrix. Through its biweekly meetings over the next 15 months, the Council recommended (and the VCSA approved) closure of 211 (87%) tasks as completed. As part of the Campaign Plan, the “Commanders’ Plan” was targeted toward installation, garrison and MTF commanders and consisted of a message to commanders in the body of the Plan. It

At the direction of Army leadership, the Task Force undertook a comprehensive program review in November 2009, which resulted in recommendations for a revised course of action during Phase III of the Campaign Plan. Phase III of the Campaign Plan, “HP/RR/SP Implementation,” begins the dissolution of the Task Force and the transition of the functions of the Task Force back to a transformed Army HP/RR/SP Governance as outlined in the next section. The Council will continue to implement and approve multidisciplinary HP/RR/SP-related solutions.

5. Summary

After almost a decade of conflict, Army Transformation and untold Soldier transitions, the Force is tired and stretched. The rising Army suicide rate prompted the immediate and dedicated action of the Army’s Senior Leadership. The Army undertook a multi-pronged approach to review current Army policy, programs and services for relevance and effectiveness; consulted with external agencies and academia to study suicide; conducted Army-wide stand-down training; and implemented change

provided an integrated directive that could be immediately implemented at the local level. The model shown in this section (Figure 42) was proposed at the start of the Campaign Plan. After 15 months of increasing experiential knowledge and dedicated effort, the Task Force created a proposed *HP/RR/SP Governance Model* to reintegrate HP/RR/SP back into the ARSTAF.

Phase III of the Campaign Plan, which is revised with this report, begins the transition of Task Force functions to seat the HP/RR/SP campaign back into the ARSTAF and the dissolution of the Task Force.

RECOMMENDED ACTIONS

- ★ [HQDA] Continue to consult with external agencies and academia to research and study HP/RR/SP.
- ★ [HQDA] Implement the new proposed *HP/RR/SP Program Governance Model* as presented in this report.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 35 – Army Suicide Prevention Campaign



Next: Program Governance for HP/RR/SP



>

VI – Program Governance for HP/RR/SP

IMPORTANT NOTE

To provide context and depth to this discussion, this report discusses proposed Army enterprise-based precepts as a complement to current HQDA Staff and functional proponent-based governance, policy, structure and process. Although the Secretary of the Army (SecArmy) has not approved any specific approach to enterprise-based transformation of Army business operations, this chapter proposes a pilot HP/RR/SP governance model that parallels Army enterprise proposals. These proposed enterprise-based concepts and recommendations provide one option for the alignment of HP/RR/SP governance, policy, structure and process both horizontally and vertically.

The previous sections recount the Army's experiences and lessons learned over the course of the HP/RR/SP Campaign. One overarching theme that remains consistent throughout this report is that every aspect of Health Promotion, Risk Reduction and Suicide Prevention (HP/RR/SP) is multifaceted. It should be no surprise, therefore, that the governance structure the Army adopts to lead and manage its HP/RR/SP efforts must be holistic. This section details and discusses the transformation of HP/RR/SP governance, policy, structure and process. This transformed governance structure will fulfill the Campaign Plan's Phase III objective of reintegrating interim HP/RR/SP governance back into the Army's permanent structure. It meets Army leadership's mandate for a program governance model that integrates the proponents, policy, structure, process and implementation functions for HP/RR/SP programs from HQDA to the garrison and including the geographically dispersed and deployed populations.

The *HP/RR/SP Program Governance Model* is based upon proposed Army enterprise-based precepts; its concepts for change, conclusions and recommendations are generally aligned with recommendations for Army business transformation. The focus area of HP/RR/SP is a small subset of the Army's total business transformation. This report acknowledges the fluid nature of the Army business transformation model. This section opens with the transition from Phase II to Phase III of the Campaign Plan, and then begins its discussion of Phase III with an optional overview of the proposed Army business transformation model. The discussion of the means of execution for Phase III – the *HP/RR/SP Governance Model* – constitutes the balance of this section. The key attributes of the governance model to be discussed are:

- The roles and interactions of senior Army leaders, HQDA Principal Officials and ACOM/DRU commanders at all levels from HQDA to implementation at the garrison level.
- The alignment of HP/RR/SP program governance across the Event Cycle and Care Continuum to ensure that the proponents for HP/RR/SP programs also have implementing authority.
- Management of programs within *The HP/RR/SP Program Portfolio* using the Event Cycle and Care Continuum and business management techniques including stated goals and objectives,

measures of performance, risk management and continuous process improvement to achieve health promotion, risk reduction and suicide prevention.⁹⁸

These aspects of restructuring of HP/RR/SP governance come with an important caveat: the Army must mitigate the risks associated with change management to avoid creating gaps and redundancies in the quality and delivery of current programs that are imperative to sustaining units, Soldiers and Families while prosecuting overseas contingency operations.

1. Completion of Phase II of the Campaign Plan – Establishing the Army Health Promotion Council and Dissolution of the Task Force

The reconstitution of the interim Army Suicide Prevention Council as the enduring Army Health Promotion Council will complete Phase II of the Campaign Plan by providing a permanent body that will continue to provide oversight as well as advising and recommending solutions to the VCSA (as depicted in Phase III at Figure 43). As part of the transformation of HP/RR/SP governance, the Health Promotion Council’s primary purpose will be to serve as the HQDA change agent. It will be co-chaired by military and civilian Flag-level Officers and administratively supported by the Army Suicide Prevention Program (ASPP).

The reconstitution of the interim Army Suicide Prevention Council as the enduring Army Health Promotion Council will complete Phase II of the Campaign Plan by providing a permanent body that will continue to provide oversight as well as advising and recommending solutions to the VCSA (as depicted in Phase III at Figure 43). As part of the transformation of HP/RR/SP governance, the Army Health Promotion Council’s primary purpose will be to serve as the HQDA change agent. It will be co-chaired by military and civilian Flag-level Officers and administratively supported by the Army Suicide Prevention Program (ASPP).

The Army Health Promotion Council will maintain its function as a multidisciplinary forum of key stakeholders (Secretariat, and ARSTAF Principal Officials, functional proponents and Army Command representatives) – in the grade of Colonel or higher, or the civilian equivalent – who will continue to implement enduring P-DOTMLPF-R solutions as the Army’s “eyes on” the HP/RR/SP change process.⁹⁹

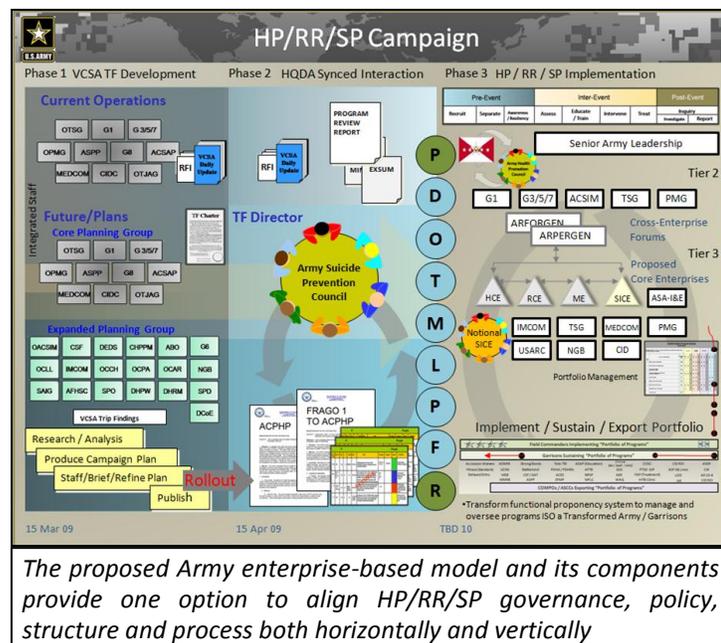


Figure 43 – HP/RR/SP Program Governance in Phase III

⁹⁸ This section discusses the management responsibilities for the HP/RR/SP Program Portfolio; a detailed description of the portfolio management process follows next in Section VII of the report, “Managing the HP/RR/SP Program Portfolio.”

⁹⁹ P-DOTMLPF-R is the acronym for the conceptual model used to conduct a holistic analysis of processes and systems. A P-DOTMLPF-R analysis considers policy, doctrine, organization, training, materiel, leadership and education, personnel, facilities

This governance body will use the *HP/RR/SP Sync Matrix* to integrate and synchronize recommended solutions for approval and implementation by senior Army leaders. The conclusions and recommended actions of this report will serve as the Army Health Promotion Council’s initial “play book” for updating and expanding the scope of tasks on the *HP/RR/SP Sync Matrix*. The Army Health Promotion Council will also serve as the VCSA’s advisor on the reintegration of HP/RR/SP governance, policy, structure, process and programs.

The Task Force’s mission of providing administrative and substantive support to the Council, research and assessment for Army leadership and monitoring HP/RR/SP implementation and effects will transition to the enduring ASPP.¹⁰⁰ The Task Force will dissolve when the transition is complete.

RECOMMENDED ACTIONS

- ★ [HQDA] Continue senior Army leader oversight and guidance regarding Army HP/RR/SP efforts.
- ★ [HQDA] Use the recommended the *HP/RR/SP Program Governance Model* to integrate proponents, policy, structure, process and implementation functions of the program portfolio from HQDA to the garrison and forward operating base levels.
- ★ [HQDA] While transitioning to the new HP/RR/SP governance, ensure change management does not create new gaps and redundancies in the quality and delivery of current programs and services to Soldiers and Families.
- ★ [HQDA] Reconstitute the interim Army Suicide Prevention Council (ASPC) as the enduring Army Health Promotion Council (AHPC) to provide oversight, advice and recommendations on HP/RR/SP to senior Army leadership.
- ★ [AHPC] Use the *HP/RR/SP Sync Matrix* to integrate and synchronize recommended solutions for senior Army leadership approval.
- ★ [AHPC] Advise senior Army leaders on the reintegration of HP/RR/SP governance, policy, structure and process.
- ★ [ASPTF] Transition ASPTF staff functions to the Army Suicide Prevention Program (ASPP).
- ★ [HQDA] Terminate and dissolve the ASPTF when transition of its staff functions to the ASPP is complete.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 36 – Completion of Campaign Plan, Phase II, and Establishment of the AHPC

and resources. DOTMLPF is a recognized DoD term. See JP 1-02, *DoD Dictionary of Military and Associated Terms*, 31 Oct 2009. The composition of the legacy ASPC is described in Section V of the report, “*The Army Suicide Prevention Campaign*.”

¹⁰⁰ As part of governance transformation, ARSTAF responsibility for the ASPP should be realigned from the DCS, G-1 to ACSIM.

2. Understanding Army Enterprise-Based Proposals for Business Transformation to Enter Phase III -

An enterprise-based approach to Army business transformation is designed to encourage leaders to take a holistic view of Army objectives and resources to achieve efficiencies and increase effectiveness in operations. Current Army enterprise-based business transformation proposals pursue these goals by restructuring processes to reduce functional “silos” and establish in their place collaborative forums; adapting and modifying policies, processes and procedures to optimize outputs; and distributing resources to achieve balance between effectiveness, efficiency and risk. The governance of the Army’s HP/RR/SP efforts is particularly well-suited for the enterprise structure, given its broad multidisciplinary base, the critical nature of Soldier/Family care and its emphasis on providing direct and sustained customer service.

a. Tutorial of Army Enterprise-Based Proposals for Business Transformation

Figure 44 illustrates the proposed Army enterprise-based business transformation model. This model has been proposed as part of Army institutional adaptation, the continuation of the Army’s transformation of the generating force. It provides a continued holistic review of leadership, problem-solving and collaborative processes to maximize efficiency and effectiveness across the Army. Because the Secretary of the Army has not approved any specific approach to enterprise-based transformation of Army business operations, this chapter’s discussion of specific enterprise-based forums is intended only to suggest one model that could be adopted to align HP/RR/SP governance, policy, structure and process both horizontally and vertically.

Readers familiar with proposed Army enterprise-based business transformation concepts and processes can bypass this tutorial and go to the **“Implementation of Phase III of the Campaign Plan”** section below (page 137)

Current Army enterprise-based proposals comprise three tiers. The SecArmy presides over the Army Enterprise Board (AEB) at the highest tier (Tier 1). The AEB is responsible for reviewing strategic Army issues and providing advice to the SecArmy. As the Department’s senior strategic advisory body, the AEB serves as a forum for collaboration among senior leaders of the Department of the Army. AEB recommendations to the SecArmy are intended to support Army enterprise-wide results in the best interest of the Army and the Department of Defense. Although not yet chartered by the Secretary of the Army, Tier 2 represents the HQDA Staff acting as the Army Management Enterprise (AME). It is proposed that subject to the authority, direction, and control of the SecArmy, the Under Secretary of the Army (USA)/Chief Management Officer (CMO) may convene the AME, assisted by the VCSA. The AME, comprised of both Secretariat and ARSTAF Principal Officials is envisioned as providing a forum in which military and civilian leaders proactively collaborate on common issues regarding the business operations of the Army. It is proposed that the AME will advise the SecArmy and the USA/CMO

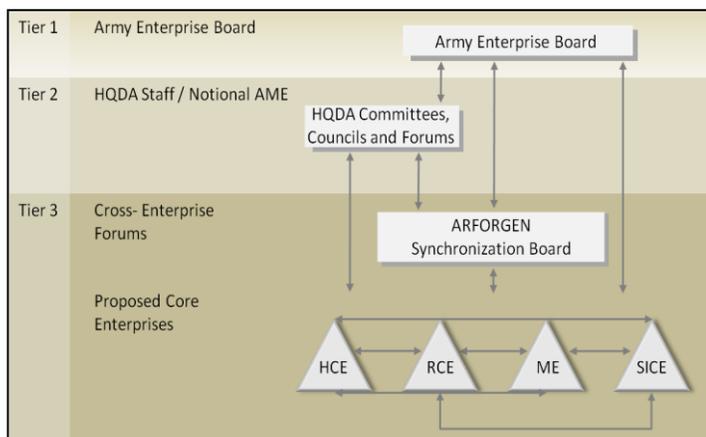


Figure 44 – Notional HQDA Advisory Forum Structure

on how best to integrate business operations and innovate business transformation initiatives to produce the most capable and ready Army at best value for our Nation. Tier 3 represents four notional, functionally-aligned Core Enterprises (CEs)—the Human Capital Core Enterprise (HCE), Materiel Enterprise (ME), Readiness Core Enterprise (RCE) and Services and Infrastructure Core Enterprise (SICE).

As a practical matter, it is envisioned that responsibility for HP/RR/SP governance and oversight will be delegated by the SecArmy to the VCSA, with the preponderance of program execution vested in the HQDA Principal Officials (whether acting in their current roles as defined by law and regulation) or as members of the proposed AME or notional CEs.

Members of the HQDA Staff (whether acting in their current roles as defined by law and regulation or as members of the proposed AME or notional CEs), would comprise HP/RR/SP-related forums, such as the Army Health Promotion Council. In addition, individual members of the HQDA Staff, including the DCS, G-1, CIO/G-6, ACSIM, TSG and PMG each execute policy, structure and process responsibilities for various HP/RR/SP programs in both their individual capacities as HQDA Principal Officials and functional proponents and collectively as members of the Army Health Promotion Council.

The four proposed, and functionally aligned, CEs in the areas of Human Capital (HCE, chaired by the ASA(M&RA)), Materiel (MCE, chaired by the ASA(ALT)), Readiness (RCE, chaired by the Commander, FORSCOM), and Services and Infrastructure (SICE, chaired by the ASA(I&E)), correspond to a rough division of the functional responsibilities assigned to SecArmy under Title 10 of the U.S. Code. The CEs are intended as forums to promote collaboration, share ideas and devise potential solutions to common problems arising in their areas of focus. The CEs convene senior civilian and military Army leaders to collaborate on issues pertinent to each CE's functional scope. For example, members of the SICE include the Commander, IMCOM, and the MEDCOM and CID Commanders, among others. CE members share mutual interests, but neither the CE collective nor the individual members of the CE possess any authority, or perform any duties or responsibilities, independent of the authorities, duties and responsibilities vested by law in the individual officials constituting the CE.

According to current enterprise-based modeling precepts, Tier 3 structure also may include the activation by the SecArmy of other temporary or enduring cross-enterprise forums to integrate and synchronize cross-enterprise issues (issues that may impact two or more CEs). The ARFORGEN Synchronization Board, depicted at Figure 44, charged with synchronizing readiness input across the Army, provides an example of a cross-enterprise forum. Because all of the CEs and all elements of the Army hold significant equities in the ARFORGEN process, the requirement for a cross-enterprise forum to share information and provide coordinated advice to senior Army leaders is apparent.

The dynamics of these proposed enterprise-based precepts may provide some important benefits to the HP/RR/SP program. An enterprise-based approach to organizational analysis and design has the potential to create the right layers of governance (policy, structure and process), with the right leaders (multidisciplinary forums), armed with the right knowledge (situational awareness) to make decisions at the right time to achieve continuous process improvement at each level. The enterprise-based management of Army business operations is intended to achieve end to end, top to bottom coordination and collaboration across the Army (or across all four core enterprises), with a view to eliminating "silo'ed" management.

Enterprise-based modeling may enable the integration and synchronization of functions across HQDA, the ACOMs, ASCCs, DRUs and FOAs as a single, coordinated effort, rather than a series of parallel managerial systems. It has the potential to align HQDA-promulgated policy, structure and process with organizations that have the implementing arms to direct and monitor execution and compliance at field and garrison levels. It promotes standard business rules to achieve the key enablers of professional development, performance measurement and change and risk management. Finally, it is envisioned as providing a measure of economy and equity by ensuring collaboration, vertically and horizontally, across the Army.

The Multiple Roles of Army Leaders Under Proposed Enterprise-Based Precepts

Proposed enterprise-based precepts recognize many roles and interactions among senior leaders. The SecArmy presides over the AEB, of which the Chief of Staff, Army, members of the Secretariat and the ACOM Commanders, are members. Subject to the authority, direction, and control of the SecArmy, the USA/CMO may convene the AME, assisted by the VCSA. CE chairs and members also occupy multiple roles with collaboration extending from HQDA through ACOMs, ASCCs, DRUs and FOAs to field and garrison levels as depicted in Figure 45. The ACSIM, for instance, serves as the ARSTAF proponent for installation management, supports the ASA (I&E) in his role as the chair of the proposed SICE, co-chairs the Installation (II) Program Evaluation Group (PEG)¹⁰¹ and commands IMCOM. The TSG and PMG are ARSTAF proponents for health services and law enforcement, respectively, members of the proposed SICE, and the commanders of MEDCOM and CID.

	HQDA Principal Official / Functional Proponent (Tier 2)	Proposed CE (Tier 3)	ASCC/ACOM/DRU Commander	PPBES
SA (w/ advice from AEB)	ACSIM	SICE Member	IMCOM	Co-Chair, II PEG
VCSA as SA delegate w/ support from HQDA Staff	TSG	SICE Member	MEDCOM	DHP SRG
	PMG	SICE Member	CID	-----
	-----	HCE Member	TRADOC	-----
	G1	HCE Member	-----	Co-Chair, MM PEG
	-----	RCE Member	FORSCOM	-----

Figure 45 – Multiple Roles of Army Leaders Under Proposed Enterprise-Based Precepts

Similarly, senior leaders across the Army – from HQDA Principal Officials to ACOM Commanders – will play multiple critical roles in informing HP/RR/SP governance, policy, structure and process. Whether as members of the HQDA Staff or as member of a CE, if chartered, they will be expected to validate, integrate, and synchronize HQDA policy development and manpower/dollar resourcing requirements; as commanders, they direct program and service execution and compliance at lower levels.

Following proposed enterprise-based precepts may add depth and breadth to Army business management and to the HP/RR/SP program. If responsibility for the management and oversight of the HP/RR/SP program is delegated as envisioned, the VCSA can recommend to the CMO and SecArmy the requisite HP/RR/SP policy, structure and process changes, refer issues for staffing to the applicable HQDA Principal Officials (whether in their roles as members of the HQDA Staff pursuant to law and regulation or as members of the notional AME), or submit matters to one or more of the CEs for review and recommendation.

¹⁰¹ The II PEG is a component of the Planning, Programming, Budgeting and Execution System (PPBES), the Army’s primary resource and allocation system.

Enterprise-based precepts provide one option for top to bottom management and oversight of the HP/RR/SP program. In their role as members of the HQDA Staff, CE members should provide feedback to functional proponents on adjustments in policy, structure, process and technology that will affect decisions across the Army in the domains of governance and resourcing. For example, they may undertake to validate, prioritize, synchronize and submit HP/RR/SP requirements collection (e.g., manpower concept plans and POM resource submissions) to HQDA. Similarly, CE members may be employed to synchronize the development of policy and propose resource guidance (allocation and distribution of manpower/dollar resources to inform and sustain garrison programs and services). Additionally, CE members, in their extant roles as commanders (e.g., IMCOM, MEDCOM, CID, NETCOM, etc.), could be appropriately positioned to provide more efficient and effective oversight of program implementation and compliance.

3. Implementation of Phase III of the Campaign Plan

The transition of the functions of the interim Suicide Prevention Council and Task Force to permanent ARSTAF elements is an important step in the evolution of the Campaign and fulfillment of the mandate to reintegrate their functions. The experiential knowledge of HP/RR/SP issues that the Army accrued during Phases I and II, however, clearly indicated that simple reintegration back to current proponents – in other words, a return to “business as usual” – would not suffice. What was needed in Phase III was a transformation of the leadership and management of HP/RR/SP across the depth and breadth of the Army structure.

The *HP/RR/SP Program Governance Model* satisfies this need. The model is grounded in enterprise-based precepts and integrates the proponents, policy, structure, process and implementation functions for HP/RR/SP programs from HQDA to the garrison levels.

a. Realignment of HP/RR/SP Governance

The operation of the HP/RR/SP program, from HQDA to garrison leaders and program managers who are responsible for implementing the *HP/RR/SP Program Portfolio*, is presented in condensed form in Figure 46. The figure presents an overlay of the recommended governance model.

(1) Relationship Between HQDA and Core Enterprises/Cross Enterprise

The VCSA, acting as the SecArmy’s presumptive delegate and informed by the Army Health Promotion Council (top left corner), is

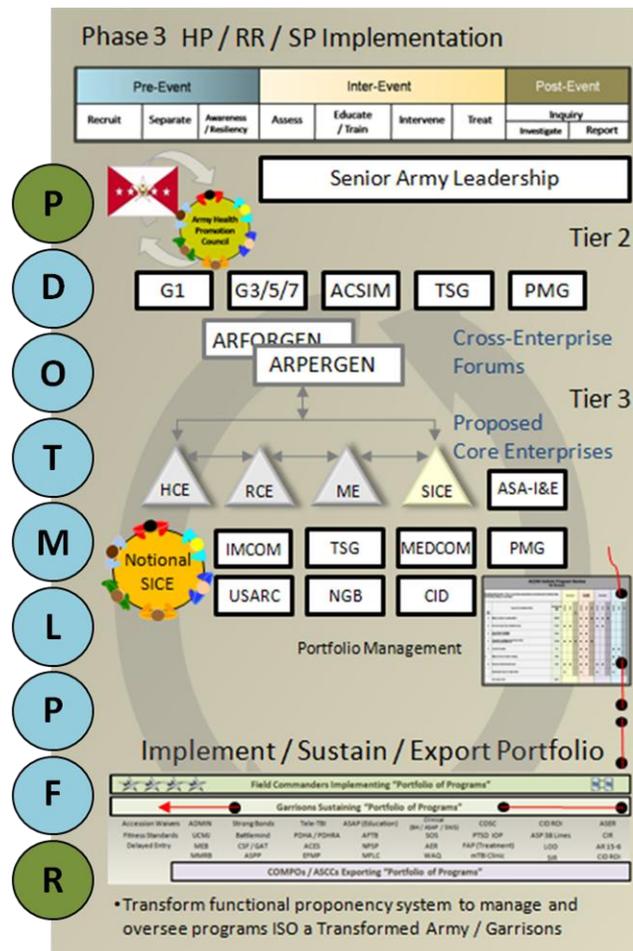


Figure 46 – Phase III HP/RR/SP Implementation

VI

responsible and accountable for HP/RR/SP management and oversight. Members of the ARSTAF (e.g., DCS, G-1; DCS, G-3/5/7; ACSIM; etc.) working in either their statutory and regulatory roles as HQDA Principal Officials and/or with and through proposed CE and cross-enterprise forums, inform the HQDA Staff (acting in either its statutory and regulatory role or as the AME) on policy, structure, people, process and technology requirements.

The as yet unchartered SICE Board is highlighted in Figure 46 as an illustration of an enterprise-based collaborative forum of potential applicability and utility to the governance and oversight of the HP/RR/SP program. The SICE members most likely to be directly involved in HP/RR/SP programs/services governance are the ASA(I&E), IMCOM Commander, TSG, PMG, NGB, USARC, CID and CIO/G-6. The CIO plays an essential role in the access to and management of data to support program, service and customer analysis and decision making. This same process applies similarly to other Army HP/RR/SP business operations such as policy, process, information and systems relating to the end to end financial, logistical, facility management, human capital, acquisition, administrative and other functions of the Army that support commanders, Soldiers and Families.

(2) Cross Enterprise Oversight (ARFORGEN and ARPERGEN Forums)

Proposed Army enterprise-based precepts provide for cross enterprise forums. Figure 46 includes two cross-enterprise synchronization forums, ARFORGEN and ARPERGEN, as examples. The ARFORGEN cycle has been described as the structured progression of increased unit readiness over time, resulting in recurring periods of availability of trained, ready and cohesive units in support of combatant commanders. The ARFORGEN forum would function to synchronize policy, programs and processes across all proposed CEs (i.e., activities related to the rotational cycle of units and equipment).

While the ARFORGEN cycle has proven to be a useful model for managing the availability of units, its limitations in managing the deployment of individual Soldiers are apparent – the deployment schedules of units and individuals are not synchronized. While the deployment/redeployment cycle or Combat Training Center (CTC) rotations are generally the only transitions that a unit will have, individual Soldiers experience many other types of transitions (such as PCS, PME, medical treatment, pregnancy, etc.) that will impact their deployment availability.¹⁰² The ARFORGEN construct does not account for this reality.

In order to ensure individual Soldier deployment policy, programs and processes are addressed by the Army, the creation of an ARPERGEN forum is recommended. As highlighted in Section IV, “*The Composite Life Cycle Model*,” the ARPERGEN Synchronization Forum would provide an additional opportunity for Army senior leaders, in conjunction with other collaborative forums, such as the HQDA Staff or the CEs, to synchronize events related to the rotational cycle of Soldiers and Families. The ARPERGEN Synchronization

Forum would provide a cross-enterprise forum to evaluate and validate the *HP/RR/SP Program Portfolio* using

The creation of a new cross-enterprise forum, the ARPERGEN Synchronization Forum, is recommended.

standard performance measures and risk analysis. Similar to ARFORGEN efforts to increase Army capacity of “ready” units, ARPERGEN efforts would strive to fill those ready units with prepared [ready] Soldiers, supported by prepared Families. It would not only ensure integration and synchronization of

¹⁰² A detailed discussion of transitions (and their stressful effects on Soldiers and their Families) is contained in Section IV of this report, “*The Composite Life Cycle*.”

equities across the Army but, more importantly, ensure the portfolio provides end to end, top to bottom Soldier and Family coverage. The ARPERGEN Synchronization Forum could review personnel readiness, for example, to ensure personnel policies provide for timely unit fills so Soldiers and Families can receive critical pre-deployment HP/RR/SP programs before deploying.

The ARPERGEN Synchronization Forum could be chaired by the CMO with support from the VCSA and should include senior representation from both the ASA(M&RA), for supervision of manpower and reserve affairs matters, and the ASA (I&E), for infrastructure and service oversight. Additionally, key stakeholders from across the HQDA, the ACOMs, ASCCs, DRUs and FOAs should be represented to ensure a holistic approach to Soldier and Family readiness. This collaborative forum would synchronize implementation of and compliance with changes in HP/RR/SP programs as recommended by the Army Health Promotion Council. In essence, it would provide enduring management of changes to Soldier and Family programs and services.

As outlined in the next section, “*Managing the HP/RR/SP Program Portfolio*,” the ARPERGEN Synchronization Forum would provide cross-enterprise validation of the full portfolio of 70 programs. It would review and recommend changes to the management of HP/RR/SP Program to ensure efficient and effective performance and risk analysis. For example, it would synchronize cross-enterprise efforts to ensure HP/RR/SP programs have the expeditionary elements necessary to export programs to theater. Taking advantage of the proposed CE structure to meet these expeditionary requirements, it could provide a measure of synchronization across the HCE, MCE, RCE and SICE to align programs such as SHARP, ASAP and FAP with deploying corps and division HQs. In a nutshell, the ARPERGEN Synchronization Forum provides the mortar (Soldier and Family Readiness) to the ARFORGEN building blocks (Unit Readiness) to provide seamless and sustainable readiness across the Army.

(3) Relationship between Core Enterprises and Field/Garrisons

Figure 46 also illustrates the potential interaction between CEs and field and garrison business operations. The table at the bottom of the panel, labeled “Implement/Sustain/ Export,” provides a cutaway of the *HP/RR/SP Program Governance Model* (Figure 47, page 141), and depicts the entities responsible for implementing, sustaining and exporting HP/RR/SP programs as they correspond to the Event Cycle and Care Continuum. This aligns programs and services with commanders and garrison program/service providers in support of Soldiers and Families at Army garrisons, in the Reserve Component (RC) and to ASCCs in support of forward theaters.

The scorecard depicted in Figure 46 (below the SICE example) is illustrative of the evaluative process of the *HP/RR/SP Program Portfolio* to adjust policy, structure and process. The scorecard uses common metrics to measure program characteristics including quality, productivity, cost, access/delivery and expeditionary capabilities. It is connected to the garrison level by the red thread, which ties business operations to the organizational level that directly impacts customer services and value.

As depicted in Figure 46, the notional SICE provides a collaborative forum to address issues and concerns related to its portion of the *HP/RR/SP Program Portfolio*. It works with the Secretariat, ARSTAF, commanders, garrisons, the RC and ASCCs to integrate and synchronize business management affecting the delivery of the portfolio of programs to the customer. In this example, the notional SICE, supported by the ACSIM, is the body that integrates and synchronizes business operations between HQDA policy, structure and process and field/garrison execution. From a resourcing perspective, for example, the core enterprise would review and validate its portion of the *HP/RR/SP Program Portfolio*

and participate in the II PEG during the requirements phase of the POM process. A full discussion of the *HP/RR/SP Program Portfolio* follows next in Section VII, “*Managing the HP/RR/SP Program Portfolio.*”

CONCLUSION

- ★ The *HP/RR/SP Program Governance Model* could be based on proposed Army enterprise-based precepts with a view to integrating the proponents, policy, structure, process and implementation functions for HP/RR/SP programs from HQDA to the garrison level. (page 131)
- ★ The VCSA, acting as the SecArmy’s presumptive delegate, and informed by the Army Health Promotion Council, provides HP/RR/SP management and oversight, whether in his role as an HQDA Principal Official or as a key figure in the notional AME. (page 137)
- ★ The ARFORGEN cycle is useful for managing the availability of units but is limited in its ability to manage the deployment of individual Soldiers. Soldiers experience many types of non-unit transitions that impact their deployment availability. (page 138)
- ★ Similar to ARFORGEN efforts to increase Army capacity of “ready” units, ARPERGEN efforts would strive to fill those ready units with ready Soldiers, supported by prepared Families. (page 138)
- ★ The ARPERGEN Synchronization Forum provides the mortar (Soldier and Family Readiness) to the ARFORGEN building blocks (Unit Readiness) to provide seamless and sustainable readiness across the Army. (page 139)
- ★ The *HP/RR/SP Program Governance Model* depicts the governing bodies responsible for implementing, sustaining and exporting HP/RR/SP programs throughout the Care Continuum. (page 139)
- ★ The *HP/RR/SP Program Portfolio* scorecard uses common metrics to measure program characteristics including quality, productivity, cost, access/delivery and expeditionary capabilities. (page 139)

RECOMMENDED ACTIONS

- ★ [HQDA] Implement the *HP/RR/SP Program Governance Model* to synchronize HP/RR/SP policy, infrastructure, process, people and technology throughout the Care Continuum.
- ★ [HQDA] Delegate to the VCSA the responsibility and authority to manage and oversee the HP/RR/SP Program.
- ★ [HQDA] Convert the ASPC to the new enduring Army Health Promotion Council as an advisory body to the AME.
- ★ [HQDA] Create the ARPERGEN Synchronization Forum, either as an HQDA Committee or as a cross-enterprise forum, to synchronize Soldier and Family readiness policy, programs and processes across the Army.
- ★ [HQDA] Devise a scorecard for program evaluation based on the *HP/RR/SP Program Portfolio Model*. Use the standard process and metrics for both program and portfolio evaluation.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 37 – Realignment of HP/RR/SP Governance, Policy, Structure, & Process

b. The HP/RR/SP Program Governance Model

The *HP/RR/SP Program Governance Model* at Figure 47 provides the proposed methodology and design for realignment of governance, policy, structure, people, process and technology. The model provides the recommended vertical and horizontal alignment of HQDA Principal Officials, functional proponents, commands (i.e., ACOMs, DRUs, and FOAs), CEs (if chartered), subordinate commanders, garrisons, program/service providers, and COMPOs and ASCCs across the Event Cycle and Care Continuum.

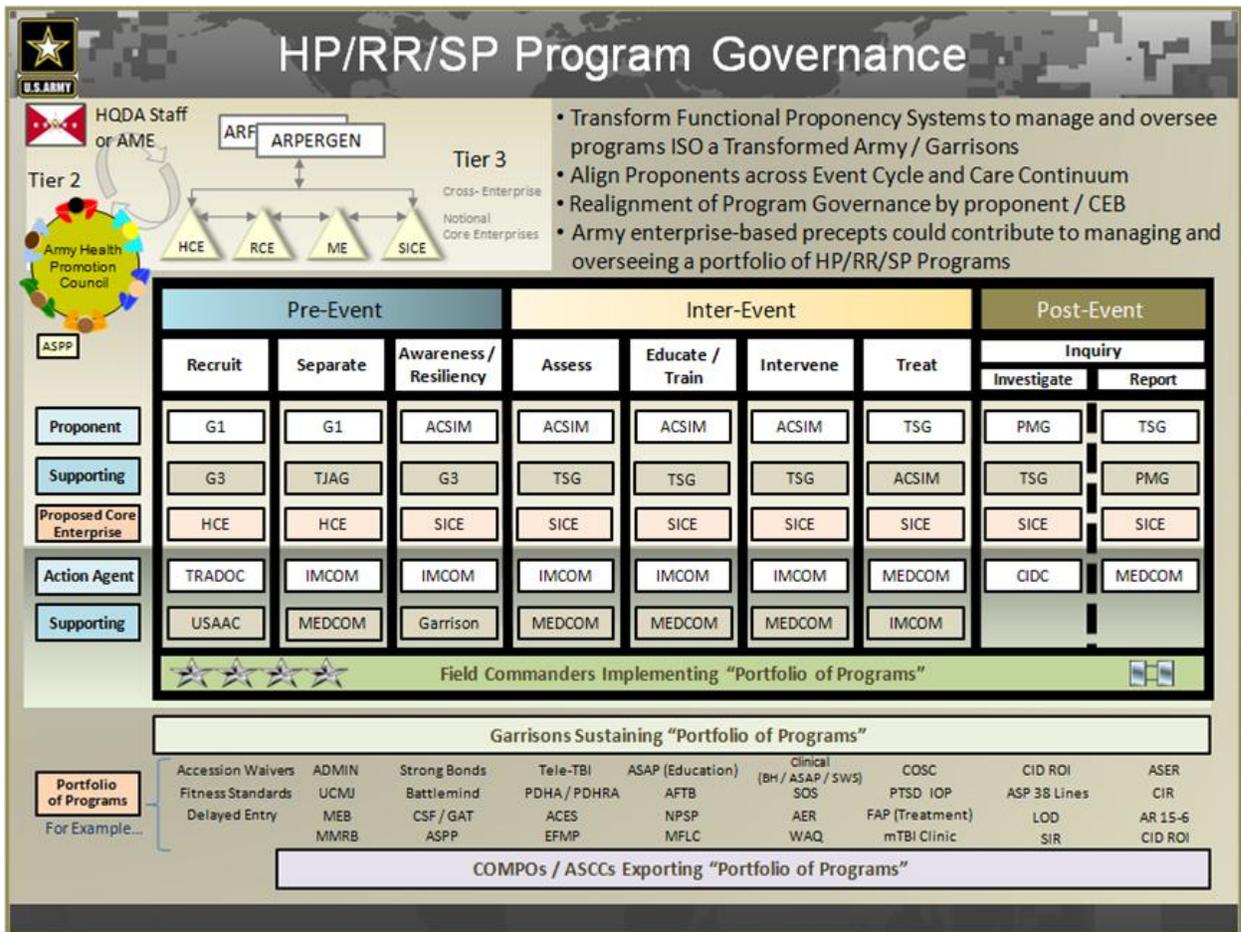


Figure 47 – HP/RR/SP Program Governance

The model is comprised of layers of governance and implied governance interactions as depicted from top to bottom – below the Event Cycle and Care Continuum – and the subordinate commanders and managers involved in governing HP/RR/SP programs and services. It is also read horizontally left to right – sequenced to the Event Cycle and Care Continuum – to demonstrate the end to end governance and business framework to provide and deliver holistic enterprise-based HP/RR/SP solutions.

The *HP/RR/SP Program Governance Model* establishes the governance and business management design for the *HP/RR/SP Program Portfolio*. It specifically establishes the structural realignment of senior Army leaders responsible and accountable for governance and oversight, the Army Health Promotion Council, HQDA Principal Officials and functional proponents and portfolio management; the employment of collaborative forums like the proposed SICE and proposes the establishment of a cross

enterprise ARPERGEN forum; and the realignment of commands and execution of the *HP/RR/SP Program Portfolio* at field/garrison level. Each of these participating entities is aligned vertically, by authority, across each phase of the Care Continuum. For example, the ACSIM is proposed as the primary proponent for the “Awareness and Resiliency” phase; the primary CE, if chartered, would be the SICE; and the primary action agent is IMCOM. Representative programs for this phase include Strong Bonds, Battlemind, Comprehensive Soldier Fitness (CSF)/Global Assessment Tool (GAT) and ASPP.

The model is divided into subsections to discuss HP/RR/SP governance at each layer from top to bottom. The subsections correspond to the following report subtitles followed by a discussion of the governance, business management and terms of reference, as appropriate:

- The Event Cycle and Care Continuum: This subsection defines and describes the Event Cycle and Care Continuum as the governance structure paradigm.
- Field Commanders: This section describes the roles and responsibilities of commanders to implement the *HP/RR/SP Program Portfolio*.
- Garrisons: This section describes the roles and responsibilities of garrison leaders and program and service providers to sustain the *HP/RR/SP Program Portfolio*.
- COMPOs and ASCCs: This section describes the roles and responsibilities of COMPOs and ASCCs to export the critical components of the *HP/RR/SP Program Portfolio*.

The Event Cycle and Care Continuum are the hallmark of the *HP/RR/SP Program Governance Model* and distinguish the *HP/RR/SP Program Portfolio* from other Army business management portfolios. The Event Cycle and Care Continuum are used to delineate dynamic governance, policy, structure and processes that enable –

- Horizontal and vertical integration and synchronization of governance across the Army;
- Downward vertical alignment of governance enterprise framework and business management execution from HQDA to field and garrison program implementation and compliance;
- Upward vertical alignment from customer feedback and value metrics; through program and service resource requirements, requirements collection and validation to Army strategic policy and resource process;
- Identification of gaps and redundancies in HP/RR/SP program/service coverage to units, Soldiers and Families;
- Guidance by commanders who have the authority to directly affect the governance and business management of the *HP/RR/SP Program Portfolio*;
- Development of continuous process improvement and compliance measures for HP/RR/SP programs/services relative to the sequential development of Soldier and Family health promotion and risk reduction; and
- Realignment of information reporting with data management to achieve situational awareness.

CONCLUSIONS

- ★ The recommended *HP/RR/SP Program Governance Model* vertically aligns and horizontally integrates Army senior leaders, HQDA Principal Officials, functional proponents, the proposed CEs, commands, garrisons, program and service providers, and COMPOs and ASCCs across the Event Cycle and Care Continuum. (page 141)
- ★ The Event Cycle and Care Continuum are the hallmark of the *HP/RR/SP Program Governance Model*; together they uniquely define the *HP/RR/SP Program Portfolio* from other Army portfolios. (page 142)

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 38 – The HP/RR/SP Program Governance Model

(1) Army Leadership Oversight

The SecArmy delegated to the VCSA oversight for HP/RR/SP policy and programs. Figure 48 is a cut-away of the *HP/RR/SP Program Governance Model*, which depicts the opportunities for the VCSA to influence subordinate command and staff levels. The VCSA can provide guidance through the HQDA Staff or potentially, via the AME, directly to functional proponents or could work through the Army Health Promotion Council. The Army Health Promotion Council synchronizes cross-enterprise activities

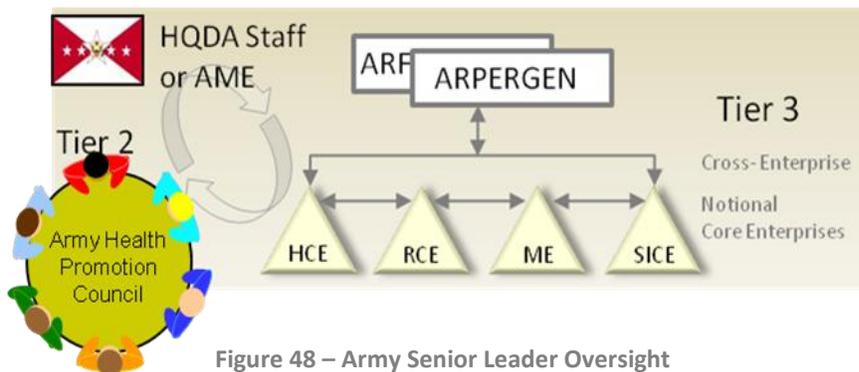


Figure 48 – Army Senior Leader Oversight

to inform the VCSA on Army policy and programming across P-DOTMLPF-R domains, or provides a forum for him to nominate issues to the AEB for deliberation and discussion, with a view to providing fully coordinated advice to the SecArmy.

RECOMMENDED ACTIONS

- ★ [AHPC] Synchronize cross enterprise activities to inform the senior Army leadership on Army policy and programming across P-DOTMLPF-R domains.
- ★ [AHPC] Nominate HP/RR/SP policy, structure and process for VCSA approval or referral to the HQDA Staff/AME and/or to the AEB.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 39 – Army Leadership Oversight



(2) The Event Cycle and Care Continuum

The *HP/RR/SP Program Governance Model* is based on alignment of Army governance along the Event Cycle and Care Continuum. The cycle and continuum are complementary to one another, with each phase of the Care Continuum nested below the Event Cycle, as it corresponds to the pre-event,



Figure 49 – The Event Cycle and Care Continuum

inter-event, or post-event stage. The Event Cycle depicts the sequence of events affecting the person, while the Care Continuum depicts the institution’s response to each event. Taken together, the Event Cycle and Care Continuum provide a sequential methodology to align the appropriate governing authorities (HQDA Principal Officials, functional proponents, potentially the CEs, commanders, and field and garrison programs), who have primary responsibility at each point along the continuum. The Event Cycle and Care Continuum are discussed below.

(a) The Event Cycle

The Event Cycle longitudinally places proponent and programmatic responsibilities across a potential individual high risk behavior or suicide event.¹⁰³ Using a hypothetical high risk behavior or suicide event as a paradigm promotes comprehensive, holistic and “bottom up” consideration of programs and services. The Event Cycle is separated into three distinct stages of pre-event, inter-event and post-event, which are delineated by the following criteria:

Pre-Event:

- Individuals in the pre-event stage are generally perceived as unaffected by stressors and demonstrate no indicators of increased risk. This stage may last indefinitely across a career or lifetime, or transition to a subsequent event based on the individual’s response to acute, recurring, or cumulative stress.
- The exception to this population is Soldiers who may be processed for separation from the Service. This separation process recognizes Soldier behavior that may require separation from the Service starting upon a Soldier’s entry and continuing to retirement. Separation is included in the pre-event stage but may be used in all stages.
- Programs and services in this stage are collectively delivered to all Soldiers without consideration of individual characteristics or signals of risky behavior. Examples of pre-event programs include:
 - Accession fitness standards programs administered by USAAC
 - Suicide awareness programs provided by the ASPP
 - GAT administered by CSF
 - Strong Bonds (effective in both the pre-event and inter-event stages)

¹⁰³ A high risk event refers to a high risk behavior with a serious outcome often resulting in leadership, law enforcement or medical intervention (e.g., attempted suicide, sexual assault, workplace violence, etc.). Generally each outcome prompts an investigation and medical intervention.

Inter-Event:

- Individuals in the inter-event stage have signaled they are at increased risk and require institutional intervention (e.g., self-referral, command referral, law enforcement involvement, emergency service response, etc.). The duration of this stage is dependent on the individual's response to intervention.
- Programs in the inter-event stage are targeted to deliver services to individual Soldiers and Families based upon the occurrence of a specific indicator that the individual is at increased risk. Examples of programs that provide risk indicators for intervention or services in support of intervention include:
 - ASAP (pre-event and inter-event)
 - Army Emergency Relief (AER)
 - Medical Treatment (e.g., mTBI, PTSD, etc.)
 - FAP (inter-event and post-event)
 - SHARP (inter-event and post-event)
 - Strong Bonds (pre-event and inter-event)

Post-Event:

- The post-event stage coincides with the outcome of probable high risk behavior requiring institutional intervention. This may include placement of the individual back into the inter-event stage for incidents of attempted suicide, rape, DUI or assault, etc. It also results in investigative and reporting requirements for outcomes associated with attempted suicide, serious injuries, crimes or death as discussed in Section VIII, *“Investigations and Reporting,”* beginning on page 183.
- Post-event stage programs represent the Army response to a completed suicide, suicide attempt or other serious outcomes of high risk behavior. Programs in the post-event domain include:
 - CID Report of Investigation
 - AR 15-6 investigations
 - Serious Incident Reports (SIR)
 - DoD Suicide Event Report (DoDSER)
 - ABHIDE (Army Behavioral Health Integrated Data Environment)
 - SHARP
 - FAP
 - ASAP

(b) The Care Continuum

Proponents and programs aligned under each stage of the Event Cycle are further categorized by the primary type of care or service provided to the Soldier.¹⁰⁴ Because the Care Continuum represents an institutional response, it provides a focused methodology to align governance, policy and programs to efficiently meet HP/RR/SP requirements. The phases of the Care Continuum include:

¹⁰⁴ A single program can address several different phases in the Care Continuum. Programs are categorized, however, based upon the predominant care or service provided.

- **Recruit:** Programs whose primary purpose is to identify, evaluate and access individuals into the Army. The Delayed Entry Program is an example of a recruiting program.
- **Separate:** Programs whose primary purpose is to implement legal or administrative processes that may result in an individual being discharged from the Army. The administrative separation provisions in AR 635-200 are an example of a separation program.
- **Awareness/Resiliency:** Programs whose primary purpose is to provide information, education and training given to the population at large to increase general awareness of certain stressors or high risk behaviors. The CSF is an example of an awareness/resiliency program that uses the GAT and master resiliency training to provide individuals with information on personal strengths and challenges. Additionally, the Strong Bonds program is used to educate Soldiers and their Families on healthy relationships.
- **Assess:** Programs whose primary purpose is to determine certain risk factors in individuals. The PDHA/PDHRA is an example of an assessment program that seeks to identify at-risk Soldiers based upon questionnaire responses. Additionally, TBI screening is used to assess if Soldiers have a potential concussion injury.
- **Educate/Train:** Programs whose primary purpose is to provide individuals with targeted education or training addressing the specific stressor or high risk behavior identified. For example, Military Family Life Consultants (MFLC) provide services to orient and educate Soldiers and Families on HP/RR/SP programs and services. Additionally, FAP counseling educates spouses on healthy interpersonal relationships within the Family unit.
- **Intervene:** Programs whose primary purpose is to provide short-term services that rapidly reduce or inhibit negative outcomes or behaviors. For example, AER is an intervention program that can provide immediate support in a financial emergency. Additionally, the SHARP links victims of sexual harassment and assault with intervention programs and services.
- **Treat:** Programs whose primary purpose is to provide long-term or a sustained effort to reduce or eliminate a negative outcome or the propensity to engage in high risk or other negative behaviors. The mTBI Clinic is a treatment program for injured Soldiers. Additionally, ASAP counseling provides treatment for substance abuse and dependence.
- **Inquiry:** Programs whose primary purpose is to provide interpretation (investigation) or information (report) of the facts and circumstances following a high risk or suicide event. A CID Report of Investigation (ROI) is an example of an investigative program; the DoDSER is an example of a report program; and the Army Behavioral Health Integrated Data Environment (ABHIDE) is an example of an integrated data environment.

CONCLUSIONS

- ★ The Event Cycle depicts the sequence of events affecting a person; the Care Continuum depicts the institution's response to each event from the Event Cycle. (page 144)
- ★ The Event Cycle is separated into three distinct stages of Pre-Event, Inter-Event and Post-Event, which are delineated by the criteria listed on pages 144-145. (pages 144-145)
- ★ Because the Care Continuum represents an institutional response, it provides a focused methodology to align governance, policy and programs to efficiently meet HP/RR/SP requirements. (page 145)
- ★ The phases of the Care Continuum include: Recruit, Separate, Awareness/Resiliency, Assess, Train/Educate, Intervene, Treat and Inquiry. (pages 145-146) (Continued)

RECOMMENDED ACTIONS

- ★ [HQDA] Use the Event Cycle and Care Continuum in tandem as a sequential methodology to align the appropriate authorities who have primary responsibility at each point along the Event Cycle and Care Continuum.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 40 – The Event Cycle & Care Continuum

(3) Alignment of Functional Proponents, Proposed CEs, Cross-Enterprise Forums and Action Agents

The configuration of functional proponents, the proposed CEs, cross-enterprise forums (e.g., ARPERGEN, ARFORGEN, etc.) and action agents across the Event Cycle and Care Continuum specifically align authorities for policy and program integration and execution for each phase of the Care Continuum. This provides a natural cross-walk to ensure a seamless institutional response and holistic coverage across the Event Cycle. The functional proponent is responsible for adjusting policy and programs based on downstream requirements originating with field and garrisons and validated end to end and top to bottom through staffing across HQDA, Army Commands and other organizations, or via the proposed CEs.

As depicted in Figure 50, the proposed CEs and cross-enterprise forums appear to be apt tools to intermediate the equities between higher and lower echelons. HQDA, ACOMs, ASCCs, DRUs and FOAs are responsible for cascading solutions down to the lowest organizational level to ensure integrated, synchronized and standardized policy, processes and programmatic resources. The proposed CEs and cross-enterprise forums consider the full Care Continuum in providing implementing guidance to lower

	Pre-Event			Inter-Event				Post-Event	
	Recruit	Separate	Awareness / Resiliency	Assess	Educate / Train	Intervene	Treat	Inquiry	
								Investigate	Report
Proponent	G1	G1	ACSIM	ACSIM	ACSIM	ACSIM	TSG	PMG	TSG
Proposed Core Enterprise	HCE	HCE	SICE	SICE	SICE	SICE	SICE	SICE	SICE
Action Agent	TRADOC	IMCOM	IMCOM	IMCOM	IMCOM	IMCOM	MEDCOM	CIDC	MEDCOM

Figure 50 – Governance Interaction

echelons. This ensures strategic policies and programmatic solutions are appropriately optimized for execution at garrisons, in the RC and through the ASCCs. The HQDA staff, or notionally, a CE or cross enterprise forum, for example, each could recommend adjustments in a PEG or across multiple PEGs to achieve an interdisciplinary optimization. Similarly, they could propose new policy to temporarily rebalance force structure between redeployed units and garrison programs and services (e.g., medical providers, military police, chaplains, staff judge advocates). The employment of enterprise-based precepts creates a natural appreciation among leaders for all requirements, while delivering balanced, optimized capabilities. It provides a significant advantage over more a narrowly focused proponent-based system.



The HQDA Staff, or notional CEs and cross-enterprise forums also may leverage program improvements through business transformation focus areas, including:

- Continuous Process Improvement—a structured approach to analyzing and identifying process improvement opportunities. The Army has selected Lean Six Sigma (LSS) as a technique to identify and implement improvement initiatives.
- Organizational Analysis and Design—creates a world-class organization structure that focuses on the customer and concentrates on the core business.
- Situational Awareness—the ability to generate actionable knowledge through the use of timely and accurate information about the Army enterprise, its processes and external factors.
- Compliance Processes – vertically aligned from HQDA to garrison to ensure execution of policy, process, resources, etc. It is essential that process is aligned with those proponents who have either proprietary knowledge or an implementing arm (chain of command) to ensure that they can audit and enforce execution.

Implementation of the new HP/RR/SP governance design will require changes in policy, structure, people, process and technology. Although the governance model recommends broad changes across vertical and horizontal governance structure, it supports the recommendation to migrate specific HP/RR/SP programs from one functional proponent to another.

The Task Force conducted a comprehensive review of HP/RR/SP programs to determine if each program’s current proponent and implementing arm were aligned with the *HP/RR/SP Program Governance Model*. The Task Force identified eight programs and program components and recommends a change of proponenty to achieve proper alignment. These programs are listed in Table 13.



ACSIM to G-1	Total Army Sponsorship Program
G-1 to ACSIM	Army Suicide Prevention Program
G-1 to ACSIM	Army Reserve Suicide Prevention Program
G-1 to ACSIM	Sexual Harassment/Assault Prevention and Response Program
G-1 to ACSIM	Army Substance Abuse Program (ASAP) Confidential Alcohol Treatment & Education Pilot
G-1 to ACSIM	ASAP Employee Assistance Program
G-1 to ACSIM	ASAP Military and Civilian Urinalysis Program
G-3 to G-1	Comprehensive Soldier Fitness Program

Table 12 – Program Migration

The justification for the realignment of these programs is apparent: programs that require structure and resource management at the installation level for implementation must be aligned with the entity (ACSIM) that has an installation-level implementing arm (IMCOM). For programs recommended for transfer from the DCS, G-1 to the ACSIM, the DCS, G-1 lacks this capability. On the other hand, the programs recommended for migration to the DCS, G-1 do not require an installation-level presence for implementation.

RECOMMENDED ACTIONS

- ★ [HQDA] Adjust policy and programs in accordance with the Care Continuum and based on (validated) downstream requirements originating with field and garrisons.
- ★ [HQDA] Proponents will implement policy, structure and process solutions through the HQDA Staff or potentially through the CEs to ensure integrated, synchronized and standardized compliance.
- ★ [HQDA/ARPERGEN] Utilize the Event Cycle and full Care Continuum to ensure top to bottom and end to end governance of HP/RR/SP policy, structure and process.
- ★ [HQDA] Realign HQDA proponents by migrating the eight specific HP/RR/SP programs and program components identified in Table 13, Program Migration, on page 148.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 41 – Alignment of Proponents, Core Enterprises, and Action Agents

(4) Potential CE and Cross-Enterprise Impact on HP/RR/SP Governance

Similar to the garrison Community Health Promotion Council (CHPC) described in AR 600-63 and DA PAM 600-24, CEs could participate in the HP/RR/SP Program only if formally chartered to do so. Any such charter should inform and protect the independent but interdependent nature of the CE members, as proponents and commanders, to ensure meaningful inclusion in a multi-disciplinary, collaborative forum. Among other protocols, the charter should address thresholds for establishing a cross-enterprise forum to address issues identified as cross-enterprise. This is particularly important in the evaluation and assessment of HP/RR/SP programs, which often template a broad multi-disciplinary community in support of units, Soldiers and Families. For example the ACSIM’s holistic review of Army Family Covenant programs should be fully validated by the HQDA Staff or, if properly chartered by the SecArmy, the SICE. Because personnel and readiness policies and programs are implicated by the HP/RR/SP Program, writ large, it should also be validated by an HQDA committee of cross enterprise forums that incorporate review and collaboration by stakeholders across the Army and/or the other notional CEs under a protocol similar to that employed by the current ARFORGEN Synchronization Board. This report recommends the establishment of an ARPERGEN Synchronization Forum as an ideal HQDA committee or cross enterprise board through which to address the results and recommendations of all HP/RR/SP program evaluations.

Employing enterprise-based precepts may enhance the Army’s ability to –

- Integrate a multi-disciplinary approach at all levels including HQDA Principal Officials, functional proponents, potential CEs, cross-enterprise, commands and garrisons for planning, programming, budgeting and execution;
- Rapidly (but holistically) implement new policy or programmatic guidance;
- Rapidly incorporate field and garrison feedback into policy and programmatic processes across the Army;
- Rapidly synchronize and respond to temporary conditions by deploying or “surging” additional resources;
- Reallocate resources among proponents and commands as required to efficiently/effectively meet emerging trends;
- Initiate, expand or terminate pilot or demonstration programs; and
- Validate and action requirements/capabilities earlier in the Army program cycles.

To realize these benefits, the Army must provide fully integrated, multidisciplinary coordination to reduce gaps and redundancies through the following recommendations –

- Use the Event Cycle and Care Continuum to ensure an end to end HP/RR/SP response to Soldier and Family programs/services;
- Provide a deliberate and inclusive process to address HP/RR/SP policies and programs;
- Ensure processes are informed by field and garrison commanders, program/service providers who are responsible for first line customer support;
- Realign macro program processes to ensure policy and program elements are appropriately aligned vertically from HQDA to field/garrison;
- Ensure program funding is appropriately categorized and grouped for efficient and transparent validation, programming and execution;
- Ensure program execution is audited and adjusted based on effective and efficient access/delivery of programs and services to units, Soldiers and Families; and
- Rebalance force structure and manning templates to support the generating force for requirements in garrison and to accompany the Force in theater as appropriate.

RECOMMENDED ACTIONS

- ★ [HQDA] The Army must provide fully integrated, multidisciplinary coordination to reduce gaps and redundancies through the recommendations outlined on page 149.

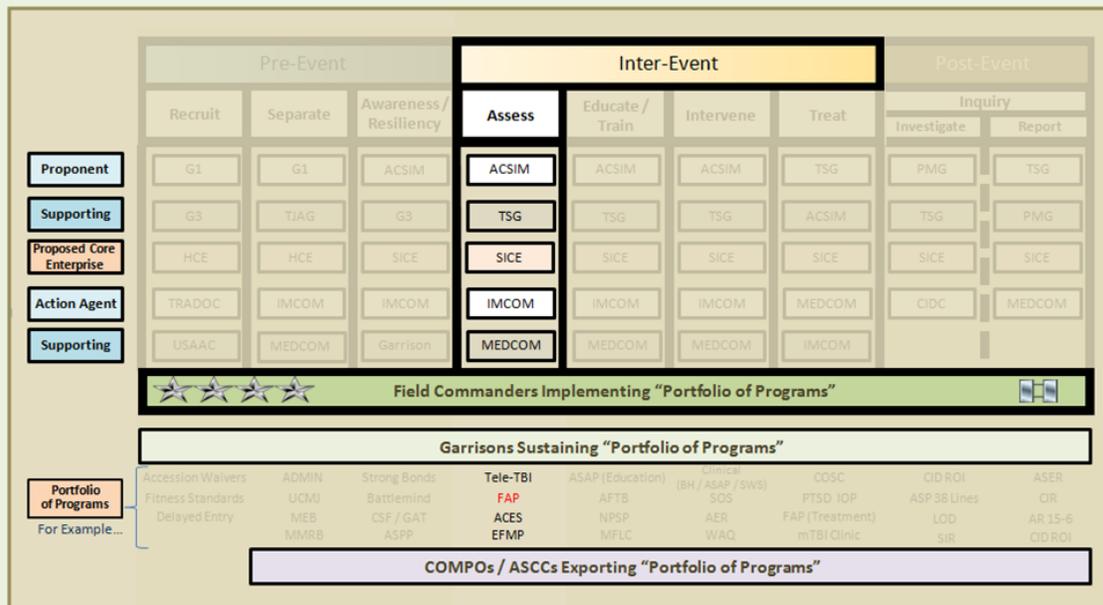
Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 42 – Potential CE and Cross-Enterprise Impact on HP/RR/SP Governance

Vignette 26 – Vertical Integration and Horizontal Coordination

VERTICAL INTEGRATION & HORIZONTAL COORDINATION— THE CLINICAL FAP

The holistic HP/RR/SP Program Governance Model compels vertical integration and horizontal coordination of the program. This concept can be illustrated through the clinical Family Advocacy Program (FAP):



(Continued)

VERTICAL INTEGRATION & HORIZONTAL COORDINATION— THE CLINICAL FAP

Vertical Integration (Top to Bottom): The categorization of programs using the Event Cycle and Care Continuum rubric illustrates responsibilities and relationships. Note the clinical FAP governance responsibilities and relationships listed under the “Inter-Event” stage (Event Cycle) and the “Assess” phase (Care Continuum) in the figure:

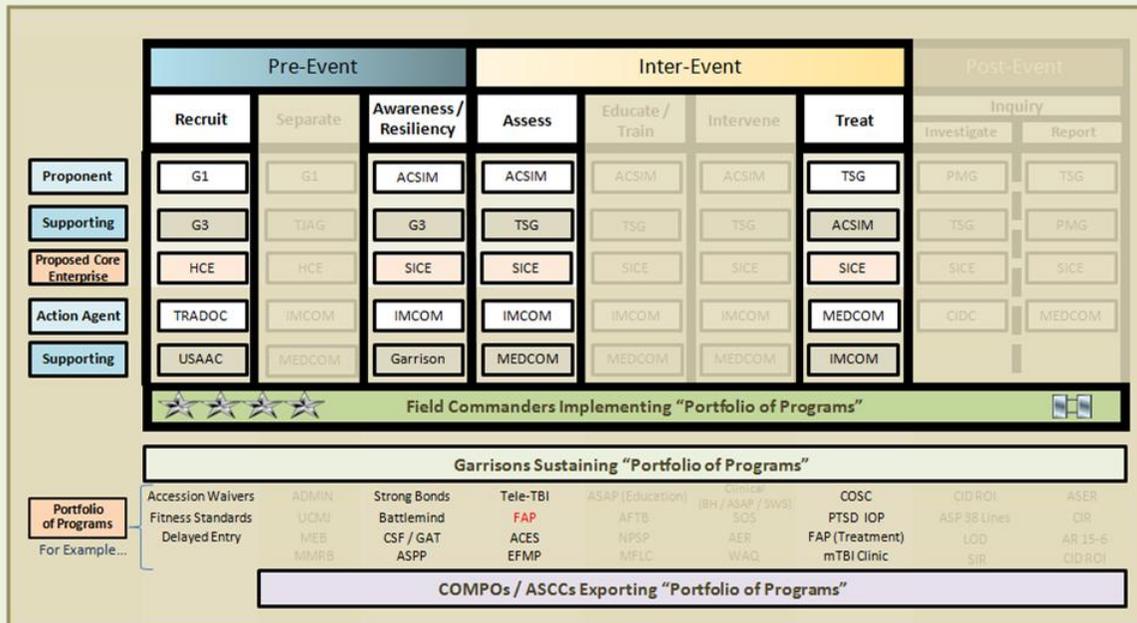
- Although the ACSIM is the proponent for the majority of programs under “Assess,” the TSG is the proponent for clinical FAP (shown here as the supporting proponent). If formally chartered, the SICE would be the primary CE. MEDCOM is the supporting action agent. TSG, with ACSIM in support, implements program guidance and resources (downward) via policy, structure and process through the proposed SICE for synchronization across the *HP/RR/SP Program Portfolio*. Additionally, the TSG and ACSIM conduct requirements collection (upward) for validation by the SICE and ARPERGEN Synchronization Forum in anticipation of submission to HQDA for inclusion in strategic resourcing cycles Planning, Programming, Budgeting and Execution System (PPBES).
- Field commanders implement the program by ensuring that Soldiers are appropriately scheduled for clinical appointments whether self or command referred. Commanders work with FAP counselors and Soldiers to develop and implement treatment plans. Without their involvement and participation, Soldiers may not comply with treatment, miss appointments or deploy/PCS without completing their treatment plan.
- Garrisons and MTFs are responsible to sustain the FAP program. Garrison commanders and program managers/service providers implement the FAP program as a part of the *HP/RR/SP Program Portfolio* (ASAP, SHARP, Strong Bonds, etc.). They work with medical FAP providers to identify program requirements (manpower and dollar resourcing) and provide customer feedback (commanders, Soldiers and Families) to MEDCOM/IMCOM, TSG/ACSIM and notionally to the SICE/ARPERGEN for strategic management of the *HP/RR/SP Program Portfolio*.
- Expeditionary components of the programs are exported to the ASCCs and RC. In this case it might include elements of FAP (policy, structure and process) deploying with corps and division HQs.

Horizontal Integration (End to End): The Event Cycle and Care Continuum provide a conceptual structure for coordination across all elements involved in program governance, whether at HQDA, functional proponent, notional CE, or program/service implementation levels:

- Subject to the authority, direction and control of the SecArmy, and to staffing across HQDA and with other stakeholders, the VCSA should be delegated the responsibility and authority to approve program adjustments across the *HP/RR/SP Program Portfolio*. The VCSA should consider recommendations from the HQDA Staff, the Army Health Promotion Council and, if established, the ARPERGEN Synchronization Forum to initiate changes in FAP within the context of the entire portfolio.

(Continued)

VERTICAL INTEGRATION & HORIZONTAL COORDINATION— THE CLINICAL FAP



- Proponents: TSG will work with ACSIM through either the HQDA Staff, or potentially through the SICE to plan and program guidance and resources or to address modifications to policy, structure and process, validated by the ARPERGEN Synchronization Forum, if established, to ensure FAP management in the *HP/RR/SP Program Portfolio* from top to bottom and end to end. FAP is measured as part of the *HP/RR/SP Program Portfolio* performance and risk analysis. Hence, it is considered complementary and competitive with other programs in the portfolio to achieve performance objectives and risk analysis by reducing gaps and redundancies.
- MEDCOM and ACSIM work through the HQDA Staff, or potentially through the SICE, to ensure end to end promulgation and implementation of approved policy, structure and process. MEDCOM, as the action agent of the clinical FAP (Treat phase of the Care Continuum), participates at the garrison through the CHPC, which may involve the local garrison in increasing program awareness.
- Garrison commanders, MTFs, field commanders, and program/service providers ensure end to end customer coverage through lateral coordination at the CHPC and other community forums. FAP also provides individual Family program intervention/coverage through the non-clinical component.

This model provides holistic management and oversight of the program from multiple perspectives:

- The program proponent (TSG) can influence the program directly through the supporting action agent (MEDCOM), the HQDA forum (the Army Health Promotion Council) and potentially through participation in the core enterprise system as a member of the SICE. All changes to the program and program portfolio would be validated by the ARPERGEN Synchronization Forum, if established, reviewed by the HQDA Staff (acting in its statutory and regulatory role or as the AME), and approved by the VCSA and or the SecArmy, as appropriate.
- Field commanders can provide input into program effectiveness and performance through the HQDA Staff or potentially through the CE collaboration process. Similar to the CHPC at garrison level, they can submit input through a variety of forums to the SICE, if chartered, and to the Health Promotion Council and ARPERGEN Synchronization Forum, if established.
- Garrisons and MTFs can provide input through MEDCOM/IMCOM to the TSG/ACSIM (ARSTAF level) who could leverage the SICE and ARPERGEN Synchronization Forum, if established, for evaluation and validation of sustainment plans.

(Continued)

VI

VERTICAL INTEGRATION & HORIZONTAL COORDINATION— THE CLINICAL FAP

- COMPOs/ASCCs can seek technical guidance from the supporting action agent (MEDCOM) or the proponent (ACSIM) in developing an exportable version of the program for the RC or expeditionary environment.
- VCSA can influence and provide guidance to the ARSTAF proponent (ACSIM) either directly or through the Army Health Promotion Council process or through the ARPERGEN Synchronization Forum, if established.

Source: ASPTF

(5) Commanders' Roles and Responsibilities

Commanders, in both garrison and deployed environments, implement the “Portfolio of Programs” that constitutes the Army’s institutional response to Soldier and Family needs or behavior across the Event Cycle. Commanders implement these programs/services by directing or facilitating Soldiers’ participation based on demonstrated (or anticipated) behaviors or stated needs.

A commander’s primary responsibility is to ensure the readiness, health, morale, welfare and discipline of the unit. In the HP/RR/SP context, this responsibility means to manage unit members across the Event Cycle (pre-event, inter-event and post-event) and the Care Continuum (from Recruit through Inquiry).



Figure 51 – Field Commanders Implementing the Program Portfolio

Maintaining unit members in the pre-event stage of the Event Cycle is the most effective and efficient means of optimizing unit readiness. Commanders must ensure health intervention and unit discipline (including administrative separations). Additionally, they provide awareness and resiliency programs (for example, ensuring Soldiers/Families receive suicide prevention training and complete a resiliency self-assessment) to maximize unit health and morale and minimizes risk in the unit.

The Soldier’s transition from pre-event to inter-event may not be immediately obvious. Commanders must recognize signals that indicate a unit member is seeking help or engaging in risk-taking behavior; in addition, the commander must recognize/understand that an institutional response is required. For example, a Soldier may signal financial stress to the commander by receiving a “no-pay due” notice or requesting an emergency loan. The commander would evaluate this information to determine if the Soldier had serious financial problems and would be a candidate for referral to Army Community Service (ACS) for financial counseling (if the issues are reparable) or possibly processed for separation.¹⁰⁵ Other signals of risk related stress may come from external sources such as a law enforcement contact or positive urinalysis. Section IV of this report, “*The Composite Life Cycle*,” identifies potential stressors that commanders should anticipate and mitigate to preclude a Soldier from engaging in high risk behavior.

¹⁰⁵ If a Soldier in a high-security position experienced serious financial difficulties due to a long-term gambling addiction, for instance, separation may be the appropriate response.

Commanders of Soldiers in the inter-event stage must act as the “implementer” of programs and services by performing three critical functions – referring a Soldier to appropriate program/service providers, facilitating and monitoring Soldier participation, and reporting actions taken in response to high risk behavior. The commander’s role during the inter-event stage is to determine the individual’s status in relationship to the Care Continuum and to identify which corresponding programs are appropriate. This integrative function – connecting the Soldier to the right program based upon the Soldier’s current need – is critical.

Commanders also play an important role in facilitating program participation by modifying mission requirements, when feasible, to remove impediments that prevent Soldiers from participating in HP/RR/SP programs and services. For example, a commander could:

- Designate the treatment program as a Soldier’s place of duty, thus preventing a Soldier from leaving treatment against medical advice. This is equally true for patient care at civilian treatment facilities.
- Direct that all unit members receive behavioral health screening after stressful events, as a means to reduce stigma.¹⁰⁶
- Reallocate duty assignments so a Soldier and spouse can attend a Strong Bonds retreat.
- Ensure Soldiers with positive urinalysis results for illicit substances are referred to counseling and disciplined/processed for separation as required.

The reporting of post-event incidents and the subsequent investigation provides transparency to the Army response to a particular type of high risk behavior and informs policy, structure and process. The results of law enforcement investigations, AR 15-6 investigations or commander’s inquiries, for example, need to be uniformly and consistently captured and shared with leadership to ensure programs are responsive. One means to ensure continuous process improvement of the *HP/RR/SP Program Portfolio* is through the use of DA Form 4833, *Commander’s Report of Disciplinary or Administrative Action*. The commander completes the DA Form 4833 not only to inform higher headquarters of actions taken to reduce the population of high risk personnel, but this data could also be used to inform HP/RR/SP program governance of resource requirements or program efficacy.

CONCLUSIONS

- ★ Commanders implement HP/RR/SP programs/services by directing or facilitating Soldiers participation based on demonstrated (or anticipated) behaviors or stated needs. (page 153)
- ★ Commanders lead/manage Soldiers across the pre-event, inter-event and post-event stages. Management becomes more difficult and resource intensive as Soldiers shift to the right in the Event Cycle. (page 153)
- ★ Maintaining unit members in the pre-event stage of the Event Cycle is the most effective and efficient means of optimizing Soldier/unit readiness. (page 153)

(Continued)

¹⁰⁶ This screening is not a “command directed evaluation” as defined in DoDD 6490.1, *Mental Health Evaluations of Members of the Armed Forces*. Screening is consistent with current protocols used for Post Deployment Health Assessment/Reassessment (PDHA/PDHRA) screening.

- ★ The commander’s role during the inter-event stage is to determine the individual’s status in relationship to the Care Continuum and identify which corresponding programs are appropriate. This integrative function – connecting the Soldier to the right program based upon the Soldier’s current need – is critical. (page 153)
- ★ Commanders of Soldiers in the inter-event stage must act as the “implementer” of programs and services by performing three critical functions – referring Soldiers to appropriate program/service providers, facilitating and monitoring Soldier participation and reporting actions taken in response to high risk behavior. (page 153)
- ★ Commanders complete the *Commander’s Report of Disciplinary or Administrative Action* (DA Form 4833) to inform higher headquarters of actions taken to reduce the population of high risk personnel. This data could be used to inform HP/RR/SP program governance of resource requirements or program efficacy. (page 154)

RECOMMENDED ACTIONS

- ★ [HQDA] Direct education in PME/PCC to educate commanders on leading/managing Soldiers across the Event Cycle and Care Continuum. Training/awareness must inculcate in leaders an explicit understanding that the ***pre-event stage and corresponding Care Continuum provide optimum Soldier/unit readiness.***
- ★ [CDRs] Recognize and understand signals that indicate Soldiers are seeking help or engaging in high risk behavior and facilitate/direct their participation in appropriate programs/services.
- ★ [CDRs] Implement the “inter-event stage” programs and services by performing three critical functions: refer Soldiers to appropriate program/service providers, facilitate and monitor Soldier participation and report actions taken in response to high risk behavior.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 43 – Commanders' Roles and Responsibilities

(6) Garrisons “Sustaining” the Program Portfolio

Garrison commanders, leaders and program/service providers perform several vital functions in governing HP/RR/SP programs/services. They implement and sustain program/service policy, structure and process. They ensure unity of effort through the Community Health Promotion Council (CHPC) and actively participate in portfolio program management by monitoring program/service performance, compliance and generating/validating requirements.

HP/RR/SP programs provide services to the Soldiers and Families that live, work and play on camps, posts and stations across the Army.¹⁰⁷



Figure 52 – Garrisons Sustaining the Program Portfolio

Garrison leaders sustain facilities, people and processes to implement HP/RR/SP programs/services to manage the Army’s response to individual events across the Event Cycle. For example, the clinical ASAP program is a key component of the portfolio and must be sustained at the garrison level with appropriate staffing, facilities and processes in order to deliver efficient and effective services to

¹⁰⁷ When feasible and appropriate, garrisons also export particular HP/RR/SP programs with associated and scaled resources and structure to forward operating bases.

program customers. If commanders refer Soldiers to ASAP, but the program cannot provide timely service due to insufficient capacity, the intended effects of the program will not be achieved and the overall HP/RR/SP goal of enhancing readiness by mitigating high risk behavior will not be realized.

Army policy requires the CHPC membership to include:

- Garrison Commander (CHPC chair)
- Major tenant commanders
- Suicide Prevention Program Manager
- Health Promotion Coordinator
- Garrison Command Sergeant Major
- Director, Human Resources Directorate (HRD)
- Family Advocacy Program Manager
- Commander, MTF
- Director of Logistics
- Director for Plans, Training, and Mobilization
- CDR, Dental Activity/Director of Dental Services
- Staff Chaplain
- Public Affairs Officer
- Alcohol and Drug Control Officer

Source: AR 600-63, *Army Health Promotion*

The sustainment function at the garrison level is overseen by the CHPC, the body responsible for coordinating and managing the *HP/RR/SP Program Portfolio* on an installation. The multidisciplinary nature of the CHPC is demonstrated by its required membership as depicted in Figure 53. The figure illustrates the composition of the CHPC. The composition of the ARPERGEN Synchronization Forum that this report proposes to establish would be similar to that of the CHPC, albeit at the HQDA level. Both governing forums include representatives from stakeholders across the Army – or, stated another way, from the proposed RCE (FORSCOM/tenant commanders), HCE (TRADOC/HRD) and SICE (IMCOM/garrison commander and program/service providers).

Figure 53 – Multidisciplinary Nature of the CHPC

This alignment is intentional.¹⁰⁸ The CHPC is the action agent for sustaining the *HP/RR/SP Program Portfolio* at the garrison level and performs a role similar to that which the ARPERGEN Synchronization Forum would perform at the HQDA level. Garrisons, as a subset of the *HP/RR/SP Program Governance Model*, implement the continuous process improvement cycle to balance the *HP/RR/SP Program Portfolio*. Leaders use Army Lean Six Sigma (LSS) to enable efficiency by eliminating non-core function processes and maximizing the effectiveness of core programs (reduction of gaps and elimination of redundancies).

Garrisons also perform the critical LSS function of receiving and hearing the “voice of the customer” (commanders, Soldiers and Families) for HP/RR/SP programs. The CHPC moderates and channels customer feedback to identify and generate new requirements for consideration by the appropriate program proponents. For example, a major tenant unit commander on an installation may request FAP training/education be included as a part of the unit pre-deployment cycle. Based on requirements and program capabilities, this request could be approved locally. However, if the CHPC validates this requirement as a best business practice, they should forward the requirement to the program proponent (ACSIM) for evaluation and eventual consideration by the SICE and validation by the HQDA Staff. The ARPERGEN Synchronization Forum, as proposed, would also have to validate the requirement because the proposed modification would impact the equities of other Army organizations and, if chartered, the CEs (e.g., FORSCOM/RCE; ASA(M&RA)/HCE). If the AME approves FAP training/education for pre-deployment cycles, the program modification would be added to the balanced *HP/RR/SP Program Portfolio* and implemented Army-wide.

¹⁰⁸ The intentional alignment of CHPC entities to mirror ARPERGEN membership will be discussed in depth in Section VII of this report, “Managing the HP/RR/SP Program Portfolio.”

(7) COMPOs / ASCCs “Export” the Program Portfolio

Because HP/RR/SP programs are Soldier and Family focused, their availability is not limited to the garrison environment – Soldiers and Families must be able to access them wherever they are located. HP/RR/SP programs must be exportable. These programs, when feasible or appropriate, should be made available to deployed Soldiers as well as to RC Soldiers and their Families regardless of duty status.



COMPOs / ASCCs Exporting “Portfolio of Programs”

Figure 54 – Exporting the Program Portfolio to COMPOs/ASCCs

The ARSTAF-level RC agencies, NGB and OCAR, through their implementing arms, are responsible to participate in the *HP/RR/SP Program Portfolio* process by coordinating with program proponents to develop and export appropriate HP/RR/SP programs/services to support RC Soldiers not on active duty and their Families. This responsibility is executed by the major commands within each component: State Adjutants General for the ARNG and Regional Readiness Commands for the USAR. These commands operate CHPC-equivalent functions. RC CHPCs or similar bodies manage their *HP/RR/SP Program Portfolio* through appropriate resourcing of people, programs and processes. They also validate new requirements for programs/services as part of the portfolio management process.

The exportation of HP/RR/SP programs to an expeditionary environment is managed by the various ASCCs. Although ASCCs do not operate a CHPC, ASCC commanders are responsible for generating requirements and coordinating with proponents to develop and export HP/RR/SP programs to support Soldiers while deployed. The Strong Bonds program is illustrative of an exportable feature of an HP/RR/SP program. U.S. Army Central Command (ARCENT), the ASCC responsible for exporting programs to support Soldiers deployed to the U. S. Central Command (USCENTCOM) area of operations, could generate a requirement to coordinate participation in the Strong Bonds program during deployed Soldiers’ R&R leave.¹⁰⁹ This requirement would be evaluated by the program proponent (Office of the Chief of Chaplains), validated by the HQDA Staff and, by the SICE, once chartered, and ultimately reviewed by stakeholders across the Army, where the equities of all would be considered and balanced before the program modification would be included in the *HP/RR/SP Program Portfolio*.

CONCLUSIONS

- ★ Garrison commanders, leaders and program/service providers perform several vital functions in governing HP/RR/SP programs/services. They implement and sustain program/service policy, structure and process. (page 155)
- ★ Garrison leaders sustain facilities, people and processes to implement HP/RR/SP programs/services to manage the Army’s response to individual events across the Event Cycle. (page 155)
- ★ The sustainment function at the garrison level is overseen by the CHPC, the body responsible for coordinating and managing the *HP/RR/SP Program Portfolio* on an installation. (pages 156)
- ★ Garrisons, as a subset of the *HP/RR/SP Program Governance Model*, implement the continuous process improvement cycle to balance the *HP/RR/SP Program Portfolio*. (page 156)

(Continued)

¹⁰⁹ A program does not require physical presence in the deployed area to be exportable; it simply has to support the expeditionary mission.

- ★ HP/RR/SP programs are Soldier and Family focused and must be available to Soldiers and Families wherever they are located. (page 157)
- ★ ASCC commanders are responsible for generating requirements and coordinating with proponents to develop and export HP/RR/SP programs to support Soldiers while deployed. (page 157)

RECOMMENDED ACTIONS

- ★ [IMCOM] Use the CHPC to monitor HP/RR/SP policy, structure, process and program execution; validate requirements for existing and generate requirements for new/modified programs.
- ★ [IMCOM] Garrison leaders sustain facilities, people and processes to implement HP/RR/SP programs/services to manage the Army's response to individual events across the Event Cycle.
- ★ [IMCOM] Use the CHPC to moderate and channel feedback from program customers to identify and generate new requirements for consideration by the HQDA Staff, and potentially by the CEs, if chartered.
- ★ [NGB and OCAR] As members of the ARPERGEN forum, participate in the *HP/RR/SP Program Portfolio* management process to identify exportable program metrics in support of RC Soldiers while not on active duty and their Families
- ★ [ASCCs] Coordinate with HQDA to export relevant programs from the *HP/RR/SP Program Portfolio* to support Soldiers while deployed (e.g., ASAP, FAP, SHARP, etc.).

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 44 – Garrisons Sustaining and ASCC/COMPO Exporting

4. Summary

The governance paradigm that is used to transition the Campaign Plan to its final phase is the *HP/RR/SP Program Governance Model*. The model represents a comprehensive transformation of the governance of Army HP/RR/SP policy, structure and process. It employs the statutory and regulatory HQDA Secretariat/ARSTAF model and proposed enterprise-based precepts and implements the final phase of the Campaign Plan by creating an integrated model for oversight and program management from top to bottom – from HQDA to the lowest implementing level or the organization.

The unique, customer-focused nature of HP/RR/SP mandates that its requirements be identified and generated from the individual, rather than the institutional, perspective. These requirements are captured utilizing the “Event Cycle” and “Care Continuum.” The Event Cycle represents the longitudinal progression of an individual through a high risk event (pre-event, inter-event and post-event); the Care Continuum depicts the Army's institutional response. Taken together, the two represent a seamless, inclusive continuum of HP/RR/SP requirements.

The key features of the *HP/RR/SP Program Governance Model* include:

- Creation of a permanent Army Health Promotion Council that, in conjunction with the HQDA Staff/AME, provides HQDA-level and VCSA oversight of HP/RR/SP efforts.
- Creation of a new cross-enterprise forum, the Army Personnel Generation (ARPERGEN) Synchronization Forum, to synchronize HP/RR/SP issues across the Army.

- Vertical alignment of proponents, action agents and programs across the Care Continuum and Event Cycle.
- Application of the portfolio management method to manage the total inventory of Army HP/RR/SP programs and services.

This section discussed the transformation of the HP/RR/SP governance structure to optimize both access and delivery of programs and services to units, Soldiers and Families. Section VII, “*Managing the HP/RR/SP Program Portfolio*,” will discuss the business rules for ensuring that the Army sustains an appropriate and balanced mix of HP/RR/SP programs and services to achieve this goal. The *HP/RR/SP Program Portfolio* utilizes the Care Continuum to generate requirements, standardize measurements to evaluate programs and the portfolio and continuous process improvement to ensure ongoing efficiency and effectiveness in the Army’s HP/RR/SP efforts.

RECOMMENDED ACTIONS

- ★ [HQDA] Implement the *HP/RR/SP Program Governance Model* as the organizing construct for oversight for HP/RR/SP programs/services (top to bottom, end to end).
- ★ [HQDA] Implement customer-focus feedback on HP/RR/SP programs/services to ensure an individual (rather than the institutional) customer perspective by using the Event Cycle and Care Continuum.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 45 – Program Governance for HP/RR/SP

VII – Managing the HP/RR/SP Program Portfolio



“It's urgent that we take a comprehensive look at the many Army programs we have in these areas and ensure they're all coordinated, effective and up to date, and that Soldiers, Family members, Civilians and the Army community at large are aware of them.”

– BG Colleen McGuire, ASPTF Director
Army News Service, 24 April 2009

Quote 18 – BG Colleen McGuire, 24 Apr 09

1. Introduction to Portfolio Management

The previous section of this report describes the commencement of Phase III of the Campaign Plan. Phase III applies proposed Army enterprise precepts to create transformed, multidisciplinary HP/RR/SP governance to realign policy and program responsibilities across the Event Cycle and Care Continuum. This section will discuss how the governance structure will employ the portfolio management process to implement the Army's HP/RR/SP programs/services.

Portfolio management is the Army's process for prioritizing and committing resources based upon validated requirements. The overall purpose of creating a portfolio is to align programs with the Army's strategic goals and objectives. In the HP/RR/SP portfolio context, this goal is pursued through the adaptation of oversight and management processes that optimize HP/RR/SP programs/services.

The program portfolio management concept is substantially different from the Army's legacy management system, where individual proponents develop requirements, implement solutions and manage programs within their own “silo” without systematic consideration of other equities. This collaborative governance process changes the program management paradigm from a technical proponent-based, garrison-centric system to a strategic functionally-focused model that delivers the needed support to today's expeditionary Army. The management of programs under the portfolio concept promotes this shift of governance focus from the individual program proponents to the entire group of related programs – in this case, the group of programs that provide HP/RR/SP care and services.

The central organizing construct of the *HP/RR/SP Program Portfolio* is the Care Continuum. Simply put, the Care Continuum defines the portfolio. The programs that are directly relevant to the Care Continuum constitute the Army's institutional response to individual Soldier and Family behavior across the Event Cycle. The goal of the portfolio management process is to achieve total HP/RR/SP program balance both end to end (across the proposed Army enterprise) and top to bottom (from HQDA to the garrison level).

Portfolio management executes the Army’s HP/RR/SP strategy by establishing business rules that ensure efficient and effective distribution of resources and capabilities. Effectiveness is achieved by ensuring the portfolio contains **complementary** programs that provide comprehensive coverage of portfolio requirements without gaps. Efficiency is achieved by ensuring the programs in the portfolio **compete** to fulfill requirements without creating redundancies.

*Portfolio management executes the Army’s HP/RR/SP strategy by **establishing business rules** that ensure efficient and effective distribution of resources and capabilities.*

The use of the program portfolio process within the proposed Army enterprise-based business transformation model provides the method for affecting a coordinated, multidisciplinary approach to balance performance and risk to optimize the Army’s HP/RR/SP programs/services. This section describes the proposed process that program proponents, along with components of the model such as core enterprises, cross enterprise forums and the Army Management Enterprise (AME), will use to develop and maintain a balanced *HP/RR/SP Program Portfolio*. The *Portfolio Management Model* provides a deliberate, methodical and sequential process to identify, measure, achieve and maintain programs within a balanced portfolio.

The Report Team’s review of Army programs identified 70 programs that address the requirements of the Care Continuum.¹¹⁰ This group of programs, represented by a variety of proponents, constitute the “potential” *Army HP/RR/SP Program Portfolio* that the core and cross enterprise forums will assess to assemble the balanced portfolio. This section will discuss and illustrate the *HP/RR/SP Portfolio Management Model* (at Figure 55) by using these 70 programs as the example.

The key attributes of portfolio management to be discussed include:

- The primary role of the Care Continuum in defining and managing the *HP/RR/SP Program Portfolio*. Portfolio management is requirements-driven. Since the Care Continuum represents the inclusive list of HP/RR/SP requirements, it is used as the tool for the requirements assessment of potential programs. The Care Continuum is used at each stage of the *Portfolio Management Model* to assess and validate individual programs as well as the portfolio as a whole.
- The Care Continuum is used to identify those programs from the larger set of Army programs that specifically address HP/RR/SP. This grouping of programs represents the **Potential Portfolio**.
- Application of standardized metrics to assess the capabilities of HP/RR/SP programs during program evaluation by the respective core enterprise. Each potential HP/RR/SP program is scored against the standard metrics and incorporated into the scorecard for comparative analysis. Only viable programs (based on scoring) are incorporated into the **Interim Portfolio**.
- Assessment of the Interim Portfolio by a cross enterprise forum utilizing performance measures and risk analysis to ensure efficiency and effectiveness to achieve the **Balanced Portfolio**.
- Utilization of continuous process improvement (CPI) to identify and validate new requirements and to develop and incorporate new capabilities into the *HP/RR/SP Program Portfolio*.

¹¹⁰ The 70 programs are listed in Annex G.

The remainder of this section provides a step by step review of *HP/RR/SP Program Portfolio* management, followed by a discussion of how the process can inform the Army’s efforts to rebalance operating and generating force requirements in support of HP/RR/SP programs and services.

CONCLUSIONS

- ★ Portfolio management is the Army’s process for prioritizing and committing resources based upon validated requirements. The overall purpose of creating a portfolio is to align programs with the Army’s strategic goals and objectives. (page 161)
- ★ The management of programs under the portfolio concept promotes the shift of governance focus from the individual program proponents to the entire group of related programs – in this case, the group of programs that provide HP/RR/SP care and services. (page 161)
- ★ The central organizing construct of the *HP/RR/SP Program Portfolio* is the Care Continuum. Simply put, the Care Continuum defines the portfolio. (page 161)
- ★ The concept for *HP/RR/SP Program Portfolio* management changes the Army’s program management paradigm from a technical proponent-based, garrison-centric system to a strategic, holistic customer-focused model that delivers the needed support to today’s expeditionary Army. (page 161)

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 46 – Introduction to Program Management

2. The Portfolio Management Process



“We must take a good, hard, and honest look at our current processes and develop ways to more effectively and more efficiently serve our Soldiers, their Families, and our country.”

– LTG Robert E. Durbin
Army News Service, 4 August 2009

Quote 19 – LTG Robert Durbin, 4 Aug 09

A major theme of this report is that the management of the Army’s HP/RR/SP efforts must be holistic and multidisciplinary. The traditional Army approach to delivering programs and services through narrowly focused technical channels from the policy proponent to implementing arm (e.g., ACSIM/IMCOM or PMG/CID) does not deliver the broad range of products and services required by our commanders, Soldiers and Families. Section VI, “*Program Governance for HP/RR/SP*,” transforms the way the Army manages HP/RR/SP program/services.

The deliverable for this transformed governance system is a portfolio of programs that provides comprehensive programs and services across the Care Continuum. The core enterprise system provides the structure for ensuring holistic coverage through the creation of multidisciplinary management forums – the core enterprises and cross enterprise forums. These forums manage the full portfolio of HP/RR/SP programs from the strategic perspective. Figure 55 illustrates the *HP/RR/SP Portfolio Management Model* for use by the transformed governance structure.

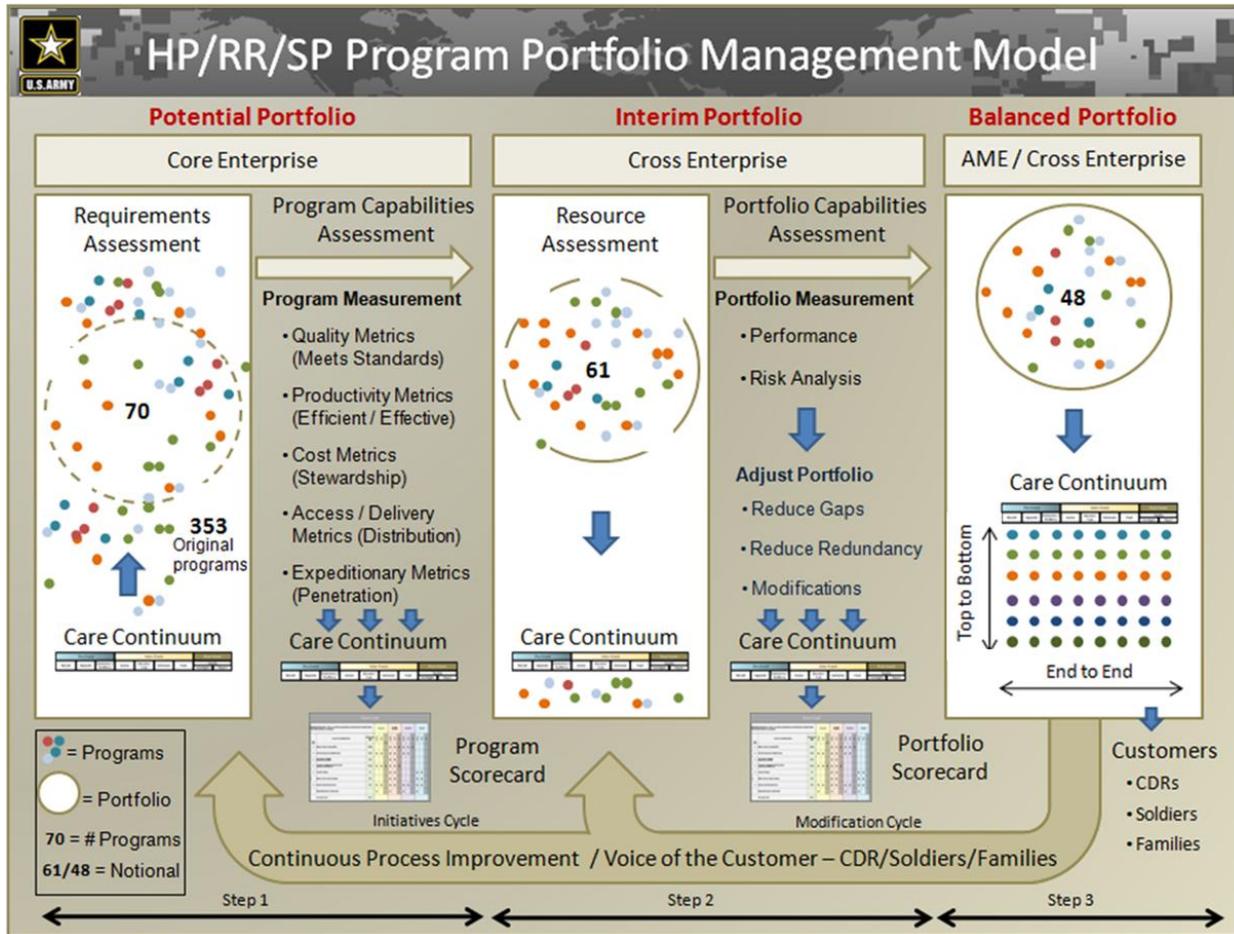


Figure 55 – HP/RR/SP Portfolio Management Model

The development of the *HP/RR/SP Program Portfolio* begins with the “requirements assessment” process (Step 1). At Step 1, members of each core enterprise assess their entire inventory of programs against the requirements of the Care Continuum to assemble the **Potential Portfolio** and then conduct a Program Capabilities Assessment utilizing standardized metrics and scoring criteria. At Step 2, the cross enterprise forum conducts a Resource Assessment on the **Interim Portfolio** by evaluating and scoring the entire portfolio based on performance and risk analysis. Step 3 presents the **Balanced Portfolio** as approved by the proposed AME, with programs balanced horizontally (across the Army Enterprise) and vertically (from HQDA to the implementing level). The final process depicted in the figure is CPI, which is the method used for identifying and validating new HP/RR/SP requirements and modifying existing programs.

The *HP/RR/SP Portfolio Management Model* is divided into subsections to discuss each step of the management process. The subsections correspond to the following report subtitles:

- Building the Potential Portfolio: Requirements and Program Capabilities Assessment
- Assembling the Interim Portfolio: Portfolio Capabilities Assessment
- Validating and Approving the Balanced Portfolio: Portfolio approved by the proposed AME
- Optimizing the Balanced Portfolio: Continuous Process Improvement

a. Building the Potential Portfolio (Step 1): Requirements and Program Capabilities Assessment

A prerequisite of any effective management process is a systematic means for identifying its size and scope. In the HP/RR/SP context, the Care Continuum serves as the construct that captures the full range of requirements. The initial step towards creating the *HP/RR/SP Program Portfolio* for the members of each core enterprise is to screen their full program inventory against the Care Continuum. Programs with a primary component that addresses a stage (or multiple stages) of the Care Continuum are identified as HP/RR/SP programs. For example, the clinical Army Substance Abuse Program (ASAP) is primarily concerned with treatment; it would therefore be categorized under the “Treat” phase of the Care Continuum and considered an HP/RR/SP program. On the other hand, a community recreational program (such as youth sports) may not be considered an HP/RR/SP program because it does not primarily address any of the phases of the Care Continuum. The results of this Requirements Assessment determine which programs undergo the Program Capabilities Assessment and evaluation to determine whether they will be included in the Interim Portfolio.

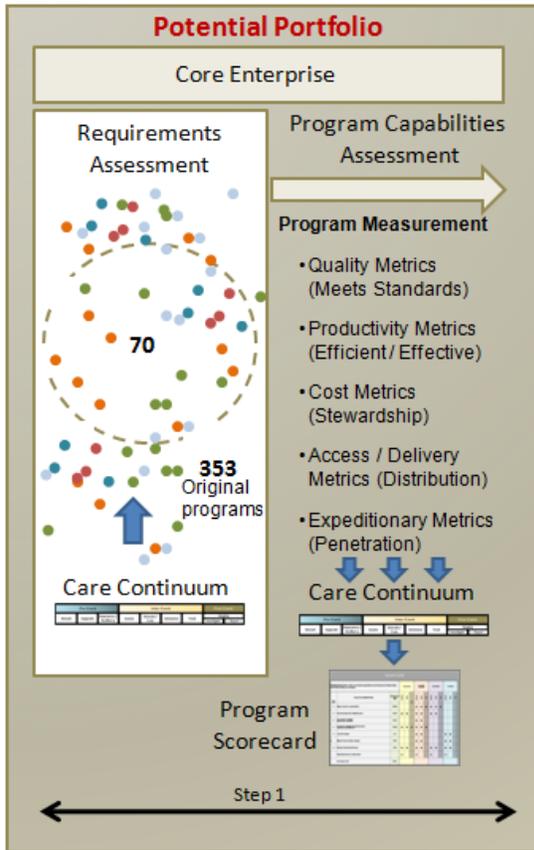


Figure 56 – Potential Portfolio

standardized data sheet to facilitate uniform responses. The Report Team received 622 responses to the data call and (after reducing redundancies in data submission) reviewed 353 programs, of which 70 aligned with the Care Continuum.¹¹¹ These data are reflected in the Requirements Assessment block of Figure 56, where the review of 353 programs resulted in the Potential Portfolio of 70 programs.

The Army-wide data call conducted by the Report Team is illustrative of the process used to assemble the Potential Portfolio. The Report Team conducted the data call from November 2009 through January 2010, using a

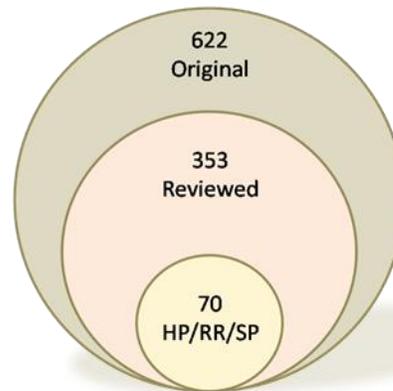


Figure 57 – Program Data Refinement

¹¹¹ The Report Team’s review of all 622 responses revealed that 269 were duplicative; the remaining 353 were reviewed for relevance to HP/RR/SP. The 70 identified programs are listed in Annex G.

In the next step of the portfolio management process, program capabilities are evaluated using specific, objective and standardized performance measures. In a multidisciplinary system such as the proposed Army enterprise, a key attribute of these measures must be the use of common terminology and criteria that can be interpreted and analyzed by all users. Current program performance evaluation systems (where they exist at all) do not usually meet this standard – they generally are developed and used only by the individual program proponents.¹¹² This gap can be addressed through the design and deployment of standardized performance measures that address the important aspects of HP/RR/SP programs. The application of this objective evaluative scoring process provides visibility, transparency and mitigates the possible conflicts of interest and parochialism that may result from proponents' self-evaluation of their programs, without regard for larger organizational equities.

*To be **effective**, the programs within a portfolio address all requirements without gaps. To be **efficient**, the programs must compete with each other to avoid redundancies.*

The use of the common measures described below allows programs from different proponents to be meaningfully evaluated and compared, and allows the portfolio to be analyzed and managed to optimize effectiveness and efficiency.

To complete the Program Capabilities Assessment, core enterprise members develop and utilize five discrete HP/RR/SP program metrics to evaluate each program in the Potential Portfolio and complete a Program Scorecard for use by the core enterprise during the next stage of the portfolio management process. The program measurement metrics include:

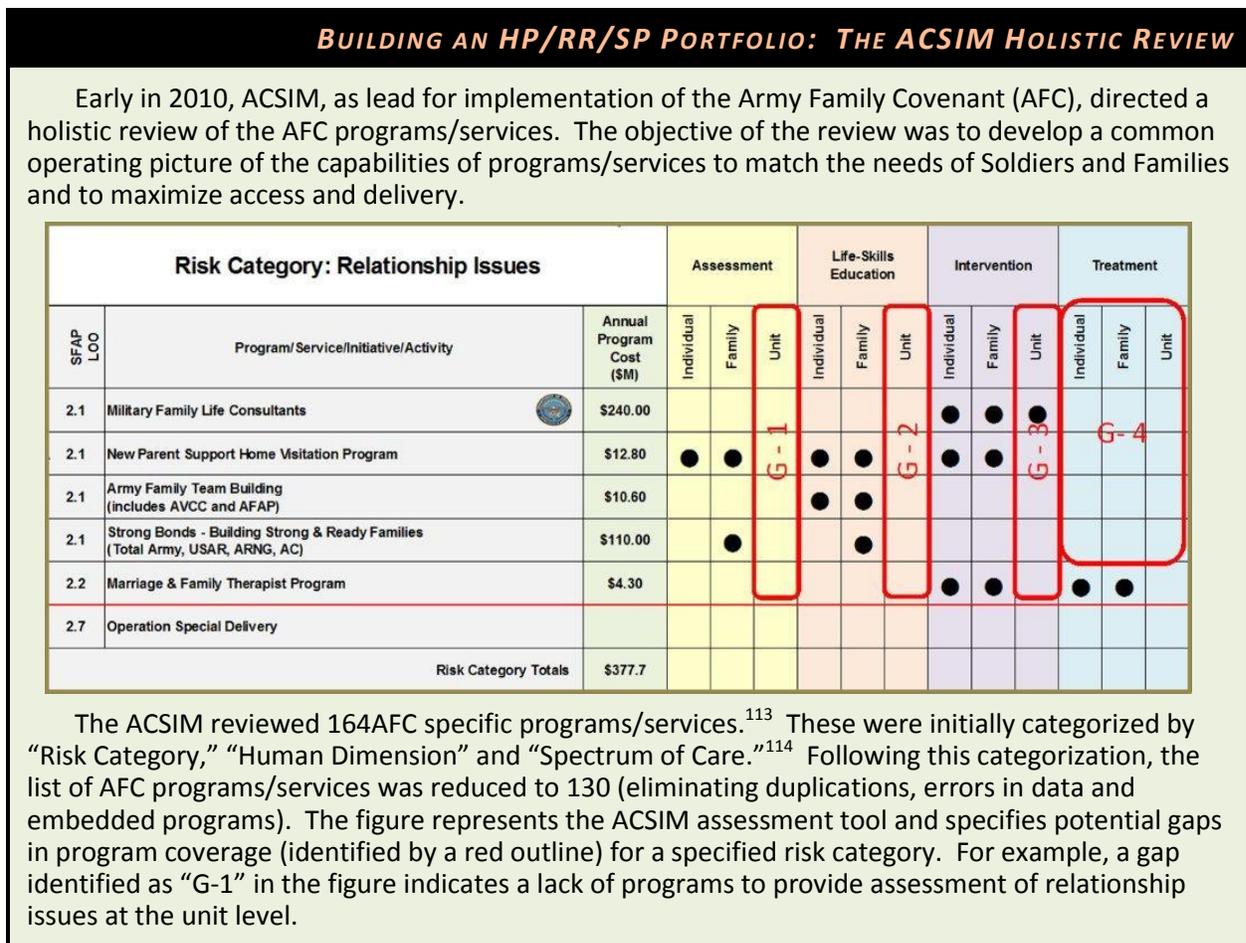
- **Quality** – The program's ability to adhere consistently to measurable and verifiable standards and achieve uniform output that satisfies specific customer or user requirements. For example, in the nonclinical ASAP, the standard used by the Medical Review Officer to evaluate the use of prescription drugs that result in positive urinalysis (clearance of drug use based upon the existence of a prescription, regardless of prescription date) would be an unfavorable program quality metric, as it does not satisfy the specific customer requirement to identify illicit drug use.
- **Productivity** – The efficiency and effectiveness of the program. For example, clinical ASAP is required to provide substance abuse counseling services. For these services to be provided efficiently, counselors must be available to customers when required. For these services to be provided effectively, counselors must be trained and properly certified.
- **Cost (Value)** – Whether the program's monetary expenditures for supplies, services, labor, products and equipment are consistent with the Army's responsibility for stewardship of resources. For example, while the Strong Bonds program has been demonstrated to promote Soldier and Family health by improving relationships, expanding the program to require every Soldier to attend it on an annual basis would be cost prohibitive.
- **Access/Delivery** – The ability to access and deliver programs/services in a variety of formats. In the HP/RR/SP context, this measure can be further refined by applying it against the Event Cycle; programs directed to the general pre-event population require higher access, while intervention programs require tailored delivery. For example, the general suicide prevention training program is presented in an interactive video format to ensure universal access to the

¹¹² The ACSIM Army Family Covenant program review discussed in Vignette 27 (page 167) is an example of an intra-proponent review. While the metrics and evaluative standards developed for use in that review may be valid, they do not appear to be readily transferable or applicable to HP/RR/SP programs operated by other proponents.

entire Army; behavioral health (BH) counseling programs, on the other hand, are structured to provide delivery of professional counseling to individuals requiring face-to-face service.

- **Expeditionary** – The capability to operate in support of the deployed and Reserve Component environments. An HP/RR/SP program capability can support the expeditionary environment either by deploying with a unit or providing support. For example, the FAP may provide an expeditionary capability by providing linkages for the deployed Soldiers and their Family to resolve issues and for program/service providers at the home and deployment locations to coordinate incident responses.

The individual program requirement/capability assessment may result in the consolidation or elimination of ineffective or inefficient programs before such programs are included in the Interim Portfolio and subjected to the Portfolio Capabilities Assessment described below. The potential effect of this internal review process is illustrated by the reduction in the notional number of programs in the Interim Portfolio (from 70 to 61) in the Resource Assessment block in Figure 58 on page 169.



Vignette 27 – The ACSIM Holistic Review

¹¹³ This number (164) was determined from reviewing the 622 data sheets submitted for the Report Team program review.

¹¹⁴ “Risk category” looks at program/service in light of what type of need they satisfy. “Human Dimension” identifies if a program/service is primarily designed to benefit an individual, the Family, or the unit. “Spectrum of Care” identifies if a program/service is primarily intended to assess a need, build life-skills knowledge or capabilities, intervene in a problem, or provide treatment; it roughly corresponds to the “inter-event” stage of the Event Cycle.

Creation of the HP/RR/SP Potential Portfolio is complete after the core enterprise has completed evaluating and scoring each program against the requirements of the Care Continuum. The next step of the process – refining an Interim Portfolio – is done at the cross enterprise level.

CONCLUSIONS

- ★ The traditional Army approach to delivering programs and services through narrowly focused technical channels from the policy proponent to implementing arm does not deliver the broad range of products and services required by our commanders, Soldiers and Families. (page 163)
- ★ A prerequisite of any effective management process is a systematic means for identifying its size and scope. In the HP/RR/SP context, the Care Continuum serves as the construct that captures the full range of requirements. (page 165)
- ★ The Report Team review identified 70 programs that would constitute the HP/RR/SP Potential Portfolio. (page 165)
- ★ Current program performance evaluation systems (where they exist at all) do not usually use common terminology and criteria that can be interpreted and analyzed by all users – they generally are developed and used only by the individual program proponents. (page 166)
- ★ An objective evaluative program scoring process by the core enterprise would mitigate the possible conflicts of interest and parochialism that may result from HQDA proponents’ self-evaluation of their respective HP/RR/SP programs. (page 166)

RECOMMENDED ACTIONS

- ★ [HQDA] Proponents must screen their inventory of potential programs against the Care Continuum to identify those for inclusion in the HP/RR/SP Potential Portfolio.
- ★ [HQDA] Complete the Program Capabilities Assessment for each individual program using the following metrics: Quality, Productivity, Cost, Access/Delivery and Expeditionary.
- ★ [CEs] The core enterprise will incorporate individual program assessments into a Program Scorecard for comparative analysis and inclusion into the Potential Portfolio based on program efficiency and effectiveness.
- ★ [CEs] Each core enterprise use the results of the Program Capabilities Assessment to adjust its portion of the Potential Portfolio by realigning and balancing HP/RR/SP programs and services against the applicable phases of the Care Continuum. The adjusted Potential Portfolio becomes the Interim Portfolio.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 47 – The Potential HP/RR/SP Program Portfolio

b. Assembling the Interim Portfolio (Step 2): Portfolio Capabilities Assessment

As discussed in Section VI, “Program Governance for HP/RR/SP,” the proposed Army enterprise-based business transformation model separates the Army’s Title 10 responsibilities into four core enterprises – Human Capital (HCE), Readiness (RCE), Material (ME) and Services/Infrastructure (SICE). Since HP/RR/SP programs/services support units, Soldiers and Families at the garrison level, it is not surprising the majority of programs/services fall within the SICE. However, single core enterprise

governance does not address all of the equities involved. For example, the addition of awareness/resiliency programs during pre-deployment training impacts RCE readiness requirements and the retention of unit command teams and Soldiers during post-deployment impacts HCE assignment decisions. To achieve a balanced portfolio of programs, therefore, a cross enterprise review is required before the portfolio can be balanced and approved by the AME.

The ARPERGEN Synchronization Forum is the appropriate forum for this review.¹¹⁵ It integrates and synchronizes HP/RR/SP core enterprise equities and ensures the portfolio provides end to end, top to bottom Soldier and Family coverage across the Army. Interim Portfolio management by the cross enterprise forum involves the preparation of a Portfolio Scorecard based upon an analysis of portfolio performance and risk against the Care Continuum. The scorecard is then utilized to determine the mix of programs to ensure a Balanced Portfolio. For example, the ACSIM is the primary proponent for programs addressing prevention/education while the Surgeon General is responsible for treatment; however, both proponents have programs in both categories. In this process, both the SICE and the ARPERGEN Synchronization Forum would vet the programs to ensure there is requisite coverage across the Care Continuum. In essence, programs are adjusted (created, eliminated or modified) to ensure they are complementary but competitive to reduce both gaps and redundancies.

Once the Interim Portfolio is adjusted, programs and services are realigned and balanced against the applicable phases of the Care Continuum. The effect of the cross enterprise review on the number of programs is illustrated by the reduction of the notional number of portfolio programs (from 61 to 48) in Figures 58 and 59. The resulting Balanced Portfolio is presented to the AME for approval in Step 3.

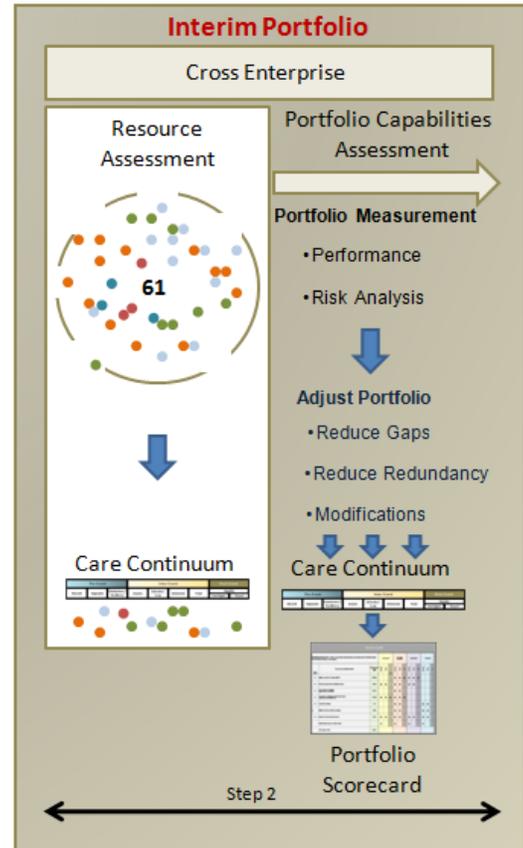


Figure 58 – Interim Portfolio

CONCLUSIONS

- ★ The ARPERGEN Forum (cross enterprise) is required to balance the portfolio across all core enterprises. (page 169)
- ★ Programs are adjusted in the portfolio (created, eliminated or modified) to ensure they are complementary but competitive to reduce both gaps and redundancies. (page 169)

(Continued)

¹¹⁵ This is not to imply that ARFORGEN (unit) issues are not implicated in HP/RR/SP portfolio management. All four core enterprises are members of both the ARFORGEN and ARPERGEN cross enterprise forums and discuss issues as appropriate. The point of the proposed Army enterprise is to provide forums and processes for collaborative decision-making by proponents and commanders.

RECOMMENDED ACTIONS

- ★ [CEs] Recommend respective programs for inclusion into the Interim Portfolio for the Portfolio Capabilities Assessment.
- ★ [ARPERGEN] Use the Care Continuum to validate the HP/RR/SP Portfolio Scorecard based on analysis of expected performance and risk.
- ★ [ARPERGEN] Use the results of the Portfolio Capabilities Assessment to adjust the Interim Portfolio by realigning and balancing HP/RR/SP programs and services against the applicable phases of the Care Continuum. The adjusted Interim Portfolio is then nominated to the proposed AME as the Balanced Portfolio.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 48 – The Interim HP/RR/SP Program Portfolio

c. Validating and Approving the Balanced Portfolio (Step 3)

The proposed AME provides final oversight and review of the HP/RR/SP program portfolio. The proposed AME approves the Balanced Portfolio produced by the ARPERGEN Synchronization Forum and ensures that it satisfies the objective of achieving total balance of all HP/RR/SP programs end to end (across the Army Enterprise) and top to bottom (from HQDA to the garrison level).

The Balanced Portfolio is then validated against Army policy, structure and processes to readjust resource programming. This means that both manpower and resource requirements are readjusted to garner resource offsets and savings. The performance and risks associated with the portfolio are measured against customer feedback as part of CPI to ensure optimum program/service coverage.

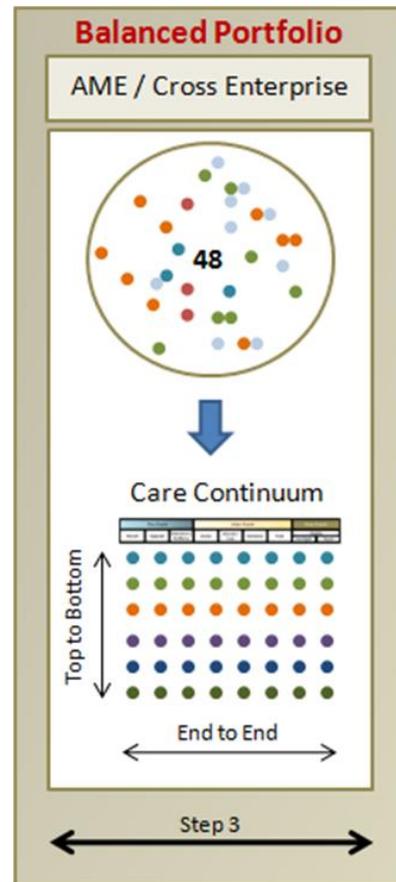


Figure 59 – Validating the Balanced Portfolio

RECOMMENDED ACTIONS

- ★ [ARPERGEN] Present the Balanced Portfolio to the proposed AME for validation.
- ★ [HQDA] The Balanced HP/RR/SP Program Portfolio is then validated against Army policy, structure and processes to readjust resource programming and garner resource offsets and savings.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 49 – Validating the HP/RR/SP Program Portfolio

The proposed AME approves the Balanced Portfolio produced by the ARPERGEN Synchronization Forum and ensures that it satisfies the objective of achieving total HP/RR/SP program balance both end to end (across the Army enterprise) and top to bottom (from HQDA to the garrison level).

d. Optimizing the Balanced Portfolio: Continuous Process Improvement

The Care Continuum represents the general breadth of requirements for HP/RR/SP programs; however, the Army's specific programmatic needs are dynamic and evolve over time. The Internet, for example, has generated fundamental changes in many Army business processes, from human capital management to delivery of BH counseling. To be a viable management process, the *HP/RR/SP Program Portfolio* must include a process to recognize and incorporate dynamic and evolving program requirements.

CPI (enabled by Lean Six Sigma (LSS)) is the management process to ensure that the *HP/RR/SP Program Portfolio* continuously evolves to meet customer requirements.¹¹⁶ CPI is a strategic approach for developing a culture of continuous improvement in the areas of reliability, process cycle times, costs in terms of less total resource consumption, quality and productivity.¹¹⁷ It is a means of identifying and implementing initiatives that continually improve organizational performance and create sustainable change. The role of the “voice of the customer” in the process is a central LSS theme and a key feature for CPI implementation.

In the HP/RR/SP portfolio context, this means communication from the portfolio's customers (commanders, Soldiers and Families) to program proponents that generates evaluation of new or modification of existing requirements. This “voice” is represented by the CPI arrow in Figure 60. As new requirements are assessed and validated, the portfolio is rebalanced through the enterprise forums.

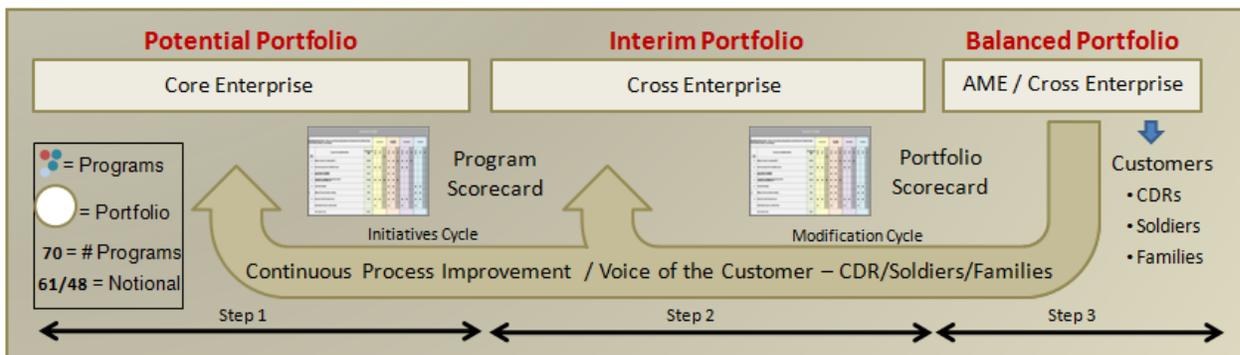


Figure 60 – Optimizing the Balanced Portfolio

The rebalancing cycle represented by the CPI arrow has two processes that can result in changes to the *HP/RR/SP Program Portfolio*. The “modification cycle” represents a rapid rebalancing of existing programs to respond to emerging requirements. The modification cycle is a short cycle that reduces management process cycle times to achieve *efficiencies* in program portfolio performance. An example of modification cycle CPI is an expansion of the Strong Bonds program through additional funding.

¹¹⁶ The Army Office of Business Transformation stated the Army selected Lean Six Sigma (LSS) as the process improvement methodology to support Army Business Transformation. LSS combines the principles of Lean (reducing and eliminating non-value activities) with Six Sigma (reducing variation, increasing quality) to improve process efficiency and effectiveness.

¹¹⁷ Report to Congress, Army Office of Business Transformation, 1 March 2010. See www.armyobt.army.mil/downloads/2010_congressional_report.pdf.

The “initiatives cycle” CPI introduces new programs that require an initial capabilities assessment. The initiatives cycle is a long cycle that ensures new/major modifications in programs are thoroughly assessed to achieve **effectiveness** in program portfolio performance. An example of an initiatives cycle CPI is the introduction of the Confidential Alcohol Treatment and Education Pilot (CATEP) program (a confidential substance abuse counseling program), which is a new program concept that requires proponent and core enterprise analysis before being considered for addition to the Balanced Portfolio.

Although a full discussion of LSS is beyond the scope of this report, it is worth highlighting that using CPI as the sustainment process for the *HP/RR/SP Program Portfolio* utilizes several important LSS concepts. First, it captures the “voice of the customer.” Second, it uses the CPI modification and initiatives cycles to incorporate the fundamental LSS concepts of efficiency (maximizing process speeds [Lean]) and effectiveness (using data-driven decisions to maximize quality [Six Sigma]). Finally, it establishes a standard process to ensure reliability (consistency) in HP/RR/SP program/service performance.

CPI MODIFICATION CYCLE: ASAP CONSOLIDATION

Since May 1994, responsibilities for execution of the Army Substance Abuse Program (ASAP) in CONUS have been split between IMCOM and MEDCOM.¹¹⁸ IMCOM is responsible for nonclinical services while MEDCOM is responsible for clinical services. This split hinders treatment coordination. To further complicate service delivery, the Army G-1 is the ASAP policy proponent. The result is three stove-piped entities with difficulty synergizing, coordinating and delivering services to commanders, Soldiers and Families. The negative effects of this lack of unity became apparent during the installation visits, which revealed that only one-third of Soldiers who tested positive multiple times were referred to the clinical ASAP for an evaluation.

After coordination at HQDA a decision was made in February 2010 to integrate the clinical and nonclinical ASAP under IMCOM command and control (with ACSIM policy oversight and resourcing) to ensure more comprehensive, effective, coordinated and integrated substance abuse services. This step will consolidate and collocate both components of the program to eliminate fragmented resourcing, streamline command and control and synchronize program/service access and delivery.

Source: Army Directive 2010-05, Shift of CONUS ASAP Counselors to U.S. Army IMCOM Control

Vignette 28 – CPI Modification Cycle: ASAP Consolidation

¹¹⁸ From 1994 to 2002, coordination was executed with the senior mission commander; in 2002 the function was assumed by the Army Installation Management Agency which was established and transferred to Army Installation Management Command upon its formation in 2006.

CPI INITIATIVES CYCLE: MILITARY FAMILY LIFE CONSULTANT PROGRAM

The evolution of the Military Family Life Consultant (MFLC) Program provides an example of an institutional response to an emerging need from the 1st Armored Division in spring 2004, after its Iraq deployment was extended from 12 to 15 months. Unit leaders realized additional support would be needed to meet the increased demand for services by Families at their home station.

The response was a pilot program placing short-term (“surge”) counselors/screeners in the community to supplement existing BH services. The success of this initiative prompted OSD to expand the program to CONUS installations and provide services to RC units, Soldiers and their Families. Services are available regardless of duty status and support unit deployments.

The latest program enhancement allows unit commanders to request MFLC services up to 120 days prior to unit deployment/redeployment, effectively integrating them into the commanders’ preparations.

Source: Army Suicide Prevention Task Force

Vignette 29 – CPI Initiatives Cycle: Military Family Life Consultant Program

CONCLUSIONS

- ★ The Army’s specific programmatic needs are dynamic and vary over time. CPI (enabled by LSS) is the management process to ensure that the *HP/RR/SP Program Portfolio* continuously evolves to meet customer requirements. (page 171)
- ★ The rebalancing cycle within the *HP/RR/SP Program Portfolio* has two components: a “modification cycle,” which represents a rapid rebalancing of existing programs to respond to emerging requirements, and an “initiatives cycle” in which CPI introduces new programs that require an initial capabilities assessment. (pages 171-172)
- ★ The **modification cycle** is a short cycle that reduces management process cycle times to achieve **efficiencies** in program portfolio performance. The **initiatives cycle** is a long cycle that ensures new/major modifications in programs are thoroughly assessed to achieve **effectiveness** in program portfolio performance. (pages 171-172)

RECOMMENDED ACTIONS

- ★ [HQDA] Utilize CPI (enabled by LSS) as the management process to ensure *HP/RR/SP Program Portfolio* continuously evolves to meet customer requirements.
- ★ [IMCOM/MEDCOM] Provide feedback from the Balanced Portfolio’s customers (commanders, Soldiers and Families) to program proponents.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 50 – Continuous Process Improvement

e. How to Build a Portfolio

This section discusses the creation and management of the *HP/RR/SP Program Portfolio*. The procedure to create a portfolio of programs, however, is not limited to HP/RR/SP; any functional area in the Army can be managed as a portfolio and realize its benefits. This brief tutorial provides the analytic and conceptual framework needed to apply portfolio management to any function.

The initial step in creating a portfolio is to define its function (what it is intended to do) and its scope, i.e., what requirement it is intended to fulfill. In the HP/RR/SP area, for example, the function of the portfolio is to provide the Army’s response to individual high risk behavior and its requirements are defined by the Care Continuum. For a program to be included in the *HP/RR/SP Program Portfolio*, it must be primarily intended to address a Care Continuum requirement. It is important to note that a portfolio is defined by function and scope and not by organizational alignment. For example, while the Army could create a “Soldier Recruiting/Retention Portfolio,” there would not be a “G-1 Portfolio” or a “III Corps Portfolio.” Portfolios generally will be multidisciplinary, holistic and focused on the end user or customer rather than the proponent or implementing command.

A useful analogy for illustrating portfolio management may be a grocery store, where each product line (such as bread, dairy, meats and produce) constitutes a portfolio. Store management must categorize each product line and decide on its composition in order to satisfy the requirements of a diverse customer base that expects many different varieties of product. A store’s produce portfolio, for instance, would have to contain many different types of fruits and vegetables to be successful.

In the *HP/RR/SP Program Portfolio*, the requirements are determined by the Care Continuum. In the notional “Soldier Recruiting/ Retention Portfolio” example used above,

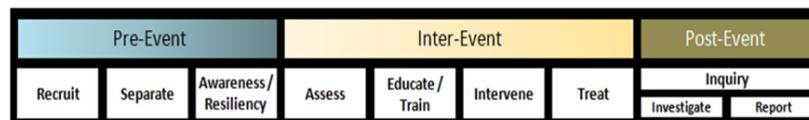


Figure 61 – The Care Continuum

the requirements could be determination of critical skills, developing retention incentives or inquiries to veterans regarding reasons for leaving the Army.

The process of identifying the programs and services that compose the portfolio begins after the function and scope of the portfolio is established. The inventory of programs is screened against requirements to determine candidates for inclusion in the Potential Portfolio. For example, the reenlistment incentive program would be included in the notional “Soldier Recruiting/Retention Portfolio;” the Army Weight Control Program would not.

There are other common key attributes that programs must possess. Programs must both complement and be competitive with each other within the portfolio so the overall portfolio can realize efficiency and effectiveness. Programs complement each other by reducing gaps

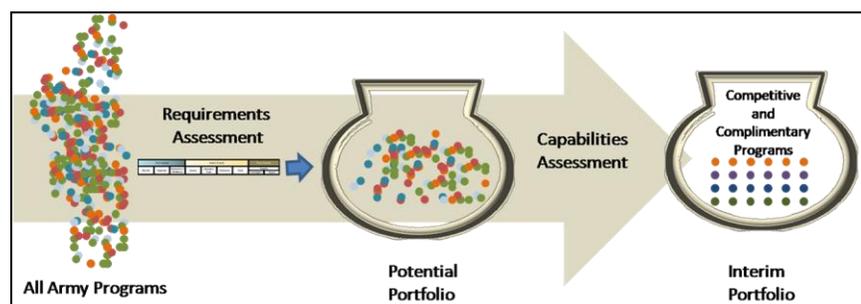


Figure 62 – Building a Program Portfolio

VII

through providing end to end, top to bottom coverage; they compete with each other to achieve optimal performance by reducing redundancies. This can be illustrated using the grocery store analogy. Each product within the bread portfolio complements the other to provide the full product selection without gaps (whole wheat, whole grain, white across a variety of breads such as sliced bread, muffins, flatbreads, etc.) that satisfies customer requirements. Complementary characteristics also include nutrition, pricing, value, packaging, etc.

Each bread product also competes with other products in the portfolio based on these same attributes. Bread products are competed to ensure that the product line (portfolio) is balanced (e.g., there are not too many of the same product line such as whole wheat with the same nutrition, pricing, value, packaging, etc.). The portfolio manager may keep an item in the bread portfolio for its complementary value (e.g., it is the only flatbread offered) or for its competitive value (e.g., it was selected over a variety of five other flatbreads).

In the *HP/RR/SP Program Portfolio*, the same principles apply. Programs/services such as in-patient psychiatric hospitalization and tele-BH counseling are maintained in the portfolio for their complementary value (they work in tandem to fulfill unique BH requirements across all population segments and, thereby, reduce gaps in customer access/delivery). Similarly, programs compete with one another to reduce redundancy. For example, although MilitaryOneSource and MFLC provide similar (but somewhat unique) counseling services, they are currently necessary to provide coverage across all population segments. However, as MilitaryOneSource expands its services to encompass MFLC's population segment, it could create redundancy in program services. As a result of this competition, MilitaryOneSource could eliminate MFLC as an enduring program in the portfolio. Any loss in unique services provided by MFLC could be mitigated as a part of the portfolio's risk analysis.

3. Implementing the Balanced Portfolio: Optimizing the Generating Force

The Army generating force¹¹⁹ (IMCOM, TRADOC, etc.) contains the structure for the organizations that implement the majority of the Army's HP/RR/SP programs/services found in the *HP/RR/SP Program Portfolio*. To execute this function, the Army has historically devoted a significant share of its resources to the generating force. However, the demands placed upon the Army to support multiple overseas contingency operations have compelled fundamental changes in force structure, with many assets redirected to the operating force.

Since 2001, the Army's overall efforts have centered on sustaining the operational tempo. The increase in HP/RR/SP requirements to support readiness in the pre-deployment phase, coupled with the increase in requirements in the deployment and redeployment phases, has stretched the limits of HP/RR/SP programs and services in the generating force. Additionally, HP/RR/SP programs and services were not synchronized to meet the evolving needs of units, Soldiers and Families under the increased operational tempo.

¹¹⁹ The generating force is that part of the Army whose primary purpose is generating and sustaining operational Army units by performing functions specified and implied by law. See FM 1-01, *Generating Force Support for Operations*, April 2008.

The result of these structure changes has been a degradation of generating force capability, at the same time that operations have increased demand for HP/RR/SP programs and services. This pressure – to provide more programs and services with fewer resources – is not likely to change. The *Portfolio Management Model*, with its emphasis on efficiency and effectiveness, is ideally suited to inform structure and force management decisions in this environment of increased demand and fewer resources. This section will discuss how the *Portfolio Management Model* can be employed to validate HP/RR/SP requirements and develop structural models/templates to satisfy these requirements.

a. Paying the Bill: Degrading the Generating Force

The Army's transformation from a garrison-based organization to a modular, expeditionary force entailed comprehensive restructuring of its combat formations to support the Army's campaign capability. The Soldiers and authorizations needed to support this transformation, for the most part, have been taken from the generating force. The generating force has been used as both the explicit and implicit bill payer for the increased demands of the operating force.¹²⁰ Since 2001, the authorized strength of operating force has increased by 63,300 while the generating force was reduced by 29,700 authorizations. The Active Component generating force authorized strength will decline further in FY 2011 to 92,100.¹²¹

In addition to the reduction in overall strength, the generating force has implicitly supported the operating force through the use of the individual replacement system, or Worldwide Individual Augmentation System (WIAS). WIAS is used to support operational requirements by deploying individual Soldiers from generating force positions. For example, in February 2010 TRADOC had 170 officers on long-term WIAS deployments.¹²² When WIAS is used, generating force positions remain unfilled.

“The Army needs to rebuild the generating force, the organizations that train and educate future leaders.”

– Honorable John McHugh, Secretary of the Army
National Congress Daily, 10 June 2010

Quote 20 – SecArmy John McHugh, 10 Jun 10

This degradation of the generating force has caused several critical gaps in Soldier and Family care. Individual installations and managers have done their best to mitigate these gaps; however, the resulting home grown programs and initiatives created unwarranted variability in the name, number, types and effectiveness of HP/RR/SP programs. Numerous HP/RR/SP home grown or local initiatives have been implemented to address a variety of niche requirements (from installation to installation), but do not address critical issues such as predictable programming, resource sustainability, Army-wide program consistency or continuity of care. This effect was confirmed during the installation-level

¹²⁰ The operating force is comprised of forces with a primary mission to conduct combat operations. See FM 1-01, *Generating Force Support for Operations*, April 2008.

¹²¹ The Task Force identified the declining capability of the generating force as an important issue during the Campaign. Several Task Force initiatives enhanced the generating force, including new authorizations for 72 chaplains and 417 AC and 400 ARNG BH provider authorizations in the operating force (two BH providers per Brigade Combat Team (BCT) and other designated brigades). In addition, TRADOC is considering BH training for the Physician Assistants at Aide Stations as a means to increase BH access.

¹²² Memorandum from TRADOC CG to CSA, “Erosion of TRADOC’s Core Competencies and Functions,” 16 February 2010.

assessment and during the initial phase of the Campaign Plan, which revealed the proliferation of uncoordinated home grown programs.

The trend of increasing operational demands is likely to continue, as will the mandate for the generating force to “do more with less.” This reality provides a compelling justification for the use of portfolio management to efficiently and effectively manage the Army’s HP/RR/SP efforts.

b. Applying Portfolio Management to Optimize Generating Force Capabilities

Constraints on available resources means that HP/RR/SP manpower and dollars must be carefully split between the operating force and generating force requirements. Given this reality, limited HP/RR/SP resources must be applied in a manner to optimize Soldier and Family support in the deployed, garrison and Reserve Component environments.

The use of portfolio management to identify and validate HP/RR/SP requirements will support this objective in several ways. First, because the Army’s operational tempo is highly dynamic and fluid, the accelerated requirements generation cycle provided by CPI will result in a more responsive and efficient *HP/RR/SP Program Portfolio*. For example, if an installation requires a “surge” of program/service providers to support a demobilizing ARNG BCT, the requirements could be temporarily met with *HP/RR/SP Program Portfolio* capabilities from across the Army.

Second, portfolio management can mitigate an important effect of transformation – the migration of HP/RR/SP personnel and authorizations to the operating force to support the operational mission. Many Soldiers (including, for example, medical, chaplain, and law enforcement) possess skills that are applicable in both the deployed and garrison environments. Soldiers with these skills assigned to operating force units are not systematically utilized to reinforce community capacity and relieve pressure on generating force providers while in garrison. This is especially important given the high demand on limited HP/RR/SP manpower resources that is creating compassion fatigue and reduced effectiveness during critical periods (e.g., the first 100 days at station post-deployment). Coordination at the ARPERGEN Synchronization Forum could alleviate this issue by revising policy and process to balance structure between operating force and generating force assets while at home station.

Vignette 30 – Rebalancing the Generating Force: Utilization of Care Providers in Garrison

REBALANCING THE GENERATING FORCE: UTILIZATION OF CARE PROVIDERS IN GARRISON

Army Transformation migrated many of the authorizations for BH providers, medical support personnel, law enforcement and chaplains from garrison support units to BCT structure. This realignment diminished the capacity to provide services in the community when units deploy. Also, this decoupling of Soldiers from their functional occupation in garrison degrades continuing development of their professional/technical expertise.

For example, medical support personnel assigned to a BCT do not receive continual professional development commensurate with their peers who are integrated in modern medical facilities in garrison. Additionally, they may not provide community support (community at large) for a more optimal provider-patient ratio. A more effective use of these BH and medical providers would be to authorize their assistance in community programs while in garrison. Integration of BCT and

(Continued)

REBALANCING THE GENERATING FORCE: UTILIZATION OF CARE PROVIDERS IN GARRISON

installation primary care at MTFs and clinics to provide Soldier care in uniformly modern facilities optimizes medical facilities, diagnostic services, and administration. Although integrated, BCT care providers could still focus on their populations; surge to support the general population as needed; and work as a centralized medical care staff to provide one-stop medical care access/delivery. These actions improve and increase access to care for Soldiers and Family members, while sustaining medical support to the ARFORGEN cycle.

“[We need] better integration among units and support structures – more open communication between commands and support services to ensure all commands know what services are available that may meet their specific needs.”

– Workgroup Outcome

DoD National Leadership Summit on Military Families, 9-10 November 2009

Quote 21 – Work Group, DoD Summit on Military Families, 9-10 Nov 09

The *Portfolio Management Model* could be utilized to determine HP/RR/SP force structure and functional requirements either via modeling or templates. Modeling can guide determination of requirements and capabilities through rules of allocation and has the advantage of being adaptive. For example, MEDCOM is currently developing a medical manpower model for primary care and BH providers that is pending validation. Modeling, however, has drawbacks; the rules of allocation take time to develop and implement, which can delay meaningful results. The development of rules of allocation have an additional complexity in the HP/RR/SP context, where they have to account for the dual usage requirements for Soldiers with skills applicable to the operating force and generating force, such as medical, chaplain and law enforcement personnel. Templates, on the other hand, are expeditious but lack the variability and adjustability of a model. Templates are likely a more suitable tool to validate short-term operating force requirements but not well suited to the longer-term variability of generating force requirements.

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Vignette 31 – Portfolio Management in Action: The Family Advocacy Program (FAP)

PORTFOLIO MANAGEMENT IN ACTION: THE FAMILY ADVOCACY PROGRAM (FAP)

As a result of the Report Team’s requirements assessment of Army programs, the Family Advocacy Program (FAP) was identified as a program in the HP/RR/SP Potential Portfolio.¹²³ FAP was identified because it addresses requirements established by the Care Continuum.

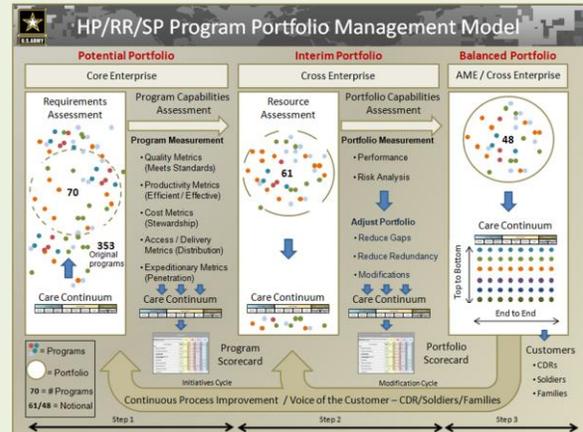
ACSIM, as the proponent for FAP, would then perform the Program Capabilities Assessment in its capacity as a member of the proposed SICE. The assessment would be performed and the program scored using standardized measures of quality, productivity, cost, access/delivery and expeditionary capability. *(Continued)*

¹²³ The FAP is committed to the prevention, education, intervention, treatment reporting and investigation of domestic violence and child abuse/neglect.

PORTFOLIO MANAGEMENT IN ACTION: THE FAMILY ADVOCACY PROGRAM (FAP)

The SICE would then review the FAP program scorecard in conjunction with the other programs in its portfolio and could make modifications to the program based upon its analysis. For example, if FAP's investigative capabilities overlapped law enforcement, ACSIM could coordinate policy with the PMG to reduce duplication of effort.

The FAP would then be included in the Interim Portfolio of programs to be reviewed at a cross enterprise forum, such as the *ARPERGEN Synchronization Forum*. At this level, the program would be analyzed as a component of the total *HP/RR/SP Program Portfolio* across all four enterprises to ensure the portfolio provides end to end (across the Care Continuum) and top to bottom (HQDA to garrison) coverage. For example, portfolio review may reveal a gap where new Soldiers in deploying units arrive too close to deployment to receive FAP training. Closing this gap would require coordination with the HCE and RCE. After the portfolio has been reviewed and validated, the cross enterprise forum prepares a Portfolio Scorecard for comparative analysis of the entire portfolio on performance and risk.



The portfolio is then presented to the proposed AME for approval. Once the portfolio is approved the programs remaining are again arrayed under the Care Continuum from top to bottom and end to end. These programs form the *HP/RR/SP Balanced Portfolio*.

Following approval of the Balanced Portfolio, the Continuous Process Improvement cycle would operate to improve and modify the FAP program. For example, if commanders determined that a FAP expeditionary capability was needed, the capability for addressing that requirement would be validated for consideration into the *HP/RR/SP Interim Portfolio* (short cycle) and the process would continue.

CONCLUSIONS

- ★ The increase in HP/RR/SP requirements to support readiness in the pre-deployment phase, coupled with the increase in requirements in the deployment and redeployment phases, has stretched the limits of HP/RR/SP programs and services in the generating force. (page 175)
- ★ The result of migrating generating force assets to the operating force has degraded generating force capability at the same time that the operating force has increased its demand for HP/RR/SP programs and services. This pressure – to provide more programs and services with fewer resources – is not likely to change. (page 176)
- ★ Numerous HP/RR/SP home grown or local initiatives have been implemented to address a variety of niche requirements but do not address critical issues such as predictable programming, resource sustainability, enterprise level program consistency or continuity of care. (page 176)

(Continued)

- ★ Portfolio management can mitigate an important effect of transformation – the migration of HP/RR/SP personnel and authorizations to the operating force to support the operational mission. Soldiers with dual roles in the operating and generating force (medical, legal, chaplain, etc.) who are assigned to operating force units are not systematically utilized to reinforce community capacity and relieve pressure on generating force providers while in garrison. (page 177)
- ★ Templates may be a more suitable tool to validate short-term operating force HP/RR/SP requirements but are not well suited to the longer-term variability of generating force requirements. (page 178)
- ★ The *Portfolio Management Model* could be used to determine HP/RR/SP force structure functional requirements, either via modeling or templates, and to support a bottom-up review of HP/RR/SP manpower by function. (page 178)

RECOMMENDED ACTIONS

- ★ [HQDA] Use the *Portfolio Management Model* (with its emphasis on efficiency and effectiveness) to inform structure and force management decisions in this environment of increased demand and fewer resources.
- ★ [HQDA] Use the *Portfolio Management Model* to evaluate and reduce home grown HP/RR/SP initiatives to achieve predictable programming, resource sustainability, enterprise level program consistency and continuity of care.
- ★ [HQDA] The ARPERGEN Synchronization Forum should review and revise policy and process to balance structure between operating force and generating force assets while at home station (medical, legal, chaplain, military police, etc.).
- ★ [ARPERGEN] Conduct a bottom-up review of HP/RR/SP manpower by function for the operating force and generating force to:
 - Determine which of the (~70) core HP/RR/SP programs need an expeditionary element.
 - Define the optimal mix of specialists needed to support both garrison and deployed populations.
 - Balance organic (operating force) and augmented (generating force) HP/RR/SP manpower.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 51 – Balancing the Operating and Generating Force for HP/RR/SP

4. Summary

Using the *HP/RR/SP Portfolio Management Model* to manage Army HP/RR/SP efforts completes application of the *HP/RR/SP Program Governance Model*. Managing HP/RR/SP programs as a portfolio ensures the Army's response to individuals across the Event Cycle is balanced by being comprehensive, addressing all phases of the Care Continuum (end to end) and being vertically integrated from HQDA to the implementing level (top to bottom).

The *Portfolio Management Model* operates as a cycle with HP/RR/SP requirements (as determined by the Care Continuum) identified at the core enterprise level through a comprehensive review of the total inventory of programs. The Report Team conducted this review in January 2010 and identified 70 relevant programs. The identified programs (categorized as the Potential Portfolio) are then evaluated and scored using specific common metrics for evaluation of both individual programs and the entire program portfolio.

The Potential Portfolio is then reviewed by the cross enterprise forum and scored based upon a performance and risk analysis using the criteria of effectiveness (closure of gaps) and efficiency (reduction of redundancies). After necessary adjustments are made, the Interim Portfolio is presented to the proposed Army Management Enterprise for approval. The end product of this process is a portfolio balanced horizontally (across the Care Continuum) and vertically (from HQDA to the implementing level).

Because HP/RR/SP requirements are dynamic and evolving, continuous process improvement (CPI) is needed. CPI incorporates the “voice of the customer” (commanders, Soldiers and Families) to consider both modified program requirements and new program initiatives that constantly update and rebalance the program portfolio.

The generating force provides the structure for HP/RR/SP programs and services; its capabilities have been substantially degraded by transformation and operational requirements. Portfolio management should be utilized to balance and optimize generating force structure.

VIII –Investigations and Reporting

“... the duty we owe to all the Families of our fallen Soldiers: Give them the truth, the best we know it, as fast as we can.”

– The Honorable Pete Geren, Former Secretary of the Army
Associated Press, 27 March 2007

Quote 22 – Former SecArmy Pete Geren, 27 Mar 07

The focus of the Army’s transformed approach to HP/RR/SP is the Event Cycle and Care Continuum. Both reflect individual behavior and the Army’s institutional response to that behavior. The overall objective of the Care Continuum (as an institutional response) is to ensure our Soldiers and Families are retained in or returned to the “pre-event” stage of the Event Cycle. The Army achieves this objective by providing both prevention and intervention programs and services that mitigate high risk behavior. In many cases, however, the use of these programs and services do not resolve the high risk behavior and the individual, as a consequence of a behavioral act, enters the post-event stage. The post-event stage represents an event that requires an official inquiry (investigation and reporting) and may consist of criminal activities, attempted suicides and completed suicides (Figure 63). The same institutional issues that exist in the pre- and inter-event cycles (gaps, redundancies, and uncoordinated processes) arise during the post-event cycle due to poorly coordinated and synchronized inter-staff/ agency policies and processes.

This section addresses the procedures taken by commands, law enforcement and medical agencies in the post-event stage. It begins with a brief summary of the shortfalls of the Army’s investigative and reporting policies and processes for non-fatal high risk behavior already detailed in Section III, “*The Lost Art of Leadership in Garrison.*” Next it addresses the roles and responsibilities of the various institutions involved in high risk deaths and the relationships and responsibilities of unit commanders, law enforcement investigators and medical authorities as part of the institutional response. It also addresses the sensitive subject of next-of-kin notification of a deceased Soldier. Throughout, the section provides recommendations for aligning and synchronizing the various roles and responsibilities for investigating and reporting deaths including next-of-kin notification. It also proposes methods for coordinating and reporting information regarding high risk behavior.

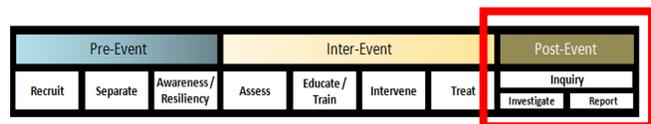


Figure 63 – Post-Event Stage and Inquiry Phase

1. Investigating and Reporting High-Risk Behavior in Non-Fatal Cases

An important aspect of a commander’s responsibility to maintain good order and discipline in the unit is to act when a Soldier in the unit is suspected of being involved in criminal activity. A commander

may direct a formal or informal investigation into the allegations of misconduct.¹²⁴ Additionally, Army policy requires command referral to the installation provost marshal for investigation of suspected criminal misconduct, with minor exceptions.¹²⁵ Similar to formal death investigations, concurrent non-fatal investigations (AR 15-6, Line of Duty (LOD), law enforcement, etc.) often occur as isolated processes with little coordination of final conclusions and reporting.¹²⁶ Ultimately, these reports may convey conflicting accounts of a single story told multiple ways.

a. Reporting Roles and Responsibilities

Criminal misconduct is reported by a variety of different organizations and agencies. The unit, military/civilian law enforcement and military/civilian medical personnel all have roles and responsibilities in the investigative and reporting process. This includes reporting for all investigations (e.g., AR 15-6, misdemeanor, felony, LOD) and reporting by support agencies (e.g., criminal labs for forensics, toxicology). Eventually, every investigation is provided to the commander for adjudication, disposition and recording in accordance with numerous policies. Unit, law enforcement and medical reporting must be synchronized to prevent unnecessary duplication of effort, avoid miscommunication of the incident and provide visibility of an individual's past criminal behavior. Synchronization of the investigative findings occurs only when commanders document disposition to law enforcement agencies and higher headquarters via the DA Form 4833, *Commander's Report of Disciplinary or Administrative Action*.

(1) Commanders

As discussed in the "Reporting Criminal Behavior" section of *"The Lost Art of Leadership in Garrison"* (page 58), commanders must report all crimes to law enforcement in accordance with AR 195-2 and AR 190-45. Commanders may initiate an AR 15-6 investigation if they suspect an alleged offense or if the nature of the offense falls below law enforcement jurisdiction. Pending the review of the AR 15-6 investigation the commander will decide the appropriate action. This could include: no action taken, an official reprimand, UCMJ action and/or administrative separation. After the commander reviews and takes appropriate action on the investigation, policy requires the commander to complete a DA Form 4833¹²⁷ and provide it to the appropriate law enforcement agency. The DA Form 4833 represents the primary communication commanders have with law enforcement agencies and higher headquarters. This report often is the only record regarding the disposition of a case.

¹²⁴ Rule for Court-Martial 303 authorizes commanders to conduct preliminary inquiries. This preliminary inquiry is often referred to as a "commander's inquiry." When conducting a commander's inquiry, commanders may, but are not required to, use the procedures set forth in AR 15-6, Procedures for Investigating Officers and Boards of Officers. A commander may also direct a formal or informal AR 15-6 investigation to ascertain the facts of the alleged misconduct. AR 15-6 establishes procedures for investigations, but does not require an investigating officer to ask a particular set of substantive questions.

¹²⁵ The exceptions are barracks larcenies of property of a value of less than \$1,500, simple assaults occurring in unit areas and not resulting in hospitalization, bigamy when there is no fraud of entitlements, and adult private consensual sexual misconduct.

¹²⁶ Line of Duty investigations are conducted to determine whether misconduct or negligence was involved in the disease, injury or death and if so to what degree. These investigations are used to determine if the incident occurred while the Soldier was in a duty status (AR 600-8-4, *Line of Duty Policy, Procedures, and Investigations*).

¹²⁷ A detailed discussion of the DA Form 4833 process is in Section III of this report, *"The Lost Art of Leadership in Garrison."*

(2) Law Enforcement

Law enforcement reports (the Military Police Report (MPR) and Report of Investigation (ROI)) are generated by the provost marshal and CID as a result of criminal activity. The information from the MPR and ROI may be entered in the Defense Incident-Based Reporting System (DIBRS), National Incident-Based Reporting System (NIBRS) and the National Crime Information Center (NCIC) for law enforcement reference. These reports are also forwarded to the unit commander with an accompanying DA Form 4833 for review and action. The DA Form 4833 must be returned to the initiating law enforcement agency to document the final disposition.

(3) Medical

Most injuries or illnesses that are the result of suspected criminal behavior identified by a medical provider must be reported to commanders and law enforcement. This includes suspected cases of spouse/child abuse, illicit drug use and injuries resulting from criminal misconduct (gunshot, knife wounds, underage drinking, etc.). This report is usually informal (telephonic) from the provider to the provost marshal or other appropriate law enforcement agency. Additionally, medical providers are responsible for reporting all suicidal behavior via the DoD Suicide Event Report (DoDSER) and all attempted suicides to law enforcement for enrollment into DIBRS.

(4) Program/Service Providers (FAP, ASAP, SHARP, etc.)

Program/service providers are required to report criminal misconduct to appropriate authorities. Although ASAP is only required to report illegal drug use findings to commanders, the commander is required to report that drug use to law enforcement. One exception to reporting requirements is that SHARP has two reporting channels; unrestricted and restricted. Victims may elect to restrict reporting to SHARP and medical providers without notifying law enforcement.

b. Reporting of Non-Fatal Suicide Behavior

Suicidal behavior is only required to be reported in the DoDSER when it results in hospitalization, theater evacuation or death. Many non-fatal suicidal behaviors go unreported because they do not meet these criteria for inclusion in the DoDSER. Non-fatal suicide behavior is defined as self-inflicted, potentially injurious behavior for which there is evidence of intent to die. Unfortunately, non-fatal suicide behavior is not well defined and only sporadically reported. For example, a Soldier who was prepared to use a gun with the intent to die but was stopped before actually pulling the trigger would be displaying non-fatal suicide behavior. In this example, if the Soldier was never hospitalized or evacuated out of the theater there would not be any record of this suicide behavior.

DoD policy requires reporting of specified incidents (including attempted and completed suicides) into the DIBRS. The DIBRS reporting requirement has not yet been implemented through Army policy but is generally enforced under current law enforcement reporting procedures. Pending clear implementing guidance, attempted suicides are not defined and, therefore, likely are grossly underreported.

(1) DoDSER

The DoDSER system standardizes data collection and generates detailed statistical reports on suicide events across the Services. In regards to non-fatal suicidal behavior, DoDSER appears to have several flaws that result in incomplete, inaccurate and untimely report submissions. First, as a DoD system, it excludes the Army Medical Command and its subordinate Regional Medical Commands from providing management or supervision. Second, the process is not readily exportable into a deployed environment. Finally, the process excludes data collection efforts on Soldiers who are not on active duty – but for whom active duty service may have contributed to their suicidal behavior. The cumulative effect of these flaws means that reports are seldom timely, accurate or actionable.

(2) DIBRS

As mentioned above, DoD mandates that specific offenses, including suicides and suicide attempts, be reported to DIBRS. Delays in implementing full reporting in DIBRS throughout the Services recently led the Government Accountability Office to call for a comprehensive management plan to address data deficiencies and staffing shortages.¹²⁸ The Department of the Army has not yet issued implementing guidance for the DIBRS reporting requirement.

CONCLUSIONS

- ★ Concurrent non-fatal investigations often occur as isolated processes with little coordination of final conclusions and reporting. (page 184)
- ★ Unit, law enforcement and medical reporting must be synchronized to prevent unnecessary duplication of effort, avoid miscommunication of the incident and provide visibility of an individual's past criminal behavior. (page 184)
- ★ The DA Form 4833 represents the primary communication commanders have with law enforcement agencies and higher headquarters. This report often is the only record regarding the disposition of a case. (page 184)
- ★ Program/service providers are required to report criminal misconduct to appropriate authorities. Any injury or illness that is the result of suspected criminal behavior must be reported to law enforcement. This includes suspected cases of spouse/child abuse, illicit drug use and injuries resulting from criminal misconduct (gunshot, knife wounds, underage drinking, etc.). (page 185)
- ★ Flaws in DoDSER processes result in reports that are not timely, accurate or actionable. (page 186)
- ★ Many non-fatal suicidal behaviors go unreported because they do not meet DoDSER criteria. This gap applies to DIBRS as well, which requires reporting of specified incidents (including attempted and completed suicides). (page 185)

(Continued)

¹²⁸ Army Times, "GAO: Domestic Violence Data Still Lacking," 10 May 2010.

RECOMMENDED ACTIONS

- ★ [HQDA] Revise policy to ensure medical program/service providers contact law enforcement regarding attempted suicides for reporting to DIBRS/NIBRS in accordance with DoD regulations.
- ★ [HQDA] Develop and institutionalize a centralized database for collecting all substantiated AR 15-6 investigation results, accessible by commanders and law enforcement.
- ★ [HQDA] Develop policy to promulgate DoD requirements for DIBRS/NIBRS reporting.
- ★ [HQDA] Improve the DoDSER system by allowing MEDCOM oversight, Reserve Component data collection and mandating timely submission.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 52 – Investigating and Reporting High Risk Behavior in Non-Fatal Cases

2. Investigating Non-Combat Soldier Deaths

Several agencies have responsibilities for investigating and reporting non-combat Soldier deaths. It requires close coordination among commands and the various law enforcement, medical and supporting agencies to ensure an accurate account of the facts and circumstances surrounding the death. This collaboration must ensure that the Soldier's Family is provided with a full account of the circumstances of death, fully supported in their time of loss, and provided with timely information regarding survivor benefits.

The inherently complex and sensitive nature of death investigations require professional and technical expertise from the law enforcement, medical and personnel communities. DoD policy assigns investigative primacy to Military Criminal Investigative Organizations (e.g., CID) and primacy for determining cause and manner of death to the Armed Forces Medical Examiner (AFME) for all non-combat Soldier deaths.

a. Investigative Roles and Responsibilities

(1) CID

CID is the sole criminal investigative agency for non-combat Soldier deaths.¹²⁹ CID investigators focus on timely reporting and conducting a thorough and timely investigation. Each investigation requires identification, preservation and custody of physical and testimonial evidence related to the investigation. CID's objective is to ascertain the circumstances, criminality and intent related to cause and manner of death. It is the totality of the investigative findings combined with AFME's autopsy that ultimately determines the cause and manner of death.

CID's investigation of a death requires complex, multi-step processing, particularly if the circumstances of death raise the possibility of suicide. The possibility of suicide introduces the difficult investigative question regarding the intent of the deceased Soldier (intention to die equates to *suicide* and unintentional to *accidental*). CID must gather all physical, testimonial and forensic evidence to

¹²⁹ For deaths that occur off the military installation (excluding traffic accidents), CID is responsible for assisting civilian law enforcement and reporting the results of the investigation.

assist in determining intent. This is not a simple task. For example, in equivocal deaths such as drug overdose, high-speed motorcycle death or mishandling of a weapon, intent is not readily apparent. In all investigations, but particularly important in equivocal deaths, CID conducts media forensic analysis of the Soldier's computer, cell phone, email accounts and other personal digital assistant (PDA) to identify indicators of intent. This may include farewell notes, web searches on suicide means, evidence of trigger events ("Dear John" letter), etc. This requires CID investigators to obtain preservation orders for private email accounts, serve search warrants, and locate and interview witnesses. Completing these investigative protocols often takes months and, when combined with pending autopsy and toxicology reports, may take longer.

MANNER OF DEATH DETERMINATION COMPLEXITY

A 23 year old Private was drinking in a barracks room when he picked up a pistol and jokingly began pointing it at his head. Witness accounts indicate he placed the weapon to his head after stating "it's not even loaded." He pulled the trigger and shot himself. The results of the investigation determined the Private died of a self-inflicted gunshot wound which was classified by the AFME pathologist as a suicide. However, investigators concluded in the investigative case summary that the death was accidental.

- Complex equivocal deaths require close coordination with AFME, unit leadership and civilian authorities.

Vignette 32 – Manner of Death Determination Complexity

(2) Unit Commander

Upon notification of the non-combat death of a Soldier, the unit commander must notify law enforcement/CID, initiate report processes (Serious Incident Report (SIR) and "34 Line Report") and conduct investigations (e.g., AR 15-6, LOD).

DA Pam 600-24, *Health Promotion, Risk Reduction and Suicide Prevention*, requires commanders to submit, in addition to the SIR, a "34 Line Report" to the Army Suicide Prevention Program (ASPP) within 30 days of a Soldier suicide or equivocal death being investigated as a suicide. The contents of each line of the report are specified, and the report is prepared using information gathered during the AR 15-6 inquiry process. This report format is also used by investigators from CID in support of the ASPP and to inform Army Senior Leadership of the details surrounding suicide events.¹³⁰ This report will be continuously modified based on requirements for additional data. Annex D contains recommended changes to the "34 Line Report" that will be staffed through the Army Health Promotion Council for validation by the VCSA.

AR 15-6 and LOD investigations are required for all suspected suicide deaths. The intent of AR 15-6 investigation is to establish additional facts and information in concert with the CID death investigation that may help identify and incorporate lessons learned to inform improvements in programs/services. The LOD investigation may be separate, or conducted in tandem with the AR 15-6 investigation. Although the LOD investigation is conducted for multiple reasons, the LOD investigation and its

¹³⁰ See the discussion of suicide data collection and reporting by the Task Force in Section V of the report, "*The Army Suicide Prevention Campaign*," beginning on page 111.

supporting evidence is usually used by the Department of Veterans Affairs (VA) when determining a Soldier's survivors or Family member's eligibility for certain VA benefits. Close coordination with CID during both investigations is required to ensure there is no unintended interference with CID's official criminal/death investigation. Deliberate coordination prior to communication with the victim's Family will also ensure the accuracy of all official communications regarding the investigation.

The AR 15-6 and LOD investigations must be provided to CID so that all relevant facts and additional leads become part of the official death investigation. Consequently, all official reporting to Army, DoD and national databases regarding death investigations, in accordance with statute and policy, is the responsibility of CID (e.g., ACI2, NCIC, DIBRS and NIBRS). However, the commander, the Army's Casualty Assistance Officer (CAO) and CID have responsibility for reporting information to the Family and must synchronize their efforts as outlined in this section.

(3) Medical Examiner

AFME is responsible for conducting medico-legal (forensic) investigations to systematically determine the cause and manner of all non-combat Soldier deaths within their jurisdictional purview. Cause of death is defined as the means of death (gunshot wound, drug overdose, asphyxiation, etc.). Manner of death is classified as homicide, suicide, accidental or natural, and in special cases, either undetermined or unclassified. As law enforcement investigators conduct their due diligence to determine intent, medical examiners are under pressure to issue the death certificate. It is imperative that these two organizations work closely to preclude the misclassification of manner of death, especially in complex cases of equivocal deaths.

AFME assimilates state or local death certificate protocols which are not standardized across the country. If the manner of death is undetermined or still under investigation, AFME does not have the means to annotate "Pending" or "Undetermined" on some death certificates. This is true for military deaths overseas. AFME pathologists annotate Soldier deaths that occur overseas on a Department of Defense Form 2064 (Certificate of Death Overseas). The DD Form 2064 is standardized for all overseas deaths, but lacks a "Pending" and "Undetermined" manner of death category. This creates instances in which the AFME manner of death determination prematurely precedes the full scope of the CID investigation. To ensure the timeliness of issuance of a death certificate, AFME often must select the manner of death while the results of the CID investigation are still pending. Unfortunately, late breaking investigative evidence and findings may contradict the documented manner of death determination. This gap is not isolated to military death investigations but is common to the determination of manner of death nationwide. Many law enforcement and medical examiners across other jurisdictions have mitigated this issue with the use of a "pending" option on the death certificate for manner of death.

The medical examiner's responsibility to determine manner of death is not an easy one, particularly if suicide is a possibility. "Accidents and suicides ... 'are difficult distinctions to make sometimes, particularly if someone doesn't leave a note or indicate in any way that they were contemplating suicide.'"¹³¹ Generally speaking, studies of suicide determinations demonstrate the magnitude of misclassification of manner of death is substantial, with 20-30% of suicides inaccurately assigned as

¹³¹ COL Benedek, David, Faculty, Uniformed Service University of the Health Sciences, quoted in *Army Times*, "Accidental Overdoses Alarm Military Officials," 9 June 2010.

accidental or undetermined.¹³² Research has shown that in 1998-99, for all branches of the military, there were likely 17% more suicides from among the equivocal deaths determined as either accidental or undetermined.¹³³ The same research showed an additional 4% of deaths were suspicious for suicide, suggesting that reporting and classification problems may conservatively account for 21% additional suicides in the military.¹³⁴ This misclassification of equivocal deaths is consistent with some civilian studies, which report as many as 38% additional suicides misclassified within categories such as accidental or undetermined.¹³⁵ Although there are limitations in generalizing these findings, such research shows the problems inherent in death classification.¹³⁶

Psychological autopsies fall under the purview of the AFME and have a very narrow, specific function – to assist in ascertaining the manner of death. It is required for select suspected suicide cases, and only when approved by AFME. DoDI 5154.30 (March 2003) states that the psychological autopsy is not to be used for event surveillance or development of preventive policies/programs. The need for psychological autopsies has decreased as a result of improved measures in determining victim intent. For example, media forensics has expanded the Army's investigative capability to examine cell phones, email/texting, web-searches and other social/electronic media. Improved media forensics has greatly assisted criminal investigators in identifying intent as part of determining manner of death. It is only after all investigative leads (witnesses, physical forensics, media forensics, etc.) have been exhausted that a psychological autopsy may be required.

While psychological autopsies have value if all other investigative leads have proven futile in determining manner of death, they have limitations. Most significantly, a psychological autopsy must be performed by a behavioral health professional with specialty training in psychological forensics, which limits the number of individuals who can conduct them. The psychological autopsy is a time intensive process which requires a great deal of information such as medical records, personnel records, Family history, etc. Finally, psychological autopsies are narrative reports with a wide variance in how the information is presented. This variance often limits its application in defining investigative leads, findings and conclusions. Nevertheless, the psychological autopsy provides an investigative tool when other investigative means to determine intent have been exhausted.

(4) Medical Treatment Facility (MTF) Commander

Medical Treatment Facility Commanders are required to submit a DoDSER for all Soldier suicides. DoD policy requires a DoDSER submission within 60 days of the death being confirmed as suicide by the

¹³² Eaton, Karen M., MS, et. al., "Strengthening the Validity of Population-Based Suicide Rate Comparisons: An Illustration Using U.S. Military and Civilian Data," *Suicide and Life-Threatening Behavior*, American Association of Suicidology, 36(2), April 2006, citing Brent, Perper & Allman, 1987; Kleck, 1988, Mohler & Earls, 2001; O'Carroll, 1989; and Phillips & Ruth, 1993.

¹³³ Carr, Joel R., DO, MPH, et. al., "Suicide Surveillance in the U.S. Military – Reporting and Classification Biases in Rate Calculations," *Suicide and Life-Threatening Behavior*, American Association of Suicidology, 34(3), Autumn 2004.

¹³⁴ Ibid.

¹³⁵ Eaton, Karen M., MS, et. al., "Strengthening the Validity of Population-Based Suicide Rate Comparisons: An Illustration Using U.S. Military and Civilian Data," *Suicide and Life-Threatening Behavior*, American Association of Suicidology, 36(2), April 2006, citing Brent et al., 1987; Mohler & Earls, 2001; Phillips & Ruth, 1993; Rothberg & Jones, 1987; and Sentell et al., 1997). (One of the limitations expressly noted by the misclassification research cited above was its grounding in data generated 1990-2000, when the manner of many of the deaths occurring during that time was still pending determination. However, more recent data and information reviewed by the Task Force confirm and support the conclusion that manner of death misclassifications may be under-reporting suicides.)

¹³⁶ Carr, op. cit.

medical examiner. The DoDSER is prepared and submitted by credentialed behavioral health clinicians (psychologists, psychiatrists, social workers or psychiatric nurses) at medical treatment facilities. It is an important tool in the analysis of suicide behavior. It provides a standard reporting mechanism to collect and report DoD suicide data in an effort to understand suicide risk factors and inform future intervention and treatment research.

Although the DoDSER provides critical data regarding a wide range of potential risk factors, its value could be enhanced by refinement of the survey methodology. The DoDSER provides a series of data categories including demographic (military information), event information and Soldier history (deployment, medical, behavioral health and Family) to allow for comparative and trend analysis. These survey categories and potential risk factors may help identify trends among the Services but still require further refinement to enhance the specificity of these data. For example, a clear delineation of potential stressors regarding relationship, financial and victim status, may improve data collection on specific contributing sub-factors. In this example, relationship stressors only identify the perceived relationship status, but do not collect potential factors relating to relationship stressors/failures including deployment, financial, substance abuse, promiscuity, etc. Likewise, collection of financial stressors focuses on overt indicators such as excessive debt or bankruptcy and job problems, but does not capture known stressors including investment/market loss, real estate devaluation, retirement preparation and loss of pension (disciplinary, divorce, etc.).

“... the Soldiers were dealing with relationship issues, but often there were factors involved such as legal, financial and medical problems...”

– GEN Pete Chiarelli, Vice Chief of Staff, Army
The Fort Jackson Leader, 27 March 2009

Quote 23 – GEN Pete Chiarelli, 27 Mar 09

Data in the DoDSER are sent directly from the behavioral health provider to DoD. This means there is no staff coordination with the Army’s medical, law enforcement and commands to provide quality assurance in the submission of this report. It is critical that Army leaders be afforded the opportunity to provide the necessary oversight to the DoDSER reporting process prior to submission to DoD. Army agencies responsible for data collection, analysis and reporting must be able to provide standard protocols and system-wide training to ensure reporting accuracy. For example, the ASPP, which is responsible for providing policy, processes and resources to assist commanders and leaders in minimizing suicidal behavior, is not officially involved in the DoDSER reporting process. This precludes their participation in DoD data management which requires the Army to develop parallel systems in order to rapidly identify and mitigate emerging suicide trends. Additionally, MEDCOM is not afforded the opportunity to promulgate reporting policy and process nor enforce reporting compliance.

b. Investigative Primacy

(1) CID/AFME

As discussed earlier, AFME has primacy for determining manner of death, while CID has primacy for all death investigations. Together, they provide a comprehensive picture as to the cause, nature and circumstances of death. Each organization relies on the other to formulate investigative findings and conclusions. AFME uses CID investigative conclusions regarding Soldier intent to make the manner of death determination between accidental and suicide. Likewise, CID relies on AFME to provide medical

expertise in establishing its investigative conclusions. Unfortunately, their collaboration is often adversely affected by the timing between issuance of the death certificate and resolution of all investigative leads. As a result, both may publish conflicting conclusions and communicate conflicting information to the victim's Family regarding manner of death. For example, a Soldier who dies from drug overdose is normally determined to be an accidental death. However, if CID finds evidence of a suicide note via media forensics (e.g., text message) following issuance of the death certificate, the manner of death may still remain accidental.

Currently, there is no formal mechanism (e.g., manner of death review board) to reconcile differing conclusions regarding manner of death. It is essential to develop policy and processes to synchronize investigative conclusions regarding the victim's intent in determining manner of death. AFME must delay (to the extent possible) its determination of the manner of death pending final investigative conclusions. It may be helpful, especially among equivocal deaths, to adopt "pending" as an option for the manner of death on the certificate of death. In essence, this would create an interim certificate with "Cause of Death" annotated, but "Manner of Death" pending. Additionally, an Army "manner of death review board" comprised of external experts could assist with the review and analysis of conclusions to determine appropriate manner in equivocal death cases. The Army must ensure however, that the use of the pending option does not impact CMAOC's support or immediate delivery of survivor benefits.

MANNER OF DEATH DETERMINATION

During the conduct of a live fire exercise, a Sergeant was shot and killed when, for reasons unknown, he crossed in front of a Specialist's line of fire. The AFME pathologist determined the cause of death as gunshot wound of the head and the manner of death as homicide. This is because AFME defines homicide as the death of a person due to the actions or inactions of another, regardless of intent. After a law enforcement investigation determined the totality of the circumstances and the Specialist's inability to foresee the actions of the decedent, the manner of death was ruled accidental.

- Equivocal death investigations require close coordination to ensure investigative accuracy, timeliness and to reduce additional stress associated with these sensitive events.

Vignette 33 – Manner of Death Determination

(2) Civilian Law Enforcement and Medical Examiners

Army law enforcement is required to coordinate with civilian law enforcement for all criminal and death investigations that occur off the installation/reservation. Per Chapter 17 of AR 10-87 (*Army Commands, Army Service Component Commands, and Direct Reporting Units*), CID establishes liaison, coordination requirements and procedures to ensure effective exchange of information with federal, state and local law enforcement agencies. The intent of this regulation is to ensure strict accountability of Soldiers and the accuracy of information pertaining to all Soldier criminal and death investigations. To implement this policy, CID routinely conducts joint and collateral investigations with their civilian counterparts. This is also true of AFME's recurring coordination among local medical examiners conducting medico-legal investigation of Soldier deaths.

Death investigations that occur outside of military jurisdiction add another layer of complexity in investigations, manner of death determination and reporting. In these cases, civilian law enforcement/investigators may retain primacy for the investigation as well as for determining cause and

manner of death. Like Soldier deaths occurring on an installation or reservation, the local medical examiner usually determines manner of death prior to law enforcement investigative resolution. Each state has its own death certificate similar to the Centers for Disease Control and Prevention (CDC) standard Certificate of Death. While, this standard death certificate has a “Pending Investigation” option for manner of death, many state death certificates do not incorporate this option. Without the option to indicate a pending manner of death status, death classification often precedes the more comprehensive investigative process. As a result, the natural friction between civilian law enforcement and medical examiners often leads to conflicting information provided to Army leaders and Families.

While the process outlined above is also true in death investigations of Reserve Component (RC) Soldiers, these cases have yet another layer of complexity. The death of an RC Soldier (not on active duty) is not always reported to military authorities. Civilian law enforcement must recognize the victim’s military status and ascertain appropriate points of contact in order to notify appropriate leaders of a pending death investigation. This leads to time lags and/or gaps in reporting and tracking non-combat deaths in the Total Force.

CONCLUSIONS

- ★ Multiple agencies have responsibilities for investigating and reporting non-combat Soldier deaths, which require close coordination to ensure an accurate account of the facts and circumstances surrounding the death. (page 187)
- ★ DoD policy assigns investigative primacy to Military Criminal Investigative Organizations (e.g., CID) and primacy for determining cause and manner of death to the AFME for all non-combat Soldier deaths. (page 187)
- ★ It is the totality of CID’s investigative findings combined with AFME’s autopsy that ultimately determines manner of death. (page 187)
- ★ In all death investigations, CID conducts media forensic analysis of the Soldier’s computer, cell phone, email accounts and other PDA to identify indicators of intent. This requires CID investigators to obtain preservation orders for private email accounts, serve search warrants, and locate and interview witnesses. (page 188)
- ★ Close coordination with CID during AR 15-6/LOD investigations is required to ensure that there is no unintended interference with CID’s official criminal/death investigation. (page 189)
- ★ Deliberate coordination prior to communication with the victim’s Family will ensure the accuracy of all official communications regarding the investigation. (page 189)
- ★ As law enforcement investigators conduct their due diligence to determine intent, medical examiners are under pressure to issue the death certificate. It is imperative that these two organizations work closely to preclude the misclassification of equivocal deaths. (page 189)
- ★ AFME often must select the manner of death while the results of the CID investigation are still pending to ensure the timeliness of issuance of a death certificate. Investigative evidence and findings may counter the documented manner of death determination. (page 189)
- ★ Manner of death determination problems may conservatively account for 21% additional suicides in the military. (page 190)
- ★ Psychological autopsies can assist criminal investigators and medical examiners in determining the manner of death. (page 190)

(Continued)

- ★ The DoDSER provides a series of data categories including demographic (military information), event information and history (deployment, medical, behavioral health and Family) to provide comparative analysis among suicide victims. (page 191)
- ★ DoDSER’s value can be enhanced by refinement of the survey methodology. Survey categories and potential risk factors may help identify suicide risk trends among the Services but still require further refinement to enhance the specificity of these data. (page 191)
- ★ DoDSER data are sent directly from a behavioral health provider to DoD without first coordinating with the Army’s medical, law enforcement and commands to provide quality assurance in the submission of this report. (page 191)
- ★ AFME/CID collaboration is often adversely affected by the timing between issuance of the death certificate and resolution of all investigative leads. Conflicting conclusions may communicate inconsistent information to the victim’s Family regarding manner of death. (pages 191-192)
- ★ There is no formal mechanism (e.g., manner of death review board) to reconcile differing conclusions regarding manner of death. It is essential to develop policy and processes to synchronize investigative conclusions regarding the victim’s intent. (page 192)
- ★ Death investigations that occur outside of military jurisdiction add another layer of complexity in investigations, manner of death determination and reporting. Civilian law enforcement/ investigators may retain primacy for the investigation and determining cause and manner of death. (page 192)
- ★ CID routinely conducts joint and collateral investigations with their civilian counterparts. Additionally, AFME may coordinate with local medical examiners conducting medico-legal investigation of Soldier deaths. (page 192)
- ★ The death of an RC Soldier (not on active duty) is not always reported to military authorities. Civilian and military law enforcement must actively coordinate for death notification and investigative status. (page 193)

RECOMMENDED ACTIONS

- ★ [HQDA] Revise policy to reemphasize CID’s investigative primacy for death investigations. Ensure the AR 15-6 and LOD investigations are coordinated under CID’s investigative lead.
- ★ [HQDA] Coordinate policy with OSD to sequence AFME determination of manner of death with CID’s final investigative conclusions. Explore the feasibility of adopting “pending” as an option for manner of death on the certificate of death.
- ★ [HQDA] Request psychological autopsy only after all other investigative leads have been exhausted or as appropriate.
- ★ [HQDA] Establish an Army “manner of death review board” (may include external experts) to conduct a review/analysis of investigative conclusions to determine manner of death in equivocal cases.
- ★ [HQDA] Coordinate with OSD to modify the DoDSER survey methodology to refine data categories including demographic (military information), event information and history (deployment, medical, behavioral health and Family) to provide comparative analysis among suicide victims. (Continued)

- ★ [HQDA] Coordinate with OSD to allow Service staffing/integration during the DoDSER reporting process.
- ★ [HQDA] Establish a system/liaison for local, state and federal civilian law enforcement/ investigators to better inform military police of non-combat deaths of RC Soldiers (not on active duty).
- ★ [OPMG] Direct CID to emphasize interagency coordination for joint and collateral investigations of all non-combat RC Soldier deaths. Develop a collaborative forum in the Law Enforcement Advisory Portal (LEAP) for law enforcement coordination of RC Soldier investigations.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 53 – Investigating Non-Combat Soldier Deaths

3. Reporting Non-Combat Soldier Deaths: Next-of-Kin Notifications

a. The Next-of-Kin Communication Process

(1) Roles and Responsibilities

Families deserve to be notified of a Soldier's death in the most expeditious manner possible. DoD policy, as promulgated in Army Directive 2010-01, requires that the next-of-kin will receive accurate and timely accounts of the circumstances surrounding the loss of their loved one.¹³⁷ Early coordination among multiple organizations is critical to ensure accurate and timely information is reported to the next-of-kin. However, this is not always the case. The Army's requirement to provide timely and accurate information of such a sensitive nature is often at odds with synchronizing the diverse set of organizations working worldwide under a high operational tempo. Current policy and processes are not ideally suited to control delivery of information among innumerable distractions associated with time, distance, extended Families, collateral reporting by the victim's friends, and the proliferation of electronic communications. These challenges require active coordination among reporting agencies to achieve optimal unity of effort and succinct, accurate and consistent reports to the next-of-kin.

The next-of-kin notification process involves four organizations: (1) the Casualty and Mortuary Affairs Operations Center (CMAOC); (2) CID; (3) AFME; and (4) the Soldier's unit. Each has a complementary role in supporting the Family. The CMAOC's Casualty Notification Officer (CNO) delivers the initial death notification to the Family and the CMAOC's Casualty Affairs Officer (CAO) provides administrative support to the Family and liaison with the other organizations; CID is responsible for reporting the circumstances of the death and investigative findings; AFME is responsible for reporting the medico-legal findings; and the unit is the focal point for the conduct of military customs and accountability of personal effects.

¹³⁷ Army Directive 2010-01, *Conduct of AR 15-6 Investigations into Suspected Suicides and Requirements for Suicide Incident Family Briefs*.

(a) Casualty and Mortuary Affairs Operations Center (CMAOC)

The CMAOC is the centralized agency for the casualty reporting system.¹³⁸ Specifically, the Casualty and Mortuary Affairs Branch (CMAB) is responsible for coordinating death investigations and reporting. Once notified by the unit of a Soldier death, the CMAOC notifies the appropriate Casualty Assistance Center (CAC) which then appoints a CNO. The CNO is responsible for the initial death notification. The CMAOC coordinates to ensure a CAO is available to work with the Family as the Army liaison. The CAO is responsible for continued personal contact with the next-of-kin. All military reporting regarding the death of a Soldier from all organizations is coordinated with the CAO. As the primary benefits administrator, the CAO works with the Family to ensure all administrative functions associated with the death of the Soldier are properly completed (financial, memorial services, DA Forms, etc.). Additionally, CMAOC must receive a copy of all death investigations to ensure investigative documentation is provided to the family.

(b) CID

CID appoints the Special Agent in Charge (SAC) to serve as the lead investigator during a death investigation. The SAC has the responsibility of coordinating with the appropriate medical examiner. The SAC serves as the Casualty Liaison Officer (CID CLO), with a responsibility for briefing the status and results of the investigation to the next-of-kin. The CID CLO contacts the next-of-kin as soon as reasonable (not to exceed five calendar days) following the CNO notification. The CID CLO contacts the CAO and next-of-kin at least once every 30 days to update them on the status of the investigation.

(c) AFME

AFME is responsible for conducting a medico-legal (forensic) investigation to determine the cause and manner of death. AFME works in concert with CID and the US Army Criminal Investigation Lab for critical insight into death determination. The final autopsy and toxicology reports are generally released to CID within 30 days of autopsy completion to support the ongoing death investigation. Additionally, AFME has a regulatory requirement to release the results of the autopsy and issue the death certificate to the next-of-kin. This is coordinated with all organizations associated with next-of-kin reporting.

(d) Unit Commander

Within 12 hours of the initial notification of the death of a Soldier, the commander must notify the chain of command by generating a Serious Incident Report (SIR) and casualty report. The commander will immediately contact the CMAOC and initiate LOD and AR 15-6 investigations in coordination with CID. After the next-of-kin notification by the CNO is complete, the unit commander has 24 hours to send a sympathy letter explaining the details surrounding the Soldier's death. In a deployed environment or other overseas locations, the commander has 72 hours to complete the letter. At 30 day intervals, the commander will report to CMAOC any new factual information gained throughout the course of the AR 15-6 investigation, even if the investigation is on-going. However, the AR 15-6 officer is required to coordinate with the CID investigating officer on a reoccurring basis to synchronize investigative activities. These reports will continue until the investigation is completed. Likewise, the commander will send follow-up letters to the Family every four to six weeks or sooner if significant facts are available.

¹³⁸ The CMAOC is a subordinate division of The Adjutant General Directorate which falls under the U.S. Army Human Resources Command. The CMAOC mission is to assist Army Families of fallen Soldiers.

(2) Synchronization of Next-of-Kin Notification

A revision to the current next-of-kin notification process is required to effectively coordinate and synchronize communications among reporting organizations. This change is essential to achieve unity of effort as investigations, reporting and other related activities evolve during the next-of-kin notification process. Figure 64 represents proposed revisions to the notification process and highlights key roles/responsibilities of the unit, CID, AFME and the CAO. It is designed to synchronize activities across the expected timeline from initial notification thru the first six months. Reporting organizations are displayed vertically with their respective actions integrated horizontally across time.

The reporting organizations are consolidated as part of a unified “Next-of-Kin (NOK) Report Team” (as depicted in the red band) and consists of representatives from the CAO, CID, AFME and the unit. The NOK Report Team will convene (in-person, telephonically, VTC, etc.) prior to each planned next-of-kin engagement to ensure notifications are synchronized, accurate and consistent. Even during unplanned communication by the Family to one or more of the reporting organizations, communications will naturally be enhanced by the collaborative process. Organizations contacted by the Family can address immediate concerns within their expertise but would have a readily available forum for ongoing consultation and next-of-kin follow-up.

The timeline presented in Figure 64 does not adjust existing regulatory suspenses. Nor does it reassign existing duties to other organizations. It stresses the need for the NOK Report Team to remain the primary hub of information flow to the next-of-kin and clearly shows coordination among all reporting agencies is essential for synchronized, accurate and consistent communication. The use of the NOK Report Team will effectively achieve these dynamics during next-of-kin notifications and will greatly reduce uncoordinated reporting.

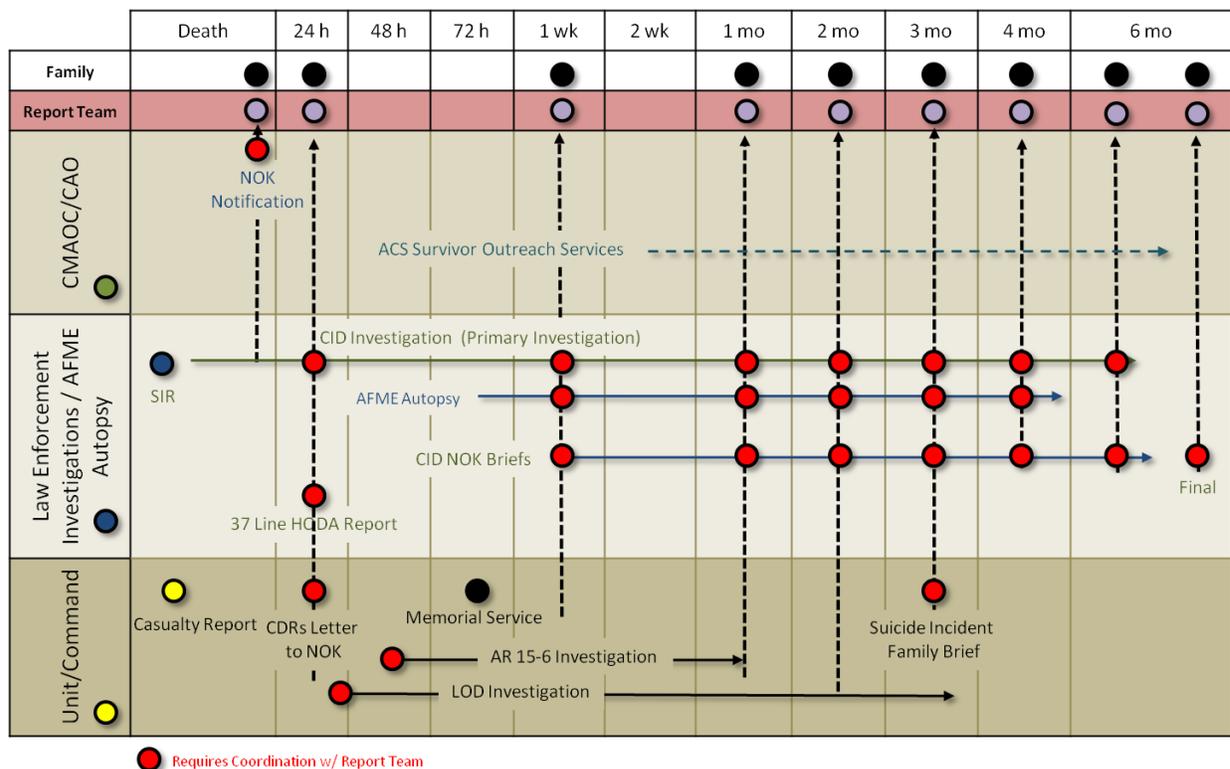


Figure 64 – Coordinated NOK Notification Process

UNCOORDINATED NEXT-OF-KIN NOTIFICATIONS

A married Staff Sergeant was fraternizing with a junior female Soldier in his squad while deployed. After approximately six months, the female dissolved the relationship via computer instant message. Within minutes, the male became very distraught, went to her living area, pulled his loaded weapon and shot her. He then shot himself. The initial verbal report to the victim's Family was that their daughter was involved in a friendly fire incident. The autopsy report and CID ROI were released to her Family at different stages and relayed information that conflicted with the initial verbal report. This led the Family to believe there was a cover up by the Army.

- The Army has an obligation to coordinate information in order to provide accurate and timely notification to next-of-kin.

Vignette 34 – Uncoordinated Next-of-Kin Notifications**CONCLUSIONS**

- ★ Families deserve to be notified of a Soldier's death in the most expeditious manner possible. Early coordination among multiple organizations is critical to ensure accurate and timely information is reported to the next-of-kin. (page 195)
- ★ The Army's requirement to provide timely and accurate information to the next-of-kin is often at odds with synchronizing a diverse set of organizations working worldwide under a high operational tempo. (page 195)
- ★ Current policy and processes are not ideally suited to control delivery of information among innumerable distractions associated with time, distance, extended Families, collateral reporting by the victim's friends and the proliferation of electronic communications. (page 195)
- ★ The next-of-kin notification process involves four organizations. Each has a complementary role in supporting the Family. The CMAOC's CAO provides administrative support and liaison; CID is responsible for reporting circumstances of death and investigative findings; AFME is responsible for medico-legal findings; and the unit is the focal point for conduct of military customs and accountability of personal effects. (page 196)
- ★ A revision to the current next-of-kin notification process is required to effectively coordinate and synchronize communications among reporting organizations. This change is essential to achieve unity of effort as a fluid situation involving investigations, reporting and other related activities evolve during the next-of-kin notification process. (page 197)

RECOMMENDED ACTIONS

- ★ [HQDA] Reinforce policy to ensure all reporting agencies coordinate as one voice during next-of-kin notifications. All organizations/agencies must coordinate with one another prior to interacting, corresponding and sharing information with the next-of-kin.
- ★ [HQDA] Develop a formal process to synchronize communication between the relevant agencies and the next-of-kin during the death investigation process using the "NOK Report Team" synchronization model.
- ★ [HQDA] Revise policy to reinforce the CID CLO as the single point of contact for investigations and investigative reporting related to death investigations.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 54 – Next-of-Kin Communications

4. Summary

Commanders, law enforcement and medical providers have multiple means of investigating and reporting high risk non-fatal behavior and high risk deaths. Although investigative reports (AR 15-6, LOD and criminal/death) provide the facts and circumstances surrounding the high risk event, there are numerous gaps in interagency investigations and investigative reporting. Investigations are uncoordinated and results are not easily accessible to decision makers. Investigative/reporting policies and processes are disjointed and incomplete, often lacking clear delineation of roles/responsibilities and fail to promulgate standard procedures and definitions. As a result, data concerning high risk behavior are not readily accessible to track incidents, determine trends and conduct predictive analyses.

The Army accepts responsibility for not only the health and welfare of its Soldiers, but also the interests of its Families. When a Soldier dies, there is no mission more important than the next-of-kin notification process to ensure timely, accurate and consistent information. Multiple participants make this process complex. Commanders, CID, the CMAOC and the AFME all have a role in communicating with the Family. They must actively coordinate during all formal and informal communication. Task organize these participants as a “NOK Report Team” as an efficient and effective way to synchronize this critical and sensitive process.

AFME and CID provide a comprehensive picture as to the cause, nature and circumstances of death. Their collaboration is often adversely affected by the timing between issuance of the death certificate and resolution of all investigative leads. Currently, there is no formal mechanism (e.g., manner of death review board) to reconcile differing conclusions regarding manner of death. As a result, both may publish conflicting findings and communicate conflicting information to the victim’s Family.

It is essential to develop policy and processes to synchronize investigative conclusions regarding the victim’s intent in determining manner of death. AFME must delay (to the extent possible) its determination of the manner of death pending final investigative conclusions. It may be helpful, especially among equivocal deaths, to adopt a “pending” option for manner of death on the certificate of death. Additionally, an Army “manner of death review board” comprised of external experts could assist with the review and analysis of conclusions to determine appropriate manner in equivocal death cases.

IX – Information Sharing and Retrieval

“Situational awareness is immediate knowledge of the conditions of an operation.”

– FM 3-0, Operations, February 2008

Quote 24 – FM 3-0, Operations

1. Introduction

The previous sections of this report have discussed issues associated with the Army’s existing information systems, and the failure of these systems to adequately inform leaders of high risk behavior. Furthermore, the lack of integrated information prohibits efficient and effective oversight, management and sustainment of the *HP/RR/SP Program Portfolio*. Situational awareness among leaders and program/service providers depends on collecting and sharing relevant, timely, accurate and actionable information about units, Soldiers, Families and programs.¹³⁹ Just as the previous sections described the proposed transformation of Army governance, this section will discuss the corresponding transformation required in the Army’s information systems to achieve this situational awareness. Unfortunately, current information systems are not designed and operated to achieve this goal.

Situational awareness is achieved through the use of data generating, collection and reporting systems that enable comprehensive data sharing, retrieval and analysis. Existing Army data systems frustrate attainment of this goal. They are, in many cases, not designed to generate, collect and report key information needed by leaders and program/service providers. Another impediment to information sharing is the fact that data systems are not interoperable between Army organizations. Compounding these problems is the perception among data system operators that the data are proprietary, when in reality, the sole owner of Army data is the Secretary of the Army (SecArmy). The problems of silo’ed programs and services are mirrored in the Army’s data infrastructure.

To overcome these obstacles, the Army began implementation of an Army Net-Centric Data Strategy (ANCDS). This enduring and global approach to Army information sharing will make data visible, accessible, institutionalized, understandable, trusted, interoperable and responsive to user needs throughout the Army and consistent with DoD policies. Until the strategy is fully implemented, the immediacy of the Army’s HP/RR/SP requirements mandates a provisional bridge solution. That solution is customized information portals and dashboards for use by leaders and program/service providers.¹⁴⁰

¹³⁹ For the remainder of this section, references to Soldier information/data also refers to Families as consistent with policy.

¹⁴⁰ As discussed in detail below, a portal is a web page with links to other sites, all related to a unifying core topic, and provides the beginning step for aggregating and sharing data organized along the Care Continuum. An example of a portal is the Law Enforcement Access Portal (LEAP). A dashboard is a graphic, organized snapshot of key data points summarized on a single web page, and offers another way of providing leaders with actionable knowledge and situational awareness.

Achieving situational awareness among HP/RR/SP programs presents a challenge because of the scope and depth of data used to inform the institutional response to individual Soldier behavior in each phase of the Care Continuum. The breadth of the Care Continuum (depicted in Figure 65), which covers activities from recruitment to inquiry, requires large, comprehensive data sets for use in leading and managing HP/RR/SP programs and services. ASAP data requirements provide an example to highlight the importance of situational awareness at every echelon:

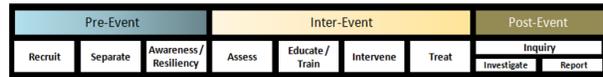


Figure 65 – The Event Cycle and Care Continuum

- **HQDA level** – Army-wide data on types and quantities of prescribed drugs (pain, anxiety, depression, etc.). This information could help design Army Substance Abuse Program (ASAP) drug testing panels and inform future research on effective surveillance/detection means. (Assess phase)
- **Core enterprise level** – Army-wide data on ASAP/behavioral health utilization rates. This information would validate staffing/facilities requirements and program efficiency. (Treat phase)
- **Installation level** – Garrison-wide data on administrative and disciplinary action regarding illicit drug use among tenant units. This information would help define medical intervention and investigative requirements. (Inquiry phase)
- **Unit level** – Unit-specific data on individual high risk behavior (DUIs, illicit drug use, other drug related crimes, etc.). This information would provide the commander a tool to ensure good order and discipline in the unit (administrative and disciplinary decisions). (Separation phase)

The stakes could not be higher. When a Soldier displays high risk behavior, the Army must respond; failure to detect and intervene immediately can have tragic consequences.

LACK OF VISIBILITY OF AN AT-RISK SOLDIER

A 28 year old Specialist with eight years in the Army was married with young children. He was going through a difficult divorce and experiencing serious financial difficulties. He was preparing for his fourth deployment and told his friends he was looking forward to the deployment as an escape from the stress of his pending divorce. He was well liked by unit members and was viewed as energetic, upbeat and squared away. No one in his unit knew that the Specialist was being treated for depression and had been previously diagnosed with an Adjustment Disorder with Anxiety and Depressed Mood. The unit did not know he was on six different medications or that he had been receiving clinical and medical treatment for depression since 2004. His unit was taken completely by surprise when the Specialist took his own life. He had participated in the Suicide Stand-down Training approximately two weeks prior to his death. Around the same time, he had purchased and registered two weapons, one of which he used to commit suicide.

- Information integration (medical and non-medical) will provide commanders and medical providers with situational awareness to develop holistic treatment/mitigation plans.

Vignette 35 – Lack of visibility of an At-Risk Soldier

This section will discuss the broad scope of information required by leaders and HP/RR/SP program/service providers. It outlines the challenges with the current design of Army data systems and further addresses misconceptions surrounding data ownership and sharing. This section provides recommendations for immediate information sharing tools to address HP/RR/SP information gaps

pending implementation of ANCDs goals. It demonstrates that the Army must examine its information requirements for HP/RR/SP and revise protocols on data collection, reporting and maintenance. Just as the Army has shifted from an institutional to an expeditionary capability, data systems must shift from a proprietary, silo'ed paradigm to a holistic net-centric environment.

2. What Leaders and Managers Need to Know: Establishing Data Requirements

In order to oversee and manage HP/RR/SP efforts effectively, Army leaders and program managers need immediate access to relevant, timely, accurate and actionable information regarding individual Soldier behavior and program performance. Just as the Care Continuum defines HP/RR/SP governance and the *HP/RR/SP Program Portfolio*, it defines information requirements to support programs/services during each phase.

- Commanders at every level need better awareness of risk (or stress) indicators to enable high risk intervention including disciplinary, administrative and medical procedures. Additionally, data can inform commanders of the outcomes of these interventions and any future actions that may be required. For example, Soldier data collected for the purposes of unit readiness, accountability or deployability could have relevance to stressors affecting the Soldier's career or Family situation. Risk indicators such as law enforcement contacts, substance abuse, indebtedness and accidents should be tracked and mitigated.
- Law enforcement officials need better situational awareness to effectively enforce good order and discipline. Easily accessible data on HP/RR/SP programs and services can inform law enforcement on investigations and investigative support programs to target and mitigate criminal and high risk behavior that may degrade the safety and security of units, Soldiers and Families. For example, readily available information could inform CID on emerging trends regarding illicit use of pharmaceuticals and subsequent development of surveillance and detection techniques and procedures.
- Medical and health care providers need better awareness of high risk and/or help-seeking behavior to inform program/service requirements, enrollments and treatment outcomes. Additionally, visibility of Soldier enrollment in (or use of) rehabilitation programs, counseling services and other health care programs can provide a comprehensive picture which can be used to develop a holistic treatment plan. For example, visible, accessible and trusted data would inform behavioral health providers of Soldier enrollment in other programs including ASAP, Family Advocacy Program (FAP), etc.
- Garrison Community Health Promotion Councils (CHPC) need better awareness of Soldier and Family stressors to develop, expand or modify local installation or command policies, processes and program/service access and delivery. A composite view of Soldier and Family stressors, for instance, could assist in synchronizing program/service access and delivery with the movement of units and Soldiers. For example, the CHPC could abbreviate programs (e.g., Strong Bonds retreat, FAP, financial counseling) to provide "in house" training seminars for a deploying unit with an unusually high number of first term Soldier marriages.

Current Army systems lack the capability to provide decision makers with this type of information. Net-centric environment could provide leaders and program/service providers with the predictive analysis to inform proactive planning and mitigation measures. It also would provide integration of heretofore disparate intervention responses to at-risk and/or high risk Soldiers and Families. For

example, a young recently redeployed Soldier who was experiencing marital and financial problems sought help from FAP and AER. He recently enrolled in a Behavioral Health (BH) program as a result of his responses to the Pre-Deployment Health Assessment (PDHA) and is also self-enrolled in the ASAP. If these individual programs and services were integrated, leaders and providers could optimize program/service utilization as part of a holistic intervention plan.

These gaps in information sharing result from flaws in the design and operation of Army data systems that inhibit their ability to generate, collect, report, retrieve and share data. These gaps preclude meaningful and comprehensive analysis of Soldiers' overall risk and health profiles. The obstacles impeding the capability for full situational awareness are discussed in the following section.

CONCLUSIONS

- ★ In order to oversee and manage HP/RR/SP efforts effectively, Army leaders and HP/RR/SP program/service providers need immediate access to relevant, timely, accurate and actionable information regarding individual Soldier behavior and program performance. (page 203)
- ★ Just as the Care Continuum defines HP/RR/SP governance and the *HP/RR/SP Program Portfolio*, it defines data requirements to support programs/services during each phase. (page 203)
- ★ Net-centric environment could provide leaders and HP/RR/SP program/service providers access to information to allow predictive analysis and inform proactive planning and mitigation measures. (page 203)

RECOMMENDED ACTIONS

- ★ [HQDA] Design and implement an *HP/RR/SP Program Portfolio* portal integrating data from all HP/RR/SP programs/services as the interim bridge to the Army's net-centric environment.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 55 – Establishing Data Requirements

3. Obstacles to Information Sharing

The Army's data infrastructure was created to support its current program structure. As discussed in Section VI of this report, "*Program Governance for HP/RR/SP*," that program structure is narrow and functional proponent-based. Just as the program infrastructure creates impediments to effective, enterprise-based governance, the Army's data infrastructure presents obstacles to comprehensive information sharing. These obstacles include design flaws that preclude collection of relevant data as well as problems of data retrieval and sharing, e.g., lack of system interoperability and a variety of misperceptions by data system managers.

a. Data Requirements Definition by Program Managers

Information that could promote HP/RR/SP situational awareness is collected and maintained by many disparate Army organizations. The scope of data collected is often insufficient to meet the HP/RR/SP information requirements of leaders and program/service providers. Data-collecting organizations assemble and report information that serves their narrow programmatic objectives, generally without regard to information requirements across the Army enterprise.

Functional data managers ... are not capturing all data necessary to provide full situational awareness to Army leaders and HP/RR/SP program/service providers. We are not asking the right questions.

For example, CID collects, secures and reports data regarding crimes including drug use in the Automated Criminal Investigative and Intelligence (ACI2) system; ASAP collects, secures and reports data regarding drug use in DAMIS (even if there is no related criminal investigation); and unit commanders collect, secure and report data regarding administrative and disciplinary actions taken for substance abuse on a DA Form 4833. These systems promote the narrow goals of each program standing alone, but do not provide a comprehensive picture of drug abuse in the individual Soldier, in the community or in the programs involved (ASAP and law enforcement).

This gap is further illustrated by the policy regarding administrative separations related to drug abuse. Commanders may report separation actions under AR 635-200 Chapter 14 (misconduct), but the regulation does not have a separate authority to fully scope the reason for separation as alcohol, drug or type of felony misconduct that might be later linked to data from CID, ASAP, FAP, etc. Additionally, current Chapter 14 separation categories are not well integrated with other reporting mechanisms. Similarly, CID reports of investigation (ROIs) also have no policy requiring a code to indicate if illicit drug use stems from prescription abuse or pharmaceutical distribution. These design deficiencies in data collection make it difficult to compare, correlate and analyze rates of either drug-related crimes or administrative separations for drug-related misconduct with ASAP data on referral rates.¹⁴¹

REDEFINING DATA NEEDS: THINKING OUTSIDE THE SILO

Law enforcement personnel are frequently the first to encounter Soldiers or Family members engaging in criminal activity and other high risk behavior. These data systems designed by law enforcement to capture these encounters include Centralized Operations Police Suite (COPS) (with its sub-component, the MP blotter) and Automated Criminal Investigative and Intelligence (ACI2) system. Information in the MP blotter is shared with services/organizations across the installation (e.g., FAP, ASAP and commanders). By policy, the only data required by COPS and ACI2 are data about criminal activity. Entry of data regarding high risk behavior is not recorded in those systems. COPS and ACI2 are designed this way by the functional program manager to meet its needs, without regard to these data needs of non-law enforcement entities. This narrow focus in data collection can impact future investigations and subsequent adjudication.

A juvenile Family member died from domestic abuse, following a series of encounters between the Family and law enforcement which could have led to intervention. MPs were called to the home several times prior to the child's death after receiving reports of crying and suspicious actions by the parents. However, because the MPs did not observe any illegal activity which would require entry of the encounter into COPS, they recorded their observations in an internal MP journal only. As a result, the encounters were not included in the MP blotter report. Unlike the MP blotter, the MP journal is not shared across the installation community. Notice of the encounters would have alerted FAP and Social Work Services (SWS) of the events and possibly triggered intervention.

Vignette 36 – Redefining Data Needs: Thinking Outside the Silo

¹⁴¹ The effects of this disjointed data collection on Army readiness and leadership is discussed in Section III of this report, "The Lost Art of Leadership in Garrison."

This myopic focus in collecting, securing and reporting program-specific data impedes situational awareness. Data need to be visible and accessible to all relevant stakeholders for analysis, not just by specific program proponents and data system managers.

b. Data Not Shared Across the Enterprise

“The only person in the Army who owns data is the Secretary of the Army. Everyone else is a caretaker or maintainer of data.”

-- The Honorable Thomas E. Kelly III, (Former) Deputy Undersecretary of the Army
NIMH Army STARRS Coordination Meeting, 30 March 2009

Quote 25 – DUSA Thomas Kelly, 30 Mar 09

The narrow programmatic focus of data systems causes impediments not only to collection of information, but also its sharing. These impediments include data system design flaws and misperceptions of data “ownership,” including the value of these data to “outsiders,” possible data corruption and the effects of privacy laws on data sharing.

(1) Data System Technical Design Flaws

Many of the databases containing HP/RR/SP information were created with non-interoperable file formats or operating systems. These systems were designed to suit the specific requirements of an individual organization’s program and technical requirements. This insular approach to information architecture frustrates data sharing.

The experience of the Report Team in collecting the information and data used in this report illustrates this problem. These data were not easy to obtain or understand. Data presented in Section III, “*The Lost Art of Leadership in Garrison*” and Section VIII, “*Investigations and Reporting*,” came from several disparate databases and were provided by a small number of individuals with sole control of these data. Although data keepers were willing to share information, the systems were not designed to provide the specific information sought. There were numerous gaps in data identified as a result of poorly constructed policy and processes. Especially notable were data constraints caused by legacy data fields that had not been updated with new codes to match emerging high risk behavior, expansion of pharmaceuticals and implementation of new program/service options. Fulfilling the Report Team’s data requests required manual queries, analyses and program “work-arounds.” Data collection often required multiple pulls for the same query, created an excessive workload and required an inordinate amount of time. Even at HQDA level, these data proved to be cumbersome and unreliable; making the process an inefficient means to gain visibility of HP/RR/SP trends. Finally, individual findings and trends in this report are understated due to recognized gaps in policy, process and databases.

(2) Data System Operator Misperceptions

Functional data managers’ misperceptions regarding data ownership are yet another consequence of the narrow focus of Army programs and their corresponding data systems. Many functional data managers, because they developed and continue to operate their data systems, mistakenly believe the systems are proprietary to their agencies. However, the SecArmy owns these data, not subordinate data stewards. Any perception to the contrary must be eliminated.

Another negative manifestation of this proprietary mindset is that functional data managers either misperceive or fail to recognize the value of the information to users outside of their program; needlessly fear these data will be interpreted incorrectly; or overestimate the scope of legal limitations imposed by privacy laws.



“Data is a strategic asset and must be managed as such. My goal is to create and support a net-enabled environment that gives decision makers access to authoritative data in a timely and secure manner.”

—Honorable John McHugh, Secretary of the Army
Army Directive 2009-03, Army Data Management, 30 October 2009

Quote 26 – SecArmy John McHugh, 30 Oct 09

(a) Failure to Recognize the Value of Data Across the Enterprise

Functional data managers, because they are often focused on their own agency’s requirements, frequently lack awareness of the value of their data to other potential data users. They may not necessarily collect, store, secure or retrieve data with other users in mind. This problem may carry over to data sharing, manifesting as a misperception that others do not really need these data. This perception must be overcome and a new climate instilled in which data sharing across the enterprise, to the extent permitted by law, becomes the norm rather than the exception. For example, the value of an AR 15-6 report to inform trend analysis of unit discipline may not be apparent to individual unit commanders. A given report may be stored only in paper format in the unit’s files and not accessible to the installation command. This diminishes situational awareness because there is no visibility of the events captured by the investigation. Another side effect of this perception is that many data managers are concerned that their information may be taken out of context, aggregated inaccurately with other information or interpreted differently from the program manager’s interpretation.

(b) Perceived Legal Limitations

Functional data managers also frequently misunderstand the effect of privacy laws on data sharing. Privacy laws place constraints upon the sharing and retrieval of personal, financial and medical information. However, there appears to be confusion in the field as to the scope of these laws and the limitations they impose. The “lore” (as compared to the “law”) about privacy protections is that these laws act as complete barriers to information sharing, when in fact the laws contain exceptions that permit sharing, especially in the HP/RR/SP context. For example, a commander may be reluctant to ask a medical treatment facility (MTF) to provide information about a Soldier in apparent distress, due to perceptions of privacy constraints. Likewise, the MTF may be reluctant to disclose allowable medical information to the commander that may be vital in recognizing the Soldier’s distress and providing appropriate support and intervention.

The Health Insurance Portability and Accountability Act (HIPAA) and Privacy Act are the main legal authorities in this area. HIPAA applies principally to medical records. The Privacy Act applies to all federally maintained records as described below.

HIPAA

HIPAA is a set of laws and regulations designed to protect privacy of patients' protected health information (PHI). HIPAA's general rule on PHI is that it can only be released with the patient's authorization; however, HIPAA also contains exceptions applicable to military personnel.¹⁴² The scope of HIPAA's privacy protections appear to be overestimated by commanders and HP/RR/SP program/service providers. This misunderstanding of the purpose and intent of the law impedes information sharing.

Commanders are entitled to certain information, but may not be entitled to the entire medical record. Examples of information that commanders may access under exceptions to the privacy laws include (1) DoD drug testing results; (2) Medical readiness and fitness for deployability (e.g., immunization status, temporary or permanent profile status, medical board related data, allergies, blood type, flight status); (3) Changes in duty status due to medical conditions (e.g., appointments and hospitalization); (4) Medical Line of Duty investigation determinations; (5) Army Weight Control Program documentation; (6) Medical conditions or treatments that are duty limiting to include medication side-effects that may impact duty performance, such as drowsiness, altered alertness or slowed cognition (providers are not required to state the medication prescribed or the underlying diagnosis); (7) Any perceived threat to life or health (suicidal behavior, homicidal behavior, acute agitation, impaired impulse control or other violent action); and (8) Appointment "no show" information when it affects continuity of healthcare.

The reality of the law is that exceptions to HIPAA allow release of relevant PHI to commanders without the Soldier's consent.¹⁴³ For example, under HIPAA's health risk exception, PHI may be released to the commander if a treatment provider determines the Soldier is a danger to themselves or others. Under the medical fitness exception, PHI can be disclosed when a Soldier's fitness for duty may be affected. Under this exception, commanders should be notified when there is a change in duty status resulting from hospitalization or as a result of medical treatment (e.g., chemotherapy, surgery, etc.). Commanders should also be notified when a medical condition (or the treatment for that condition) could alter the mental or physical performance (readiness) of the Soldier. For example, commanders should be notified when a M1 Tank crew member participating in "gunnery" has been prescribed narcotic pain medication that might limit his ability to perform his duties, or when a Soldier has been diagnosed with a behavioral health condition that would alter his/her ability to perform duties (e.g., severe depression or anxiety). In these situations, the healthcare provider has a duty to notify the unit of the limitation of duty status.¹⁴⁴

It is equally important for HP/RR/SP program/service providers (FAP, ASAP, BH, etc.) to understand the provisions under HIPAA for allowing access to PHI of Soldiers who are under their care. The HIPAA provisions for PHI do not preclude providers from accessing records generated by other service providers. It is vital that all program/service providers understand the diagnosis, treatment and medications that may impact all other areas of treatment. For example, a Soldier who has been enrolled in FAP for anger management treatment may have been previously diagnosed with a TBI (which can cause mood swings and aggressive behavior). In this case, the FAP counselor should understand the TBI

¹⁴² HIPAA's military exceptions do not apply to PHI of non-military Family members.

¹⁴³ This exception applies even if the treatment provider is a non-military source.

¹⁴⁴ For a full listing of the military exceptions to HIPAA, see DoD 6025.18-R, *DoD Health Information Privacy Regulation*, January 24, 2003.

treatment plan in order to collaborate with the TBI providers to develop a synchronized and holistic treatment plan. This has implications for both the training of care providers as well as the systems to allow appropriate access to those individuals.

These exceptions to HIPAA encompass much of these data that commanders and HP/RR/SP program/service providers may require to identify high risk behavior, provide appropriate intervention and synchronize care. There are non-medical data which do not fall under the protection of HIPAA, but have other legal provisions which preclude release. While HIPAA protects PHI, the Privacy Act protects personally identifiable information (PII) from unauthorized disclosure.

Privacy Act

The Privacy Act governs collection, maintenance, use and dissemination of PII about individuals that are maintained in systems of records by federal agencies. The Privacy Act generally bars agency disclosure of PII without the individual’s consent unless one of twelve exceptions applies. Five of those exceptions commonly occur in the military setting –

- “Need to know,” – an agency employee needs to use the PII when performing his/her duties;
- “Routine use,” – a use has been published in the Federal Register, compatible with the purpose for which the information was collected;
- “Law enforcement,” – the disclosure is to a law enforcement agency;
- “Public safety,” – the disclosure is made where there are compelling circumstances affecting someone’s health or safety, and that person is notified; and
- “Research,” – for statistical research or reporting and the record is transferred without individually identifying data.¹⁴⁵

In short, privacy laws are not as limiting as often believed and create misperceptions that impede information sharing. Familiarity by commanders and program/service providers with HIPAA and Privacy Act exceptions will improve communication and coordination. It is appropriate for program/service providers to inform commanders on the status, wellbeing and treatment of their Soldiers. “Need to know” provisions of these laws are intended to allow commanders to monitor and understand the readiness implications of medical and other program/service participation, facilitate leadership support of those programs and help Soldiers quickly return to full duty status.

CONCLUSIONS

- ★ The Army’s data infrastructure was created to support its current program structure. Just as the program infrastructure creates impediments to effective, enterprise-based governance, the Army’s data infrastructure presents obstacles to comprehensive information sharing. (page 204)

(Continued)

¹⁴⁵ The seven other exceptions are when the disclosure is made: (1) under the Freedom of Information Act; (2) to the Census Bureau for the purposes of a census survey; (3) to the National Archives and Records Administration as a record of historical value; (4) to Congress, or any committee or subcommittee within Congress; (5) to the Comptroller General in the course of the duties of the General Accounting Office; and (6) pursuant to a court order; or (7) the disclosure is made to a consumer reporting agency in accordance with 31 U.S.C. Section 3711(e).

- ★ The scope of data collected is often insufficient to meet the HP/RR/SP information requirements of leaders and HP/RR/SP program/service providers. Data-collecting organizations assemble and report information that serves their narrow programmatic objectives, generally without regard to information requirements across the Army Enterprise. (page 204)
- ★ Existing Army data systems are designed to restrict data access to a small number of gatekeepers, a characteristic which impedes efficient information sharing. (page 204)
- ★ The narrow programmatic focus of data systems causes impediments not only to collection of information, but also to its sharing. Impediments include data system design flaws and misperceptions of data “ownership,” including the value of these data to “outsiders,” possible data corruption and the effects of privacy laws on data sharing. (page 206)
- ★ Functional data managers often lack awareness of the value of their data to other potential data users. (page 207)
- ★ Army functional data managers, commanders and program/service providers frequently misunderstand the extent of privacy laws and the exceptions to those laws, causing unnecessary restriction of information flow. (page 207)

RECOMMENDED ACTIONS

- ★ [HQDA] Update policy reflecting the requirement to share existing data and design interoperability into new data systems consistent with DoD net-centric data sharing policies.
- ★ [HQDA] Update and implement policy and training to clarify the intent as well as legitimate exceptions to information sharing limitations of both the Privacy Act and HIPAA.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 56 – Obstacles to Information Sharing

4. Solutions to Promote Situational Awareness

Information sharing solutions must address systemic design and accessibility obstacles and support the proposed transformation of HP/RR/SP governance. The transformation of Army data systems is underway; however, the implementation of this enduring solution will take time – time that the Army does not have when addressing HP/RR/SP. Consequently, an interim solution for leader and HP/RR/SP program/service provider situational awareness is urgently required.

a. Enduring Solution – Army Net-Centric Data Strategy

The Army’s Chief Information Officer has established the Army Data Board to implement the ANCDs and develop an enterprise-level net-centric data strategy that will move towards data management solutions to improve information gathering and sharing.¹⁴⁶ In the future, the implementation of net-centric data concepts will alleviate current impediments and deliver the power of visible and accessible information, ensuring mission success.

¹⁴⁶ A full discussion of the plan appears in the “Initial Army Data Transformation Plan,” Office of the Army Chief Information Officer, May 2010.

The goal of the ANCDs is to improve situational awareness through application of net-centric concepts, technologies and standards, institutionalized in a governance and technical framework, to enable net-centric data assets that are visible, accessible, understandable, trusted and interoperable to all users. Federated, enterprise-wide information sharing will be enabled resulting in increased flexibility and data sharing. It also enables the pulling of data from multiple authoritative sources to achieve Army-wide solutions. Enterprise-wide data migration planning is part of the integrated architecture processes to increase data quality and trusted data assets through reduction in redundant sources. The interim solutions proposed in the next section are intended to support HP/RR/SP until the net-centric capability is fully realized.

b. Interim Solutions

Until the enduring ANCDs environment is fully developed, two interim solutions provide leaders and program managers with means to utilize the information currently available: portals and dashboards.

(1) Portals

Portals are web pages with links to other sites, all related to a unifying core topic, and provide the beginning step for aggregating and sharing data organized along the Care Continuum. For example, the Law Enforcement Advisory Portal (LEAP) (Figure 66) centralizes otherwise dispersed data for the law enforcement community. This portal, when fully developed and implemented, will promote situational awareness from top to bottom and end to end across the Care Continuum.

In the HP/RR/SP context, functional data portals provide leaders and program/service providers an authoritative source of information about their Soldiers. Portals aggregate databases that share critical data based on pre-approved alerts or notifications (“red flags”). The alerts can help commanders stay apprised by flagging Soldiers who are engaging in risky behavior or are in need of assistance.

For example, the LEAP prototype shows how a portal may serve as a data clearinghouse for providing functional information (in this case, law enforcement-related data) to commanders and law enforcement. When implemented, LEAP will provide the Army with aggregated information, portions of which can be accessed by commanders via a risk management dashboard (discussed below). From this portal (and underlying single source databases), criminal intelligence teams can provide a commander with a comprehensive data set for predictive analysis for an individual Soldier or group of Soldiers within the unit. LEAP does this by aggregating law enforcement data typically warehoused in “silos” Army databases (e.g., COPS, ACI2). The portal shares cases with the DoD Law Enforcement Defense Data Exchange system (D-DEX) and civilian partner



Figure 66 – Law Enforcement Advisory Portal

law enforcement agencies. It can receive data from outside DoD to encompass local, state and federal information for regional incidents and captures information on Soldiers who are on leave or in transition between PCS moves. The functional portal/commander data conduit model provided by LEAP could also be exported to functional areas such as medical and community services.

(2) Dashboards

A dashboard is a snapshot of key information summarized on a single web page that delivers actionable knowledge to leaders and program/service providers. Dashboards can be customized for the user's community and to allow for specific information requirements. Dashboards display aggregated data, monitor trends and track metrics so leaders can take appropriate action. In the case of an HP/RR/SP dashboard (Figure 67) the picture provided by the aggregated data would assist leaders in identifying individual or group high risk behavior and intervening as required.

(a) Content

A commanders' HP/RR/SP dashboard provides timely, actionable knowledge of the overall health and risk factors affecting the command. Law enforcement, medical and community service data are pushed to the dashboard, updating information regarding previously defined HP/RR/SP metrics. It graphically displays information on key events that can help to identify Soldiers who may be engaging in high risk behavior. Further, the dashboard permits oversight of actions taken to mitigate that risk as well as detection and analysis of help seeking or risk-taking trends.



Figure 67 – Commander's Risk Reduction Dashboard

IX

Figure 67 shows a notional commander's dashboard. It consists of "gauges" that reflect risk indicators as well as utilization of services designed to reduce risk. Additionally, it displays an overall trend-picture along with the identity of Soldiers who have met some threshold for inclusion in the "High Risk Profiles" section. It can be tailored to display information based on the commander's requirements so they can be aware of changes in trends or serious incidents.

The overall intent of the dashboard is to integrate existing data in a timely manner so commanders have greater visibility, consistent awareness and improved responsiveness in light of changing risk. It provides commanders a view of their population to monitor overall health and provides alerts to allow for rapid intervention when a Soldier moves from the pre-event stage to the inter-event stage. In turn, this informs commanders on appropriate response along the Care Continuum (assess, educate/train, intervene, treat).

(b) Continuity

Another dashboard benefit is that it provides continuity of information on Soldiers during leader transitions. A commander may have personal knowledge that a Soldier has previously demonstrated high risk behavior (e.g., relationship stressors, history of alcohol misuse or minor misconduct). The dashboard would provide visibility for at-risk behavior that has not crossed the threshold into mandatory intervention (i.e., self-referral to FAP, LE encounters, etc.). This information may be lost when the commander departs, since there is no comprehensive data system to provide the subsequent commander with the same visibility. The dashboard would provide an enduring means of transferring that visibility to the new commander in a trustworthy, accessible, understandable and institutionalized manner.

The same considerations apply to Soldiers going through transitions. A Soldier who has a history of behavioral health treatment and is taking antidepressant medication, and requires ongoing treatment at his new duty station, could be instantly identified by a gaining unit's commander via a dashboard. The dashboard would enable the gaining commander to ensure the Soldier receives the continuity of care promptly upon arrival at the new unit. The commander would have the situational awareness required to ensure the wellbeing of the Soldier.

(c) Transparency and Accountability

At each echelon, dashboards present data in a standardized format to reduce error resulting from manual "data pulls" and standardize analysis. These standardized data could be viewed at all levels of command to quickly inform leadership of data trends and risk factors affecting Soldiers, units and installations. For example, while an individual commander might use the dashboard to monitor HP/RR/SP risk factors of the unit, the garrison commander would look at these same data in aggregate to monitor larger trends across the entire installation.

This type of visibility would drive accountability for both data accuracy and timely action. Data accuracy would be improved because everyone involved with data input and management understands that others are relying on these data to make informed decisions; thus, they are being held accountable for the validity of these data. Command decision/action would improve because leaders are getting these data sooner with the expectation that appropriate action will be taken. This would be true at all levels – from unit to HQDA.

(d) Dashboards at Higher Levels of Leadership

The HP/RR/SP dashboard, managed as a portfolio of programs, could be modified to integrate additional data sets as needed based on new stressor information, trends on risk-taking behaviors or change in policy. As information about risk and HP/RR/SP program/services is fed to the HQDA level, the cross/core enterprise HP/RR/SP leadership could use this information to make determinations regarding program utilization and the overall health and wellbeing of the force (e.g., ARPERGEN and ARFORGEN forums). As research informs risk and protective factors, changes can be made to the dashboard to replace antiquated data sets that no longer represent the evolving high risk population. For example, if a prescription medication is identified as having a high potential for addiction and abuse, HQDA could add a metric to track the number of prescriptions and the percentage of the force using the medication. This would allow leaders and HP/RR/SP program/service providers to see changes in use, potential abuse and possible distribution.

CONCLUSIONS

- ★ Information sharing solutions must address systemic design and accessibility obstacles to support the proposed transformation of HP/RR/SP governance. (page 210)
- ★ The goal of the ANCDs is to improve situational awareness through application of net-centric concepts, technologies and standards, institutionalized in a governance and technical framework, to enable net-centric data assets that are visible, accessible, understandable, trusted and interoperable to all users. (page 211)
- ★ Federated, enterprise-wide information sharing will be enabled resulting in increased flexibility and data sharing. ANCDs also enables the pulling of data from multiple authoritative sources to achieve Army-wide solutions. (page 211)
- ★ Until the ANCDs environment is fully developed, portals and dashboards could provide leaders and HP/RR/SP program/service managers with a means to utilize the available data to make informed decisions. (page 211)
- ★ In an HP/RR/SP context, data portals provide leaders and HP/RR/SP program/service providers an authoritative source of information about Soldiers. (page 211)
- ★ A commanders' HP/RR/SP dashboard could provide timely, actionable knowledge of the overall health and risk factors affecting the command. The dashboard would permit oversight of actions taken to mitigate that risk as well as detection and analysis of help-seeking or risk-taking trends. (page 212)
- ★ The HP/RR/SP dashboard could be used to promote accountability by tracking resulting/corrective actions taken by commanders. (page 213)

RECOMMENDED ACTIONS

- ★ [HQDA] Continue implementation of the Army's Net-Centric Data Strategy.
- ★ [HQDA] Develop HP/RR/SP portals that aggregate databases to share critical data and create alerts or notifications ("red flags") based on predefined metrics.
- ★ [HQDA] Develop and use HP/RR/SP dashboards for commanders and HP/RR/SP program/service providers to ensure timely and actionable knowledge of the health and accountability of their Soldiers.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 57 – Promoting Situational Awareness

5. Summary

“Lowering the suicide rate will require a multi-disciplinary approach, breaking down each profession's individual silo and going at it as a team approach.”

– *General Pete Chiarelli, Vice Chief of Staff, Army
Bloggers Roundtable, March 2009*

Quote 27 – GEN Pete Chiarelli, Mar 09

Leaders and managers cannot improve what cannot be seen. The effective promotion of Army HP/RR/SP goals and the maintenance of good order and discipline are linked to providing situational awareness of our leaders and managers. Providing accurate, timely, relevant and actionable information is critical at each level of governance.

Current Army information systems are not capable of this task. Existing data systems have been created to serve narrow functional needs. In many cases, data systems do not collect the required information and are not designed for interoperability. Further compounding the problem is misperceptions regarding data ownership – many proponents believe they have proprietary ownership of the information despite clear guidance that the Secretary of the Army is the sole data owner.

Misconceptions about the restrictive nature of data privacy laws, including HIPAA and the Privacy Act, further complicate data sharing efforts. Although both laws contain exceptions that apply to the military, many people contend the laws preclude data transfer.

As the Army transforms from an environment of information silos to a holistic data network, interim bridging mechanisms (portals and dashboards) should be utilized to immediately inform leaders and program/service providers. Portals and dashboards provide transparency and actionable knowledge for commanders and program/service providers to ensure the wellbeing of our Soldiers and Families. They should provide a holistic view of HP/RR/SP risk and protective factors affecting the Soldier and unit from every level of command.

Next: HP/RR/SP Research

X –HP/RR/SP RESEARCH GOVERNANCE AND CURRENT/FUTURE RESEARCH



“Unfortunately, research on the mechanisms through which military service influence suicide risk one way or the other is sparse.”

–Dr. Thomas E. Joiner Jr.
Clinical Psychology Review, April 2010

Quote 28 – Dr. Thomas Joiner, Apr 10

1. Introduction

This report details the broad scope of the Army’s actions since 2008 to combat its rising rate of suicide. Actions taken as part of the Campaign Plan, together with the sweeping recommendations in this report, will transform the way the Army provides HP/RR/SP programs and services (e.g., the Army’s Substance Abuse Program, Family Advocacy Program, behavioral health screening and treatment, etc.). This final section discusses the complexity of Army research related to HP/RR/SP and recommends an *HP/RR/SP Research Governance Model* to provide better visibility, coordination/synchronization and transition of these efforts. This section introduces the *HP/RR/SP Research Governance Model* based upon the holistic and business-oriented precepts of the proposed Army enterprise.¹⁴⁷ The governance model provides a framework to ensure that the Army’s HP/RR/SP research focus is where it needs to be – on promoting the health and readiness of our Soldiers and Families.

For the purpose of this report, any reference to “research” implies HP/RR/SP related research and includes, but is not limited to, the following: primary (basic science), applied (translational), clinical, epidemiological, as well as studies, surveys and program evaluation. This covers the spectrum from discovery science all the way to transition of the findings to end users. It includes research performed by both internal sources (ARL, ARI, CHPPM, MRMC, etc.) and external sources (NIMH, DARPA, RAND, VA, academia, etc.).¹⁴⁸ This includes medical and non-medical research conducted at the behest of the Army to advance the *HP/RR/SP Program Portfolio*. This report fully recognizes the body of statutes, regulations and authorities governing the breadth of DoD research. It is not intended to undermine this existing body of authority but rather to introduce and recommend complementary governance and processes to improve visibility, coordination/synchronization and transition of research in support of the *HP/RR/SP Program Portfolio*.

¹⁴⁷ Readers unfamiliar with the Army enterprise and associated synchronization forums are referred to the “Review of Army Enterprise-Based Proposals for Business Transformation” on page 134, in Section VI, “*Program Governance for HP/RR/SP.*”

¹⁴⁸ Army Research Laboratory (ARL); Army Research Institute for the Behavioral and Social Sciences (ARI); Center for Health Promotion and Preventive Medicine; Medical Research and Materiel Command (MRMC); National Institute of Mental Health (NIMH); Defense Advanced Research Projects Agency (DARPA); RAND Corp. (RAND); and the U.S. Department of Veterans Affairs (VA).

Due to the broad and complex nature of the *HP/RR/SP Program Portfolio*, research must be conducted across a research spectrum (from discovery to transition) and among a diverse set of organizations. Similar to issues addressed in the portfolio of HP/RR/SP programs, a lack of HQDA governance reduces visibility, coordination/synchronization and transition leading to silo'ed efforts, resulting in research gaps and redundancies. With respect to the proposed *HP/RR/SP Research Governance Model*, the following will apply:

What the proposed HP/RR/SP Research Governance Model does –

- Provides visibility (situational awareness) of other related HP/RR/SP research to senior Army leaders such as HP/RR/SP program/service proponents, etc.;
- Provides a mechanism for the Army to prioritize HP/RR/SP research;
- Provides an Army-level forum for the exchange of information among research communities;
- Maintains a centralized repository (knowledge management) of research/results related to the *HP/RR/SP Research Portfolio*; and
- Ensures transition of research findings for operational implementation by HP/RR/SP program/service proponents.

What the proposed HP/RR/SP Research Governance Model does not do –

- Create additional layers for research approval;
- Take flexibility away from program managers and researchers;
- Stifle entrepreneurial research initiatives; and
- Mandate a standard research process across various research disciplines (e.g., medical vs. non-medical).

a. Visibility of Research

Understanding the totality of HP/RR/SP research requires unity of effort between the Army, DoD and external agencies. Currently, leaders do not have full visibility of HP/RR/SP related research. As a result, HQDA does not know the totality of research that is needed, planned, ongoing or completed; who is conducting research; the point of the research (i.e., expected results); the amount of resources expended (facilities, manpower and funding), the source of funding, or the expected return on investment; and how the research can be implemented.

There is no question that, with the leadership of Congress, the Army has dedicated significant resources (time, money and effort) to better understand and provide for HP/RR/SP related needs. In the zeal to rapidly respond to the increased rise in suicide and high risk behavior, well intentioned but independent actions have sometimes produced uncoordinated, unsynchronized and undisclosed results. As the number of projects expanded at numerous locations, funded by internal and external sources, the Army has had difficulty maintaining visibility across the spectrum of these projects, exchanging research information and transitioning/ generalizing results. This is particularly true of HP/RR/SP research that spent millions of dollars to initiate potentially valuable efforts, but conducted some research efforts independently, eliminating the benefit derived through leveraging and visibility. This research has at times lacked defined needs/opportunities, targeted customers (or additional customers who also may benefit), an ability to assess results of all the disparate activities and/or uniform implementation strategies. A general lack of visibility of these research projects stems, in part, from a

variety of uncoordinated funding sources. For example, HP/RR/SP research funding comes from a number of sources including:

- Army Research and Development (R&D) as part of the Army Program Objective Memorandum (POM)/Budget Estimate Submission (BES) process;
- Defense Health Program (DHP) as part of the DoD POM/BES process;
- Congressionally Directed Medical Research Program (CDMRP);¹⁴⁹
- Federal extramural sources (e.g. National Institutes of Health); and
- Private extramural sources (e.g. Fisher Foundation, Bill and Melinda Gates Foundation, etc).

These sources fund a large proportion of research within the Army. The Army has visibility over all appropriated R&D funds, but visibility is reduced with DHP and Congressional funds that may bypass HQDA oversight. This process is complicated by the fact that funding is allocated by and through a variety of different organizations. For instance, extramural funding typically bypasses the Army agencies that provide coordination and oversight of Army research priorities. This lack of situational awareness, coordination and synchronization of funding sources/paths degrades Army management and implementation of HP/RR/SP research efforts.

Without full awareness of currently funded research projects, it is virtually impossible to know fully when results are available, how to analyze those results and who may benefit from those results. This creates a series of problems with requirements validation, funding and implementation. Proponents that might be able to implement research results are not aware of the research, let alone the findings, and therefore have unmet program needs. Army senior leaders who fund internal research are not aware of other research findings and may fund similar research. This leads to duplicative and repetitive efforts (i.e., research in parallel or in sequence) potentially wasting valuable resources. Conversely, without visibility of sources, allocation and distribution, it is difficult to align emerging needs and opportunities with appropriate funding sources.

This lack of visibility of the front end funding and the back end results is a byproduct of the central lack of coordination. A standard centralized process is required to enable coordination and synchronization of programmed research. This lack of coordination is problematic in a couple of ways: (1) it obfuscates downstream programmatic efforts to provide transitional partnering and implementation, and (2) it dampens the Army's ability to provide funding for emerging needs and opportunities. Fulfilling both issues would enhance research coordination and synchronization, while ensuring continuous process improvement (CPI). Achieving CPI is critical to terminate unsuccessful research as well as sustaining successful research modification, transition and implementation.

b. Coordination and Synchronization of Army Research

With a lack of visibility of research funding and ongoing research, it logically follows that there is an identifiable lack of research coordination and synchronization. While the Army is good at coordinating internal funding, it is less adroit at coordinating external research from disparate funding sources and requirements. There is no Army-wide synchronization process for the proliferation of external/internal HP/RR/SP research. HP/RR/SP research needs can be generated ad-hoc and in isolation of Army

¹⁴⁹ The CDMRP is a research directorate within the Army Medical Research and Materiel Command (MRMC) that manages legislatively mandated, militarily relevant medical research. The CDMRP is a substantial program; from its establishment in 1993 through FY 2009 the CDMRP has managed \$5.4 billion in targeted appropriations.

operational requirements. Consequently, independent well-intentioned research projects are initiated for various reasons including funding opportunities/restrictions, Congressional mandates, leadership directives, operational needs, etc.¹⁵⁰ For example, a researcher at an Army medical center can receive a grant directly from the Substance Abuse Mental Health Services Administration (SAMHSA) to conduct research on prescription opiate abuse with little or no involvement from the Office of the Surgeon General (OTSG) or Medical Research and Materiel Command (MRMC) program managers (PMs). In this example, research may be both duplicative of ongoing efforts and divert Army resources (manpower and facilities) from more urgent research needs.

This lack of coordination and synchronization leads to the potential for disparate efforts that result in parallel and redundant research or gaps between topics. Currently, Army HP/RR/SP research efforts are silo'ed within their respective agencies; mirroring the current state of programs described in the *HP/RR/SP Program Governance* section of this report. In the aforementioned example, the lack of visibility of this external funding could allow multiple studies on similar opiate abuse topics across the Army, while other HP/RR/SP research needs remain unaddressed. Moreover, because each funding source can have different reporting requirements, the Army may not have visibility of the results. For instance, the medical center researcher in this example may report research findings primarily to SAMHSA, even though the work is done by the Army. In another spin on this example, the research results may be implemented locally as part of a home grown HP/RR/SP program/service, rather than being coordinated with other Army research for potential Army-wide application.

Even with improved policy and process, coordination and synchronization requires a methodology to reduce gaps and redundancy in research efforts. HP/RR/SP related research must address the full spectrum of Soldier behavior, injury and illness to align research needs (behavior, injury and illness) and research funding/efforts. This methodology should parallel the *HP/RR/SP Program Portfolio* to synchronize research with HP/RR/SP programs/services and customer needs. In line with HP/RR/SP governance and portfolio management, the Care Continuum provides the framework to direct research coordination and synchronization (See Figure 68).

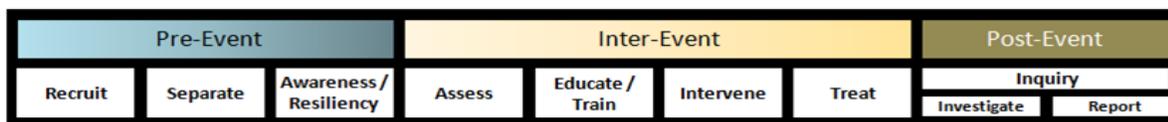


Figure 68 – Aligning HP/RR/SP Related Research Efforts Along the Care Continuum

Use of the Care Continuum will facilitate research equity across the Soldier/Family Event Cycle (pre-event, inter-event, post-event) and the institution's response (from recruit to inquiry); covering both the risk factors and the mitigation efforts related to the event. A comprehensive portfolio should include, for example, social, environmental, medical, quality of life/wellness and behavioral health research that will inform HP/RR/SP policy, processes, structure and programs. The Report Team's efforts to identify the potential *HP/RR/SP Research Portfolio* indicates that research may not be balanced. This imbalance can be attributed to the current focus, which is almost exclusively aligned with the "Treat" phase of the

¹⁵⁰ Army leaders have recognized the issues with the current research governance structure and directed MRMC to serve as the interim integrator for all health promotion, risk reduction and suicide prevention research. As a result, MRMC created the DoD Suicide Prevention Research Program (SPRP) Working Group. The purpose of this working group is to assist in the management of the DoD integrated suicide prevention research programs and assist in research recommendations.

Care Continuum potentially at the expense of other phases (i.e., recruit, assess or resiliency).¹⁵¹ This means we may not be advancing our knowledge in identification or prevention of HP/RR/SP related issues. To create a balanced portfolio, research initiatives should be aligned across the Care Continuum to ensure all aspects of HP/RR/SP are adequately addressed. It is important to note, however, a balanced portfolio does not imply that there should be a common number of research programs or funds allocated to each phase of the Care Continuum. Also, this balance may change over time based on customer needs and research opportunities.

Just as the *HP/RR/SP Program Portfolio* requires an integrated governance model to provide efficient and effective program/service delivery (page 162), the *HP/RR/SP Research Portfolio* also requires an integrated governance model to ensure effective and efficient research. To achieve this, the Army must identify stewardship for HP/RR/SP research. This stewardship would be responsible for looking across the current Army research community and coordinating relevant research into a comprehensive and balanced *HP/RR/SP Research Portfolio*.

c. Implementation of Army Research

The purpose of HP/RR/SP research is to promote readiness and improve the lives of Soldiers and Families through better programs and services. In order for research to meet these goals, results must be provided to the appropriate proponent in a clear, concise and actionable manner. This objective is not always achieved due to a lack of communication between researchers and proponents. Researchers don't always know all of the proponents who need the information/capability. Proponents often don't have visibility over research being conducted that may improve their programs/services. Additionally, once the research is complete, the proponent has to recognize the utility in the findings and agree that change is needed to improve program/service performance and delivery. Finally, Army level budgeting processes must be able to rapidly accommodate newly identified needs derived from research results.

Implementation of research results also requires coordination among Army proponents, industry and Congressional constituents to inform research funding, execution, transition and implementation. Coordination with Congressional constituents will improve alignment of Congressional funding and direction with Army operational needs. Likewise, enhanced collaboration with industry will improve alignment of independent research with Army operational needs. For example, such collaboration would reduce gaps between operational needs identified by combat developers and independent research results. In this example, combat developers may coordinate with industry on the effects of blasts/roll-overs on injury/survivability in platform design. To this end, the Army Capabilities Integration Center (ARCIC) and ASA (ALT) are currently working with Congressional constituents and industry to conduct semiannual collaborative research forums.

As indicated above, research does not always provide optimal support for HP/RR/SP objectives. Many times it is not integrated with Army operational needs, synchronized with other research, nor coordinated with proponents for implementation. Currently, senior Army leaders have limited visibility of research findings and no standard forum/process of communicating strategic research objectives to researchers. Just as there is a need for a cross enterprise forum that governs the *HP/RR/SP Program Portfolio*, there is a compelling need for a coordinating body that can provide oversight of all HP/RR/SP research efforts to ensure maximum efficacy and implementation.

¹⁵¹ The number of research programs aligned with the "treat" aspect of the Care Continuum may be over represented because MRMC was one of the few organizations that could produce a list of HP/RR/SP related research.

Portfolio management addresses these synchronization issues because it aligns research needs/opportunities, execution and implementation to ensure that results are relevant, coordinated and can be applied to support Army goals. The balanced *HP/RR/SP Research Portfolio* will ensure research appropriately addresses all phases of the Care Continuum. Further, it provides top to bottom and end to end visibility of research progress to Army leaders at all levels – from garrison to Army senior leaders.

2. Transformation of Research Governance, Structure and Process

The proposed governance model for transforming research governance applies the same paradigm used to transform HP/RR/SP program governance based upon proposed Army enterprise-based precepts. The proposed Research Synchronization Forum will provide oversight and inform senior Army leadership on research portfolios that support Army-wide research efforts. This governance model will ensure that all HP/RR/SP research (external/internal) conducted in support of the Army is visible, coordinated/ synchronized, transitional and implemented as relevant results/products. It will provide standardized methodology for senior leader oversight, a centralized research repository and effective liaison mechanisms between the Army and its external partners including, DoD/other Services, Federal agencies, industry and Congressional constituents.

Although this report focuses on HP/RR/SP, its findings with respect to research governance and portfolio management structure and processes are generally applicable to all Army research. Recommendations regarding research governance, therefore, are not restricted to HP/RR/SP. The *HP/RR/SP Research Portfolio* is ideally wedded with the proposed Army-level research governance as described herein. Accordingly, the *HP/RR/SP Research Governance Model* described in this section should be implemented for HP/RR/SP research and evaluated for its potential to govern all Army research.

a. Transforming Army HP/RR/SP Research Governance

HP/RR/SP research performed within or at the behest of the Army needs to be coordinated/ synchronized as a portfolio in a similar manner to the *HP/RR/SP Program Portfolio*. All research and results should be visible to a central research entity. In the *HP/RR/SP Program Portfolio* context, this function will be performed by the proposed ARPERGEN Synchronization Forum; in the research context, this function will be conducted by a Research Synchronization Forum (RSF).¹⁵² This new forum would ensure enterprise-wide coordination (e.g., among research agencies, researchers, etc.), maximize efficiency and deliver effective results to both senior leaders and program/service providers.

The operation of the *HP/RR/SP Research Governance Model*, from HQDA to researcher level, hinges on a Chief Science Officer (CSO) role (as depicted in Figure 69). The CSO would provide oversight for the *HP/RR/SP Research Portfolio* and other related Army research to ensure research visibility, coordination/synchronization, transition and implementation across the enterprise. The HP/RR/SP Deputy Science Officer (DSO) would be responsible for coordinating the *HP/RR/SP Research Portfolio*, identifying gaps and redundancies, reporting findings to the CSO, and recommending changes in

¹⁵² Discussed in Section IV of this report, “*The Composite Life Cycle*,” ARPERGEN refers to the Army Personnel Generation model and takes into account transitions and stressors associated with Army Life. The ARPERGEN Synchronization Forum ensures HP/RR/SP programs and services are synchronized and coordinated across the Army. (pages 178-179)

HP/RR/SP research priorities. The figure illustrates the requirement for the notional AME and CSO to have visibility of all sources of funding, the forums that will provide synchronization (Army Health Promotion Council (AHPC) and RSF) and the structure that provides enterprise research integration (HP/RR/SP DSO and Research Program Managers (PM)).

The Undersecretary of the Army, in his role as Chief Management Officer (CMO), informs Army research priorities from the HQDA enterprise level. As the CSO provides research results and progress to the senior Army leadership, feedback for priorities regarding future research is relayed back to the CSO. This exchange ensures that senior leaders are aware of Army research scope and progress, and that the CSO understands the vision and direction set by senior Army leadership. In terms of the *HP/RR/SP Research Portfolio*, the Secretariat and ARSTAF principals act as the CMO’s designees and execute governance responsibilities. These principals are informed in their roles by both the AHPC (via the DSO) and the RSF (via the CSO). This provides the principals both functional (AHPC) and technical (RSF) perspectives in setting HP/RR/SP research priorities. Although this requires additional coordination forums, they are essential to providing visibility of Army research to its leaders.

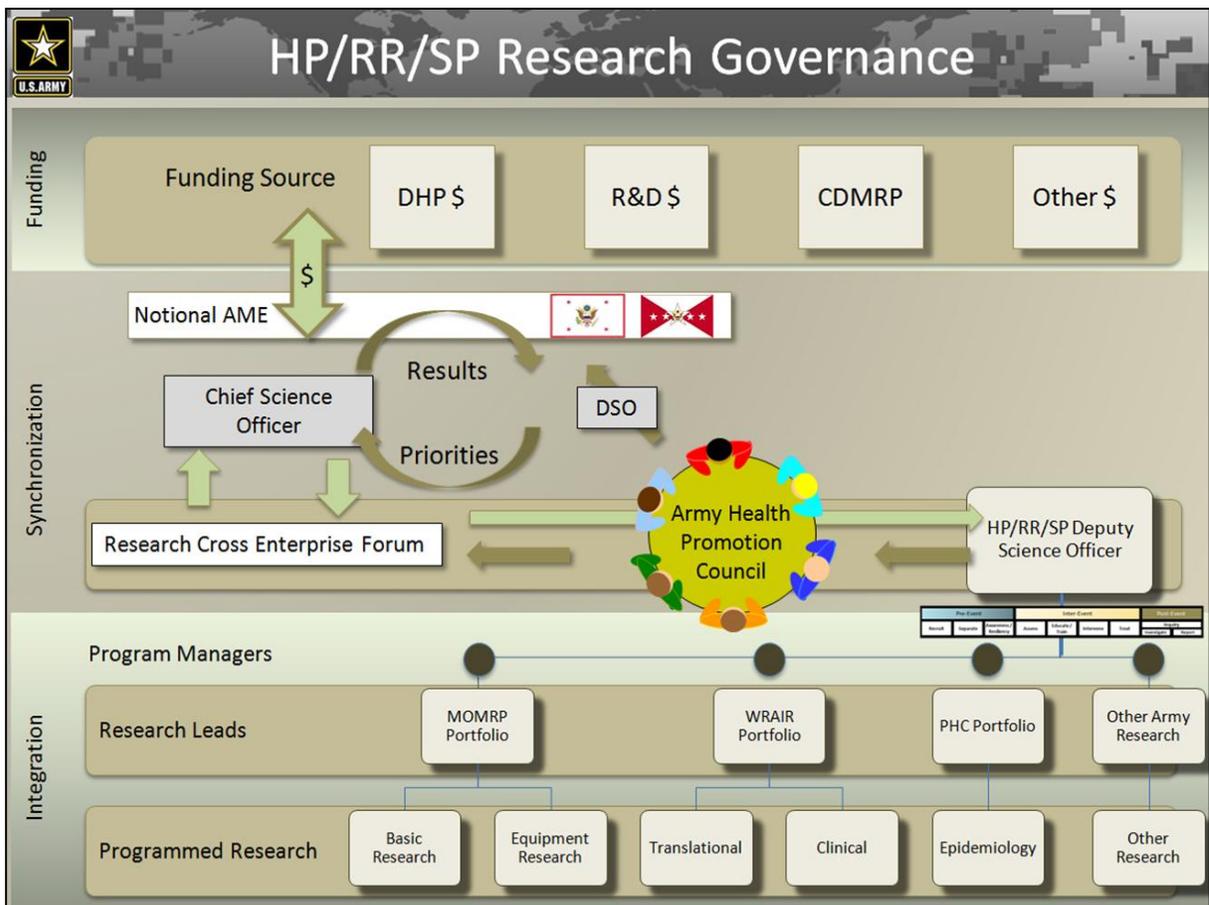


Figure 69 – HP/RR/SP Research Governance



The CSO, as a functional proponent, is the principal advisor across the HQDA enterprise for HP/RR/SP and related research (external and internal). The CSO works with other principal staffs (Secretariat, ARSTAF and external partner agencies) as a research proponent for HP/RR/SP but the role should be assessed as a pilot for coordination of Army research. Although there is a similar role in the Secretariat to provide oversight for research coordination/synchronization, there is a requirement for the role of CSO in the ARSTAF to implement coordination/synchronization. This is true of other complementary staffs that currently exist within the Secretariat and ARSTAF. The CSO should have a complete understanding of all HP/RR/SP and related research, regardless of funding source or recipient. This means the CSO should have visibility and understanding of Army research resource commitments including Army, DHP, Congressional and extramural.

The HP/RR/SP DSO as a member of the Health Promotion Council and the Research Synchronization Forum would be responsible for coordinating the *HP/RR/SP Research Portfolio*. The DSO provides the conduit for communicating findings from the individual HP/RR/SP Research Program Manager's (PMs) programs and integrates the *Research Portfolio* across the various Army research institutions. The PMs manage research by monitoring progress of the research, communicating findings to the DSO and ensuring project objectives are met.

The RSF is the primary forum where HP/RR/SP and related research is communicated across the enterprise. The point of this forum is to synchronize research efforts, validate emerging research needs/opportunities and facilitate internal/external funding. The RSF brings together the CSO and the HP/RR/SP DSO with the heads of various Army research institutes (MRMC, RDECOM, ARI, etc.). This forum may also include DoD/partner agency representatives as needed. The RSF plays an important role in integrating and synchronizing input from all HP/RR/SP related research to close gaps, reduce redundancies and make recommendations to senior Army leaders regarding the performance and risk in the *HP/RR/SP Research Portfolio*. The CSO chairs the RSF and reports these recommendations/findings to senior Army leadership.

CONCLUSIONS

- ★ A lack of HP/RR/SP research governance reduces visibility, coordination/synchronization and transition which results in silo'ed efforts and in the potential for research gaps and redundancies. (page 218)
- ★ Without full awareness of currently funded research projects, it is virtually impossible to know the current status of all HP/RR/SP research. This creates a series of problems with requirements validation, funding and implementation. (pages 219)
- ★ A standard centralized process for HP/RR/SP research coordination and synchronization is required to enable visibility, coordination and synchronization of programmed research. (page 219)
- ★ The *HP/RR/SP Research Portfolio* should be coordinated/synchronized similar to the *HP/RR/SP Program Portfolio*. (page 220)
- ★ The *HP/RR/SP Research Portfolio* addresses synchronization issues because it aligns research needs/opportunities, execution and transition to ensure that results are relevant, coordinated and can be applied to support Army goals. (page 220)
- ★ The *HP/RR/SP Research Governance Model* hinges upon a Chief Science Officer (CSO) who would provide coordination and synchronization for the *HP/RR/SP Research Portfolio* and other related Army research. (page 222)

(Continued)

- ★ The CSO, as a functional proponent, is the principal advisor to senior Army leadership for Army HP/RR/SP and related research (external and internal). The CSO should have situational awareness of all this research, regardless of funding source or recipient. (page 224)
- ★ The CSO should have visibility and understanding of Army research resource commitments, including Army, DHP, Congressional and extramural. (page 224)
- ★ The HP/RR/SP DSO as a member of the Health Promotion Council and the Research Synchronization Forum and is responsible for coordinating the *HP/RR/SP Research Portfolio*. The DSO provides the conduit for communicating findings from the individual HP/RR/SP Research Program Manager’s (PMs) programs and integrates the *Research Portfolio* across the various Army research institutions. (page 224)

RECOMMENDED ACTIONS

- ★ [HQDA] Facilitate better efficiency/effectiveness of the *HP/RR/SP Research Portfolio* using the *HP/RR/SP Research Governance Model* (including the CSO, DSO and RSF).
- ★ [HQDA] Authorize the CSO to serve as the functional proponent and principal advisor to the senior Army leadership in order to gain more situational awareness of all HP/RR/SP and related research, regardless of funding source.
- ★ [HQDA] Assess the *HP/RR/SP Research Governance Model* as a pilot for potential expansion to all Army research.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 58 – Transformation of Research Governance, Structure and Process

3. Creation of the HP/RR/SP Research Portfolio

The application of Army Enterprise concepts to the governance of Army HP/RR/SP research is intended to create an Army *HP/RR/SP Research Portfolio* that is holistic and multidisciplinary. The proposed Army enterprise management precepts can also be applied by the HP/RR/SP DSO in order to effectively and efficiently coordinate/synchronize multidisciplinary research. Likewise, enterprise management precepts apply to PMs in managing their programs as a part of the total portfolio. Figure 70 depicts the *HP/RR/SP Research Portfolio Management Model*.

At every step of development, the Care Continuum provides the lens through which HP/RR/SP research is viewed and will eventually define the Balanced Research Portfolio. The first step generates the **Potential Research Portfolio** and includes identification and assessment of research that is potentially HP/RR/SP related. The second step validates the **Interim Research Portfolio** by the RSF and includes presentation of and adjustments to the portfolio. The third step includes the presentation of the **Balanced Research Portfolio** to senior Army leadership, with research programs aligned horizontally (across the Care Continuum) and vertically (down the research development cycle). The final process depicted in the figure is continuous process improvement (CPI), which identifies and validates new HP/RR/SP research requirements, recommends modification to existing programs, or transitions findings to users (the feedback loop depicted across the bottom of the figure).

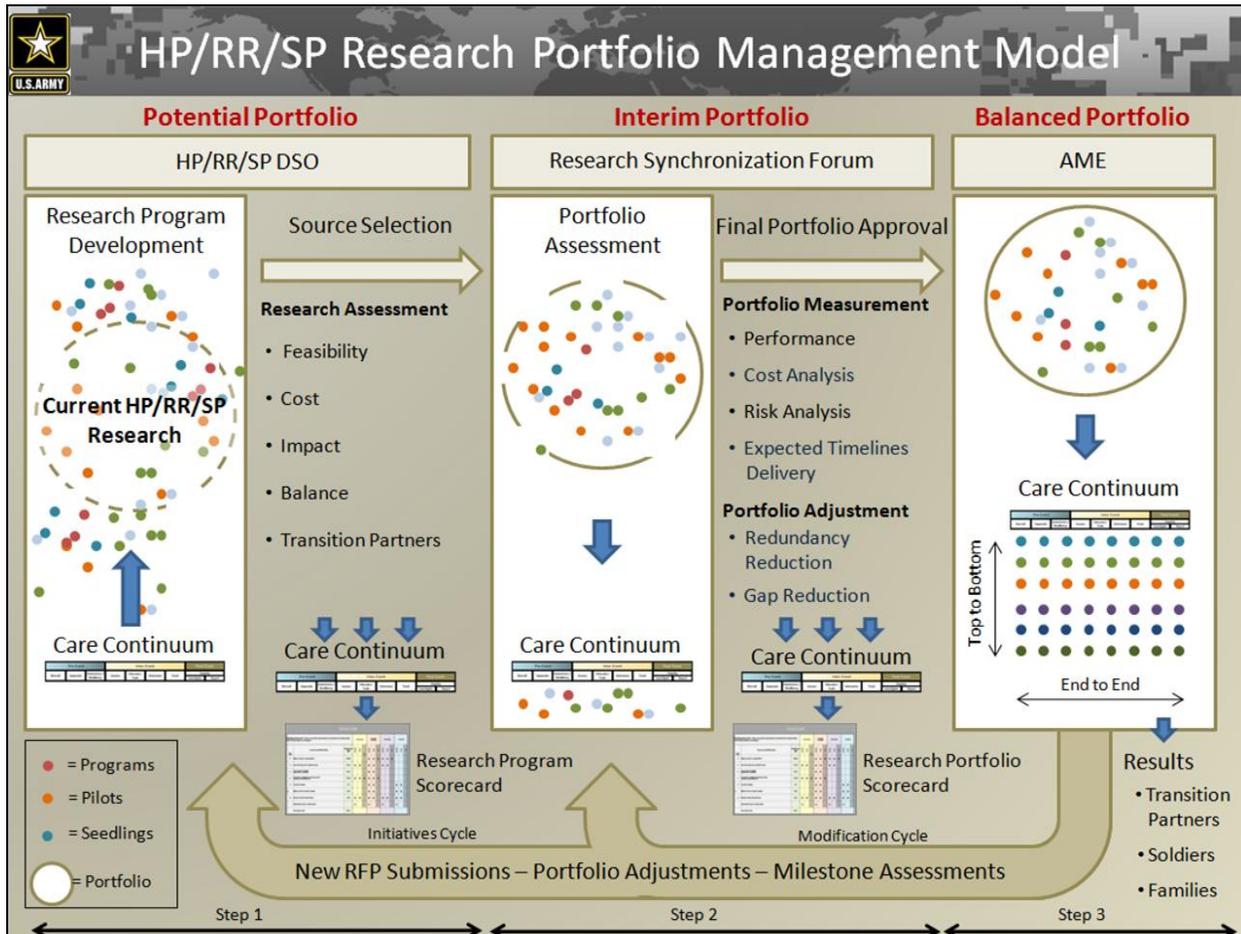


Figure 70 – HP/RR/SP Research Portfolio Management Model

a. Building the Potential Portfolio (Step 1): Requirements and Research Assessment

Initially, the CSO along with the HP/RR/SP DSO will define the inclusion criteria for the portfolio. This means that they must scope the body of ongoing research against the Care Continuum to ensure included research is aligned with a Care Continuum phase and is both complementary and competitive to the set. For example, the DSO may propose that any research related to a Diagnostic and Statistical Manual IV diagnosis (behavioral health diagnosis) would be included in the *HP/RR/SP Research Portfolio*. Once the inclusion criteria are defined, the DSO along with each of the PMs would screen the full inventory of ongoing research to identify relevant HP/RR/SP research. Research that has a primary component that addresses a stage of the Care Continuum would be identified as potential HP/RR/SP research. Each of these research programs is tentatively arrayed against the Care Continuum to identify potential gaps and redundancies in HP/RR/SP efforts.



Existing research should be described using specific, objective and standardized performance measures and product milestones. Where metrics are not already defined, the DSO should work with the PM in order to apply objective measures of progress and success using the Care Continuum as a guide. Once defined, research should be scored according to established criteria for inclusion into the *Interim Portfolio*. The application of this scoring process provides standard metrics and consistent application to mitigate an overreliance on internal evaluation of research.

The use of common measures allows programs from different proponents to be meaningfully evaluated and compared, and allows the portfolio to be analyzed and synchronized in order to optimize effectiveness and efficiency. To finalize the Potential Research Portfolio, the DSO should use objective program metrics to evaluate each program for inclusion in the portfolio and completes a Program Scorecard consisting of all programs for RSF use during the next stage of the portfolio development process. Some of the proposed program metrics may include, but are not limited to:

- **Feasibility** – analysis of the research to determine if the research is technically feasible to achieve expected results based on the research plan and within the estimated resources/time.
- **Cost (Value)** – whether the research program’s monetary expenditures for supplies, services, labor, products and equipment are consistent with the Army’s responsible stewardship of resources and in accordance with specified Army priorities. It also addresses whether or not the expected research results will garner sufficient return on investment.
- **Impact** – the projected product produced by the results of the research and likelihood of change. Change implies positive advancement in HP/RR/SP (e.g., advances in treatment or drug, device, equipment design, knowledge/information, etc.).
- **Balance** – whether the program/research provides optimization to either reduce gaps or inappropriate redundancy in the portfolio as measured by the Care Continuum.
- **Transition Partners** – whether the research program has identified appropriate internal or external entities for implementing research results and if not, help facilitate the research transition.

The development of the potential HP/RR/SP portfolio is complete after the DSO has validated each of the programs against the program metrics and has formulated recommendations for those research programs that will be included in the portfolio. The next step of the portfolio development process – assessing the Interim Research Portfolio – is done at the cross-enterprise level.

b. Assembling the Interim Portfolio (Step 2): Portfolio Assessment

HP/RR/SP research is inherently multidisciplinary and will undoubtedly be impacted by ongoing research in other areas. This is an important consideration in reducing gaps and redundancies among all research areas when assembling the *Interim Research Portfolio*. For example, research into improved body armor that mitigates blast impact (and prevents TBI) would impact the Army equipment research but would also inform “awareness” on the Care Continuum. In this case, results from the body armor studies would be relevant to both the HP/RR/SP portfolio and Army equipment. In order to achieve a balanced HP/RR/SP portfolio of programs, a comprehensive, holistic review of Army research is required.

The Research Synchronization Forum is the appropriate venue to perform this function. The RSF will integrate and synchronize Army research efforts and ensure that the research portfolio provides coverage across the Care Continuum. The *HP/RR/SP Research Portfolio* should be measured on

performance, cost, risk analysis and expected timelines for delivery. The Interim Research Portfolio is developed at the RSF as research gaps and duplications are identified and adjudicated. As a result of this effort, the Research Portfolio Scorecard will be produced for the Interim Research Portfolio. Once the adjustments to the Interim Portfolio are made by the RSF, recommendations for research programs are realigned and balanced against the applicable phase of the Care Continuum.

c. Validating the Balanced Portfolio (Step 3): Army enterprise

Army senior leadership reviews the *HP/RR/SP Balanced Research Portfolio* recommended by the RSF and ensures that it satisfies the objectives of achieving top to bottom and end to end research balance. As the integrated body of senior Army leaders (e.g., Secretariat, ARSTAF and command level), enterprise forums synchronize and integrate the *HP/RR/SP Balanced Research Portfolio*.

d. Optimizing the Balanced Portfolio: Continuous Process Improvement

Although the Care Continuum depicts the conceptual scope of HP/RR/SP research, the Army’s specific research requirements are evolving and dynamic. To be a viable research synchronization process, the HP/RR/SP research portfolio development process must include a method to recognize and respond to emerging research needs/opportunities.

As discussed and applied in the program portfolio management context, CPI enables change management. CPI provides feedback to PMs on research transitions, process cycle times, costs (in terms of less total resource consumption), quality and productivity. It is a means to identify and implement initiatives that improve organizational performance and create sustainable change. As new research needs are assessed and validated, the *HP/RR/SP Research Portfolio* is rebalanced through the enterprise forums.

The rebalancing cycle represented by the CPI arrow has two processes that can result in changes to the *HP/RR/SP Research Portfolio* – the “modification” and “initiatives” cycles. The modification cycle represents a rapid rebalancing of existing research programs to respond to emerging research needs/opportunities and preserves flexibility of both PMs and individual researchers. This modification cycle may effect change in a program or a particular line of research based on feedback from transition partners, HP/RR/SP program/service providers, end users, the research community, etc. The initiatives cycle represents a more deliberate process for introducing new research that requires assessment and RSF analysis before being considered for the portfolio. The feedback for this cycle typically comes from Army senior leaders, the AHPC, CSO/DSO or external direction (DoD, Congress, etc.). Research results and feedback from researchers/PMs are instructive to both cycles.

CONCLUSIONS

- ★ The application of the proposed Army enterprise concepts to the governance of Army HP/RR/SP research is intended to create an Army *HP/RR/SP Research Portfolio* that is holistic and multidisciplinary. (page 225)
- ★ The Care Continuum provides the lens through which all HP/RR/SP research is viewed and will eventually define the *Balanced Research Portfolio*. (page 225)

(Continued)

- ★ The *Potential Research Portfolio* includes identification and assessment of research that is potentially HP/RR/SP related. (page 226)
- ★ The *Interim Research Portfolio* is validated by the RSF and includes recommended adjustments to the portfolio. (page 227)
- ★ The *Balanced Research Portfolio* is then aligned horizontally and vertically for validation by the senior Army leadership. (page 228)
- ★ The CPI process identifies and validates new HP/RR/SP research requirements, recommends modification to existing programs, and facilitates transition to end users. (page 228)

RECOMMENDED ACTIONS

- ★ [HQDA] Utilize the *HP/RR/SP Research Portfolio Management Model* to provide top to bottom and end to end visibility, coordination and synchronization of all research efforts to close gaps and reduce redundancies.

Refer to Annex B for additional detail and supporting actions

Conclusions & Recommendations 59 – Managing the HP/RR/SP Research Portfolio

4. Current HP/RR/SP Research

A review of select ongoing Army research efforts revealed a number of projects that relate to HP/RR/SP requirements. This review does not represent a comprehensive collection of all HP/RR/SP related research. These projects are being undertaken by a wide variety of research entities, both internal and external to the Army, including the NIMH, VA, Naval Health Research Center and universities.¹⁵³ The studies include epidemiological studies, suicidal behavior studies and a risk-screening instrument study. A brief summary of each effort is below.

a. Army STARRS

The Army STARRS (Study to Assess Risk and Resilience in Service Members) study began as an initiative by the Secretary of the Army with NIMH in the fall of 2008.¹⁵⁴ The Army partnered with NIMH, the preeminent government behavioral health research organization, to conduct the STARRS study. This study, when completed, will be the largest study of suicide and behavioral health among military personnel ever undertaken. Following a competitive selection process, NIMH awarded the research grant in July 2009 to a consortium led by the Uniformed Services University of the Health Sciences (USUHS) and including Columbia University, the University of Michigan and Harvard University.

The purpose of Army STARRS is to identify modifiable risk and protective factors and moderators of suicidal behavior to inform the Army's ongoing efforts to prevent suicide and improve Soldiers' overall psychological health and functioning. The study will collect detailed information on psychological and physical health. It will examine exposure to adverse events, attitudes, social support, leadership and unit climate, training and knowledge, employment and economic status, family history and other

¹⁵³ Many research projects are cooperatively funded and managed by Army and DoD, through the Army's MRMC, a component of MEDCOM, and the Defense Health Program (DHP), respectively.

¹⁵⁴ The background for the initiation of the study is discussed in Section V of this report, "The Army Suicide Prevention Campaign" beginning on page 111.

potentially relevant data from over 300,000 Soldiers that will participate in the study.¹⁵⁵ These study participants will be followed over a five-year period, providing longitudinal information relating Soldiers' characteristics and experiences to subsequent psychological health, suicidal behavior and other relevant outcomes. The study will focus on stressful periods in a military career, including shortly before and after deployment, during deployment, and shortly after discharge.

b. U.S. Army Medical Research and Materiel Command Managed Projects

In addition to coordinating numerous efforts in resiliency, behavioral health, TBI research and stigma reduction, MPMC awarded several DHP funded suicide related research projects that are all early in their data collection phase, none of which have generated any interim analysis or recommendations. A quick review of this list illustrates the wide range of organizations that are conducting HP/RR/SP research. The projects address a wide-range of topics including:

- Association between OIF/OEF deployment and suicide, study conducted by The National Center for Telehealth and Technology, at Joint Base Lewis - McCord, for 36 months;
- USMC deployment history impact on self harm/PTSD/substance abuse, study conducted by the Navy Health Research Center, at U.S. Navy Base San Diego, for 18 months;
- Drug related overdoses among military personnel, at Darnall Army Medical Center - Fort Hood, for 18 months;
- Antidepressants and the risk of self harm behavior in younger veterans, at Massachusetts VA Medical Center, for 24 months;
- Optimized screening for suicide risk, at Florida State University, for 36 months;
- Brief cognitive therapy for military populations, at University of Utah, for 36 months;
- Efficacy of Dialectical Behavior Therapy on high risk suicidal behavior, at Bronx VA, for 36 months;
- Blister Packing of medication to reduce accidental overdose, at Denver VA, for 36 months;
- Brief intervention for inpatient suicide risk patients, at USUHS, for 36 months; and
- Pilot trial of inpatient cognitive therapy for the prevention of suicide in military personnel with acute stress disorder or PTSD, at USUHS, for 48 months.

c. Mental Health Advisory Teams (MHAT)

Since 2003, the Army has sent Mental Health Advisory Teams (MHAT) into Iraq and Afghanistan. These teams are designed to provide an assessment of behavioral health and wellbeing, examine the delivery of services and provide recommendations for program sustainment and improvement in theater.¹⁵⁶ Each subsequent MHAT builds upon the lessons learned of the previous assessment, which allows for a longitudinal study of theater behavioral health.

¹⁵⁵ The study participants consist of 90,000 active duty Soldiers as well as all new recruits (approximately 80,000 Soldiers a year) that enter the Army over a three-year period.

¹⁵⁶ The MHAT consists of behavioral science experts from Army research entities. The MHAT has visited Iraq six times and Afghanistan three times since 2003.

The most recent MHAT (MHAT 6) was conducted from February to March 2009 in Iraq (OIF) and from May to June 2009 in Afghanistan (OEF). This was the first assessment that separated maneuver from support units to determine if there were significant differences in their behavioral health and wellbeing.

MHAT 6 found the percentage of Soldiers in maneuver units that met the criteria for depression, anxiety and/or acute stress was 14.4% in OEF and 11.9% in OIF. The OEF team learned that non-commissioned officers (NCOs) on their second or third deployment were more likely to meet screening criteria for psychological problems. MHAT data show that deployment stressors take a toll on marital relationships. The increase in behavioral health problems following multiple deployments may be related or contributing to marital issues. Another significant MHAT finding revealed that longer dwell time (time for reset/recovery between deployments) correlated with lower rates of behavioral health issues. Data indicate on average it takes 36 months to return to a pre-war garrison behavioral health baseline. These data further reinforce the need for the 1:3 optimal deployment:dwell ratio and highlights the importance of help seeking behavior among repeat deployers.

*One of the Soldiers interviewed by an OEF MHAT 6 focus group stated that “to the 11 series, **seeking mental health is seen as breaking.** If you go [to] the shrink you are trying to get out of the Army.”*

Stigma towards seeking behavioral health treatment is a significant barrier in the Army. Between 2005 and 2009, analysis found there had been very little change to perceptions of stigma related to seeking behavioral health services. Self-stigma has decreased slightly (33.8% to 26.7%), indicating Soldiers are less embarrassed to seek behavioral health treatment. However, organizational stigma, feeling that unit leadership would blame the individual for the behavioral health problem, has marginally decreased (42.1% to 40.1%) since 2007. One of the Soldiers interviewed by the OEF MHAT focus group stated that “to the 11 series, seeking mental health is seen as breaking. If you go [to] the shrink you are trying to get out of the Army.”

Potentially, these MHAT findings have significant impact on where and when during deployment behavioral health treatment is best provided to Soldiers. Additional research is required to determine how to best implement these findings through HP/RR/SP programs/services in accordance with the *Composite Life Cycle Model* (page 105).

d. ACE-SI and BSHOP

The US Army Center for Health Promotion and Preventive Medicine (CHPPM) is committed to promulgating behavioral health initiatives across the Army through development, evaluation and continuous monitoring of programs of interest. Through a partnership at Rochester University, they are studying the efficacy of "Ask, Care, Escort – Suicide Intervention" (ACE-SI). ACE-SI is a training program that provides Soldiers with the awareness, knowledge and skills needed to intervene with those at risk for suicide. This mixed educational and interactive (role play) training utilizes the Army "battle buddy" concept for supporting Soldiers in distress. As part of the CPI for ACE-SI, CHPPM is undertaking a review of other existing suicide prevention programs that address suicide risk and protective factors in both military and civilian populations to assess the quality of evidence and potential utility of such programs in an Army setting.

SUICIDE PREVENTION TRAINING

A Specialist, deployed in Iraq, learned his wife wanted a divorce. He attempted suicide by trying to shoot himself with his rifle. He squeezed the trigger but the rifle did not fire. His Battle Buddy, who had recently received training on how to spot suicide warning signs and what actions to take, recognized the signs in the Specialist. After an earlier conversation with the Specialist, his Battle Buddy disabled the rifle by removing the firing pin. After the suicide attempt, the Specialist said he was an emotional wreck, with feelings of relief and anger. When his Battle Buddy walked in, the Specialist recalled asking, "Where's my firing pin?" His Battle Buddy had a medic take the Specialist to the Combat Stress Center, while he notified his commander. Right away the Specialist was able to speak with a mental health specialist.

- Battle buddies are the front line in surveillance and detection of high risk behavior and subsequent mitigation.

Vignette 37 – Suicide Prevention Training

CHPPM created the Behavioral and Social Health Outcomes Program (BSHOP) in October 2008 to identify and assess psychological and social threats (e.g., suicide and other self harm behavior, homicide and other criminal behavior, etc.) as they pertain to Soldier health and combat readiness. It further recommends ways the Army can prevent or mitigate these threats. BSHOP supports commanders and units in both garrison and during deployment.

Some of BSHOP's works include surveying current trends in social epidemiology (effects of social factors on individual and population health) and the implications these trends have on Army policy, programs and research. Some of their responsibilities include developing a suicide analysis cell that is building and maintaining a central, standardized registry of Army suicides for reporting to Army leaders; consultation with Army suicide prevention leaders; and building systems for surveillance and assessment of leader-prioritized behavioral health outcomes such as suicidal behaviors and Post-Traumatic Stress Disorder.

e. Post Traumatic Stress Disorder Research

MRMC, through its CDMRP, manages approximately \$200,000,000 in research projects on post-traumatic stress. Many of these studies are in a nascent research phase and have not yet formed conclusions or recommendations. The research covers prevention, screening, assessment, diagnosis, pharmacotherapy, psychosocial treatment (e.g., cognitive behavioral therapy) and epidemiological research. Much of the research is cross sectional, involves limited time periods and specific populations. Very little research has been conducted to date to help inform military service attrition or long-term retention following treatment.

f. Mild Traumatic Brain Injury (mTBI) Research

“[The Army] is at the forefront of TBI treatment, care and support; we are devoting major resources to scientific research. Our Medical Research and Materiel Command continues its comprehensive blast injury research program; in partnership with the VA, the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, civilian hospitals and research institutes and organizations, the Army is working aggressively to improve our understanding of TBI.”

– LTG Eric B. Schoomaker, *The Surgeon General*
“March is National Brain Injury Awareness Month,” TSG Blog, 6 March 2009

Quote 29 – LTG Eric Schoomaker, 6 Mar 09

The Army Warrior mTBI Campaign Plan was developed in response to emerging concerns related to the identification and treatment of mTBI. The plan includes three lines of efforts (LoE) – Train and Educate, Treat, and Track.

- **Train and Educate:** The emphasis of this LoE is on educating all Soldiers and leaders on the importance of seeking care for mTBI immediately after any concussive event. Soldiers learn that mTBI is a physical injury that must be identified and treated properly in an effort to avoid or mitigate persistent symptoms and long term health problems. Squad leaders and unit medics are taught to recognize the signs and symptoms of mTBI so they can respond accordingly.
- **Treat:** This LoE focuses on treating Soldiers who are diagnosed with mTBI.
- **Track:** This LoE focuses on developing effective tracking systems, mechanisms, and business rules to track those Soldiers who have or may have sustained mTBI. It is imperative that the Army develop the methods to accurately track Soldiers’ involvement in events which may or may have caused mTBI.

Data collected by the “track” LoE, along with lessons learned from the first units utilizing these protocols, will inform future research priorities. Additionally, the lessons learned will inform modifications to Post Deployment Health Assessment and Post Deployment Health Re-Assessment questionnaires to improve the accuracy of screening.

g. Research on the Stigma related to Seeking Behavioral Health Treatment

Certain DoD and Army surveys assess the attitudes of Soldiers relating to those who exhibit behavioral health-related performance issues. The following list of assessments are currently in use and have been standardized, to the extent possible, in order to improve leadership’s ability to compare results between studies.

- DoD Survey of Health Related Behaviors (HRB), 2008
- Defense Military Data Center Quick Compass of Military Members, 2008
- Mental Health Advisory Team (MHAT) VI, Operation Iraqi Freedom, 2009
- Mental Health Advisory Team (MHAT) VI, Operation Enduring Freedom, 2009
- Sample Survey of Military Personnel (SSMP), Spring and Fall 2009
- Department of the Army Inspector General Assessment of the Army Suicide Prevention Program, 2009

Data from these surveys will be used to track and monitor Soldier attitudes with regard to help seeking behavior and peer perception of behavioral health issues. While it is too early to form any conclusions, MHAT data (as described earlier) demonstrated a slight improvement in overall perceptions of those who would seek behavioral health. While this is promising, the research also shows that the Army still has a significant way to go in terms of overcoming the stigma associated with behavioral health treatment.

5. Future Research Recommendations

Based on the ASPTF's experience combined with the Report Team's research, a number of HP/RR/SP research gaps were identified that merit consideration by the proposed *HP/RR/SP Research Governance Model* (CSO, HP/RR/SP DSO, RSF and AHPC). These recommendations are presented throughout the "Conclusions and Recommendations" of each section, and are referenced in Annex B beginning on page B-39. These research recommendations are not intended as an exhaustive checklist, but rather as recommended additions to the proposed *HP/RR/SP Research Portfolio*.

6. Summary

Understanding the complexity of HP/RR/SP issues requires robust and comprehensive research. The Army's current HP/RR/SP research efforts are not fully coordinated, synchronized, and may not be sufficiently balanced across the Care Continuum. Analysis by the Report Team of readily visible research indicates an over weighted focus on medical and treatment issues and does not fully address other non-medical aspects of the continuum.

The lack of centralized governance, including an *HP/RR/SP Research Portfolio* and a centralized repository of research information, degrades senior Army leadership visibility of planned and ongoing HP/RR/SP research. This reduces actionable information necessary to inform decisions regarding the Army's overall HP/RR/SP needs and limits opportunity to transition valuable findings. Current HP/RR/SP research efforts would benefit from the application of the proposed *HP/RR/SP Research Governance Model*, which would improve visibility, coordination/synchronization and transition of HP/RR/SP research.

This section establishes the *HP/RR/SP Research Portfolio* that consists of all research programs and lines of research associated with HP/RR/SP efforts. It provides a process to align programs with the Care Continuum, measures research programs via approved standard metrics, and balances the portfolio based on performance and risk analyses. The DSO would brief this portfolio to the RSF to coordinate and synchronize efforts. As chair of the RSF, the CSO would then take the recommendations to the AME. Additionally, the Health Promotion Council would validate research needs, identify a transition proponent and recommend improvements to HP/RR/SP programs/services based on research results.

This report contains many recommendations for future research, which should be considered for inclusion in the *HP/RR/SP Research Portfolio*. The recommended research topics cover a variety of areas impacting HP/RR/SP and will serve to balance the current research portfolio.

Annex A – Glossary

Section I – Abbreviations and Acronyms

A		
ABHIDE	AD	ARCIC
Army Behavioral Health Integrated Data Environment	Active Duty	Army Capabilities Integration Center
AC	ADCO	ARFORGEN
Active Component	Alcohol and Drug Control Officer	Army Force Generation
ACE	ADHD	ARI
Ask, Care, Escort	Attention Deficit Hyperactivity Disorder	Army Research Institute
ACE-SI	AEB	ARL
Ask, Care, Escort - Suicide Intervention	Army Enterprise Board	Army Research Laboratory
ACI2	AER	ARNG
Automated Criminal Investigative and Intelligence System	Army Emergency Relief	Army National Guard
ACOM	AFC	ARPERGEN
Army Command	Army Family Covenant	Army Personnel Generation
ACPHP	AFME	ARSTAF
Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention	Armed Forces Medical Examiner	Army Staff
ACS	AHPC	ASA (ALT)
Army Community Service	Army Health Promotion Council	Assistant Secretary of the Army for Acquisition, Logistics and Technology
ACSAP	ALARACT	ASA (I&E)
The Army Center for Substance Abuse Programs	All Army Activities Message	Assistant Secretary of the Army for Installations and Environment
ACSIM	AME	ASA (M&RA)
Assistant Chief of Staff for Installation Management	Army Management Enterprise	Assistant Secretary of the Army for Manpower and Reserve Affairs
	ANCDS	
	Army Net-Centric Data Strategy	
	ARCENT	
	US Army Central Command	

ASAP

Army Substance Abuse Program

ASB

Army Science Board

ASCC

Army Service Component Command

ASIST

Applied Suicide Intervention Skills Training

ASPC

Army Suicide Prevention Council

ASPP

Army Suicide Prevention Program

ASPTF

Army Suicide Prevention Task Force

AWOL

Absent Without Leave

B

BCT

Brigade Combat Team

BES

Budget Estimate Submission

BH

Behavioral Health

BOG

Boots on the Ground

BRAC

Base Closure and Realignment

BSHOP

Behavioral and Social Health Outcomes Program

C

CAC

Casualty Assistance Center

CAO

Casualty Affairs Officer

CATEP

Confidential Alcohol Treatment and Education Pilot

CDC

Centers for Disease Control and Prevention

CDMRP

Congressionally Directed Medical Research Program

CE

Core Enterprise

CHPC

Community Health Promotion Council

CHPPM

Center for Health Promotion and Preventive Medicine

CHRA

Civilian Human Resources Agency

CI

Confidence Interval

CID

Criminal Investigation Division

CID CLO

CID Casualty Liaison Officer

CID

Criminal Investigation [Division] Command

CIO

Chief Information Officer

CMAB

Casualty and Mortuary Affairs

Branch

CMAOC

Casualty and Mortuary Affairs Operations Center

CMO

Chief Management Officer

CNO

Casualty Notification Officer

COMPO

Component

CONUS

Continental United States

COPS

Centralized Operations Police Suite

CPA

Continuous Partial Attention

CPI

Continuous Process Improvement

CRDAMC

Carl R. Darnall Army Medical Center

CSA

Chief of Staff of the Army

CSF

Comprehensive Soldier Fitness

CSO

Chief Science Officer

CTC

Combat Training Center

D

DA PAM

Department of the Army Pamphlet

DAIG
Department of the Army
Inspector General

DAMIS
Drug and Alcohol Management
Information System

DARPA
Defense Advanced Research
Projects Agency

DCOE
Defense Centers of Excellence

DCS
Deputy Chief of Staff

D-DEX
DoD Law Enforcement Defense
Data Exchange System

DFR
Dropped from the Rolls

DHP
Defense Health Program

DIBRS
Defense Incident-Based
Reporting System

DMDC
Defense Manpower Data
Center

DoD
Department of Defense

DoDD
DoD Directive

DoDI
DoD Instruction

DoD IG
DoD Inspector General

DoDSER
Department of Defense Suicide
Event Report

DRU
Direct Reporting Unit

DSO
Deputy Science Officer

DSTs
Drug Suppression Teams

DUI
Driving Under the Influence

E

EPICON
Epidemiological Consultation

ETS
Expiration Term of Service

EXSUM
Executive Summary

F

FAP
Family Advocacy Program

FOA
Field Operating Agency

FORSCOM
Forces Command

FRG
Family Readiness Group

FRSA
Family Readiness Support
Assistant

FTDTL
Forensic Toxicology Drug
Testing Laboratory

FY
Fiscal Year

G

GAT
Global Assessment Tool

GF
Generating Force

H

HCE
Human Capital Core Enterprise

HIPAA
Health Insurance Portability
and Accountability Act

HP/RR/SP
Health Promotion, Risk
Reduction and Suicide
Prevention

HQDA
Headquarters, Department of
the Army

HRB
Health Related Behaviors

I

IED
Improvised Explosive Device

ILO
In lieu of

IMCOM
Installation Management
Command

L

LE
Law Enforcement

LEAP
Law Enforcement Advisory
Portal

LOD
Line of Duty Investigation

LoE
Lines of Effort

LSS
Lean Six Sigma

M		MVV Motor Vehicle Violations	Operating Force
ME Materiel Enterprise			OIF Operation Iraqi Freedom
MEDCOM Medical Command		N	
MEPS Military Entrance Processing Station	NCIC National Crime Information Center	OPMG Office of the Provost Marshal General	
MFLC Military Family Life Consultant	NCO Non-Commissioned Officer	OPR Office of Primary Responsibility	
MHAT Mental Health Advisory Team	NETCOM Network Enterprise Technology Command	OPTEMPO Operational Tempo	
MOE Measures of Effectiveness	NGB National Guard Bureau	OSD Office of the Secretary of Defense	
MOMRP Military Operational Medicine Research Program	NIBRS National Incident-Based Reporting System	OTSG Office of The Surgeon General	
MP Military Police	NIMH National Institute of Mental Health	P	
MPI Military Police Investigator	NOK Next-of-Kin	PCC Pre Command Course	
MPR Military Police Report	O		
MRMC Medical Research Materiel Command	OCAR Office of the Chief of Army Reserve	PCS Permanent Change of Station	
MRO Medical Review Officer	OCPA Office of the Chief of Public Affairs	PDA Personal Digital Assistant	
MSD Mortality Surveillance Division	OCR Office of Coordinating Responsibility	PDHA/PDHRA Post-Deployment Health Assessment/Reassessment	
MSMR Medical Surveillance Monthly Report	ODD Oppositional Defiant Disorder	P-DOTMLPF-R Policy, Doctrine, Organization, Training, Materiel, Leadership and Education, Personnel, Facilities and Resources	
mTBI Mild Traumatic Brain Injury	OEF Operations Enduring Freedom	PEG Program Evaluation Group	
MTF Medical Treatment Facility	OF	PHI Protected Health Information	
		PII Personally Identifiable Information	

PM
Program Manager

PME
Professional Military Education

PMG
Provost Marshal General

POM
Program Objective
Memorandum

POV
Privately Owned Vehicle

PPBES
Planning, Programming,
Budgeting and Execution
System

PROFIS
Professional Filler System

PTS
Post Traumatic Stress

PTSD
Post Traumatic Stress Disorder

R

R&D
Research and Development

RC
Reserve Component

RCE
Readiness Core Enterprise

RDECOM
Research, Development and
Engineering Command

RSF
Research Synchronization
Forum

RESPECT-D
Re-engineering Systems of the
Primary Care Treatment - for
Depression

RESPECT-Mil
Re-engineering Systems of the
Primary Care Treatment in the
Military

ROI
Report of Investigation

RSF
Research Synchronization
Forum

RTI
Research Triangle Institute

S

SAC
Special Agent in Charge

SAMHSA
Substance Abuse and Mental
Health Services Administration

SecArmy
Secretary of the Army

SHARP
Sexual Harassment/Assault
Response and Prevention

SICE
Services and Infrastructure
Core Enterprise

SIR
Serious Incident Report

SMA
Sergeant Major of the Army

SPPM
Suicide Prevention Program
Manager

SPRP
Suicide Prevention Research
Program

SRG
Senior Review Group (SRG)

SSMP
Sample Survey of Military
Personnel

SSRI
Selective Serotonin Reuptake
Inhibitors

STARRS
Study to Assess Risk and
Resilience in Service Members

STRATCOM
Strategic Communication

SWS
Social Work Services

T

T2
Telehealth and Technology

TAP
Task Action Plan

TAPS
Tragedy Assistance Program for
Survivors

TBI
Traumatic Brain Injury

TDY
Temporary Duty

TRADOC
Training and Doctrine
Command

TSG
The Surgeon General

U

UA
Urinalysis

UCMJ
Uniform Code of Military
Justice

USA
Under Secretary of the Army

USAAC
US Army Accessions Command

USACIDC
United States Army Criminal
Investigation Command

USAR
United States Army Reserve

USARC
US Army Reserve Command

USAREC
US Army Recruiting Command

USCENTCOM
United States Central

Command

USNORTHCOM
United States Northern
Command

USMC
United States Marine Corps

USUHS
Uniformed Services University
of the Health Sciences

V

VA
Veterans Affairs

VCSA
Vice Chief of Staff of the Army

W

WIAS
Worldwide Individual
Augmentation System

WRAIR
Walter Reed Army Institute of
Research

WTU
Warrior Transition Unit

Section II – Terms

Term sources and the chapter and/or subsection where the term can be found in the report are identified after the definitions.

A

Access/Delivery: One of the five metrics used in the Program Capabilities Assessment. A measurement of the ability to access and deliver programs and/or services in a variety of formats to a variety of organizations. (VI,3; VII,2)

Accidental Death: Death resulting from an unintentional injury or poisoning when there is little or no evidence that the injury or poisoning occurred with the intent to harm or cause death. Source: CID Reg. 195-1, *Criminal Investigation Operational Procedures, 3 Jun 09* (II,1)

Active Duty (AD): Includes all members of the Active Component and members of the Reserve Components serving on full-time duty in excess of 30 days. Soldiers on full-time National Guard duty (Title 32 status) are not considered active duty

Amphetamine (Amp): a psychostimulant drug known to produce increased wakefulness and focus in association with decreased fatigue and appetite. Amphetamine is chemically related to methamphetamine and lisdexamfetamine, a class of potent drugs that act by increasing levels of dopamine and norepinephrine in the brain, inducing euphoria. Also used to treat symptoms of traumatic brain injury (TBI) and the daytime drowsiness symptoms of narcolepsy, postural orthostatic tachycardia syndrome (POTS) and chronic fatigue syndrome (CFS). Brand names include Adderall, Vyvanse, Dexedrine, and Benzedrine.

Army Enterprise Board (AEB): The first tier in the Army Enterprise governance system. Provides a multidisciplinary advisory body for the governance of policy, structure, people,

process and technology nominated by the subordinate tiers. (VI,2)

Army Force Generation (ARFORGEN):

A cross enterprise component of the proposed Army enterprise-based business transformation model intended to synchronize policy, programs and processes across all core enterprises related to the rotational cycle of units and equipment. (VI,3)

Army Management Enterprise (AME): A Tier 2 component of the proposed Army enterprise-based business transformation model that provides guidance and validates governance of the Core Enterprises. (VI,2)

Army Net-Centric Data Strategy (ANCDs): An enduring and global approach to Army information sharing to improve situational awareness through the application of net-centric concepts, technologies and standards, institutionalized in a governance and technical framework, to enable net-centric data assets that are visible, accessible, understandable, trusted and interoperable to all users. (IX,1)

Army Personnel Generation (ARPERGEN):

A cross enterprise component of the proposed Army enterprise-based business transformation model intended to synchronize policy, programs and processes across all core enterprises. It is proposed as a term to describe and accommodate Soldier/Civilian and Family life cycle transitions that should be considered in relationship to and as a counterbalance to the ARFORGEN. (VI,3)

Ask, Care, Escort - Suicide Intervention (ACE-SI): A training program that provides Soldiers with the awareness, knowledge and skills needed to intervene with those at risk for suicide. (X,4)

B

Balance: One of the metrics used to evaluate a specific research program. A measurement of whether the research provides optimization to either reduce gaps or inappropriate redundancy in the portfolio as measured by the Care Continuum. (X,3)

Base Realignment and Closure (BRAC): A transition mandated by law to close excess installations and realign the asset inventory to reduce operations and maintenance expenditures; aimed at increasing efficiency per Congressional and DoD objectives. (IV,2)

Behavioral and Social Health Outcomes Program (BSHOP): Created by the United States Army Public Health Command (Provisional) to identify and assess psychological and social threats as they pertain to Soldier health and combat readiness. (X,4)

C

Care Continuum: The Army's institutional response by commanders, leaders, and program/service providers to Soldier, Civilian, and Family HP/RR/SP requirements across the pre-event, inter-event, and post-event stages of the Event Cycle. (VI,2)

Cause of death: The disease or injury(s) that resulted in the death. Source: CID Regulation 195-1, *Criminal Investigation Operational Procedures*, 3 Jun 09. Compare Manner of Death, defined below. (II,1; VIII,2)

Chief Science Officer (CSO): A proposed position established by the Research Governance Model to provide oversight for the Research Portfolio to ensure research visibility, coordination/synchronization, transition and implementation across the enterprise. (X,2; X3)

Composite Life Cycle Model: A conceptual framework to identify and target transitions or stress windows during each stage of the Event Cycle and phase of the Care Continuum. It can be used to inform Army readiness and personnel policies, filter program evaluations

and shape commanders' philosophy and guidance in implementing HP/RR/SP programs. It defines the three life cycle strands as Unit, Soldier and Family. (IV,2)

Continuous Partial Attention: Segmenting one's attention in order to satisfy one's desire to be connected and stay connected to multiple sources of information. Source: Stone, Linda, *Continuous Partial Attention – Not the Same as Multi-Tasking*, 24 Jul 08. (IV,2)

Continuous Process Improvement (CPI): The final subsection of the Portfolio Management Model. It is a means of identifying and implementing initiatives to continually improve organizational performance and create sustainable change. (VII,2)

Coping/Coping Skills: The ability to overcome challenges and reduce associated stressors. Seeking help is one way of coping with stress, transitions or life events. (IV,1)

Core Enterprise (CE): The lowest tier of the proposed Army enterprise-based business transformation model. It provides multidisciplinary governance across the Human Capital, Materiel, Readiness, and Services and Infrastructure domains. (VI,2)

Cost: One of the five metrics used in the Program Capabilities Assessment. A measurement of whether the program's monetary expenditures for supplies, services, labor, products and equipment are consistent with the Army's responsibility for stewardship of resources. (VI,2; VII,2; X,4)

Cross Enterprise: A component of the proposed Army enterprise-based business transformation model. It is a forum activated by the AME on either a temporary or enduring basis to integrate and synchronize two or more core enterprises affecting over-lapping governance. (VI,3)

D

Dashboards: A graphic, organized snapshot of key data points summarized on a single web page that delivers actionable knowledge and situational awareness to leaders. (IX,4)

Defense Incident-Based Reporting System (DIBRS): A DoD mandated reporting system for criminal and other offenses such as suicide and non-fatal suicide behavior. (III,4)

Department of Defense Suicide Event Report (DoDSER): A web-based report providing a series of data categories including demographic (military information), event information and history (deployment, medical, behavioral health and family) to provide comparative analysis among suicide victims. (VII,1)

Deputy Science Officer: A proposed position established by the Research Governance Model to be responsible for coordinating the Research Portfolio, identifying gaps and redundancies, reporting findings to the Chief Science Officer and recommending changes in research priorities. (X,2; X3)

Dwell Time: The time a Soldier spends at home station before a combat deployment (e.g., OIF, OEF); operational deployment (e.g., peacekeeping, domestic civil, humanitarian international, etc.); or dependent-restricted tours (e.g., Korea). Source: G-1 Strength Analysis and Forecasting Division. (IV,2)

E

Equivocal Death: A death which cannot be readily established as natural, accidental, suicide or homicide. Source: CID Reg. 195-1, *Criminal Investigation Operational Procedures*, 3 Jun 09. (I,1; VII)

Event Cycle: A model of individual Soldier high risk behaviors (pre-event, inter-event and post-event). Longitudinally aligns with proponent and programmatic responses to those behaviors. (VI,3)

Expeditionary: One of the five metrics used in the Program Capabilities Assessment to describe and assess a program's effect on the ability to operate in support of deployed and Reserve Component environments. (VI,3; VII,2)

F

Family Life Cycle Strand: Part of the Composite Life Cycle model describing transitions affecting the Family, which may include marriage, birth of a child, marital discord, aging parents, school cycles, etc. (IV,2)

Feasibility: One of the metrics used to evaluate a specific portfolio program. An analysis and evaluation of the proposed research to determine if the research is technically possible to achieve expected results based on the research plan and within the estimated resources. (X,3)

Felony crimes: Criminal offenses punishable by death or confinement for more than one year. All drug crimes (including marijuana use) are considered to be felony crimes. Source: AR 195-2, *Criminal Investigation Activities*, 15 May 09. (III,2; III,7)

G

Generating Force: The part of the Army whose primary purpose is generating and sustaining operational Army units by performing those functions specified and implied by law. As a consequence of performing those functions, the generating force also has capabilities that are useful in supporting operations in the current operational environment. (II,6; V,2; VI,2; VI,3; VII,1; VII,3)

H

Health Insurance Portability and Accountability Act (HIPAA): A set of laws and regulations designed to protect privacy of patients' protected health information. Source: Public Law 104-191; DoD Regulation 6025.18-R, 14 Jan 03. (V,2; IX,3)

Health Promotion Council: A senior working group comprised of representatives (06 or Civilian equiv) from across the ARSTAF, Secretariat and commands who are the Army's "eyes-on" to the HP/RR/SP change process. The Council expedites governance, policy, structure and process solutions from HQDA through appropriate command/support channels to the front lines at post, camp, station and to every theater of operation. (VI,1)

High Risk Behavior: Behavior that places the individual or others in danger or harm's way (e.g., huffing, no seatbelt/helmet use, texting while driving, driving under the influence and illegal/illicit use of drugs). (III,1; III,3)

High Risk Event: High risk behavior with a serious outcome often resulting in leadership, law enforcement or medical intervention (e.g., attempted suicide, sexual assault, workplace violence, etc.). (VI,4; VII,4)

Homicide: Death resulting from a volitional act committed by another person to cause fear, harm or death. Intent to cause death is not required for classification as a homicide. For the purpose of CID investigations, criminal homicide involves the premise that the killing was done without justification or excuse. The UCMJ identifies homicide in four classes: negligent homicide, involuntary manslaughter, voluntary manslaughter and murder. Source: CID Reg. 195-1, *Criminal Investigation Operational Procedures, 3 Jun 09*. (II,1; III,1; III,2; VIII,2)

I

Impact: One of the metrics used to evaluate a specific research program; the projected level of change produced by the results of the research. (X,3)

Initiatives Cycle: The long cycle within the Rebalancing Cycle in the Program Management Model. It is used in the CPI to introduce new programs that require an initial capabilities assessment. It ensures new/major

modifications in programs are thoroughly assessed to achieve effectiveness in program portfolio performance. (VII,2)

Inter Event Stage: The middle stage in the Event Cycle. Individuals in the inter-event stage have signaled that they are at increased risk and require institutional intervention (e.g., self-referral, command referral, law enforcement involvement, emergency service response, etc.). (VI,3)

L

Lean Six Sigma (LSS): The process improvement methodology used to support Army Business Transformation. LSS combines the principles of Lean (reducing and eliminating non-value activities) with Six Sigma (reducing variation, increasing quality) to improve process efficiency and effectiveness. Source: U.S. Army Office of Business Transformation.

www.armyobt.army.mil/about-continuous-process-improvement.html (VI,3; VII,2)

M

Manner of death: The circumstances under which the death occurred and is categorized as homicide, suicide, natural, accident or undetermined. Source: CID Reg. 195-1, *Criminal Investigation Operational Procedures, 3 Jun 09*. Compare Cause of Death, defined above. (II,1; VIII,2)

Medical Review Officer: Army physicians tasked with the additional duty of reviewing drug positive cases to determine whether drug use was authorized. Sources: AR 600-85, *The Army Substance Abuse Program (*RAR 001,12 Feb 09)*; MEDCOM Reg. 40-51, *Medical Review Officers and Review of Positive Urinalysis Drug Testing Results, 30 Mar 05*. (III,1; III,2; III,3)

Mental Health Advisory Teams (MHAT): Teams of behavioral science experts designed to provide an assessment of behavioral health and wellbeing, examine the delivery of services and provide recommendations for program sustainment and improvement in a deployed environment. (IX,2; X,2)

Mild Traumatic Brain Injury (mTBI): A concussion caused by events that entail a blow or jolt to the head that may or may not cause a loss of consciousness. Source: Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury.

www.dcoe.health.mil/blog/article.aspx?id=1&postid=78. (II,2)

Misdemeanor Crimes: Any offense not punishable by death or imprisonment for a term exceeding one year. Included are violations of those provisions of state laws made applicable to U.S. military reservations. Source: AR 195-2, *Criminal Investigation Activities*, 15 May 09. (III,2; III,4; III,6; III,8; VIII,2)

Modification Cycle: The short cycle of the Rebalancing Cycle in the Program Management Model. It represents a rapid rebalancing of existing programs to respond to emerging requirements. It reduces management process cycle times to achieve efficiencies in program portfolio performance. (VII,2)

Multiple Offender: A Soldier who has committed two felonies (separate cases at different times) or had two positive drug tests. (III,3)

N

Natural death: Death due solely or nearly totally to disease and/or the aging process. Source: CID Regulation 195-1, *Criminal Investigation Operational Procedures*, 3 Jun 09. (VIII,2)

Non-fatal suicide behavior: Self-inflicted, potentially injurious behavior for which there is evidence of intent to die. (VII,1)

O

Organizational Analysis and Design: A business process that creates a world-class organization structure that focuses on the customer and concentrates on the core business. (VI,2)

Oxycodone (Oxy): an opioid analgesic medication synthesized from opium-derived thebaine. It is one of several semi-synthetic opioids that attempt to improve on existing opiates and opioids including morphine, diacetylmorphine (heroin), and codeine. Oxycodone oral medications are generally prescribed for the relief of moderate to severe pain. Brand names include OxyContin, Oxy-IR, OxyNorm, Percodan, and Roxicodone.

P

P-DOTMLPF-R: The acronym for the conceptual model used to conduct a holistic analysis of processes and systems. A P-DOTMLPF-R analysis considers policy, doctrine, organization, training, materiel, leadership and education, personnel, facilities and resources. (V,3)

Paroxetine: A selective serotonin reuptake inhibitor (SSRI) antidepressant. Paroxetine is used to treat major depression, obsessive-compulsive, panic, social anxiety, and generalized anxiety disorders in adult outpatients. Brand names include Paxil and Seroxat.

Portfolio Capabilities Assessment: The second subsection of the Portfolio Management Model. It involves the scoring and adjustment (creation, elimination or modification) of capabilities within programs in a portfolio to ensure they are complementary but competitive to reduce both gaps and redundancies. (VI,2)

Portfolio Management Model: A management model used for a specific portfolio to portray the programs within the portfolio. The model is divided into subsections of the management process (Requirements and Program Capabilities Assessment, Portfolio Capabilities Assessment, Validating and Approving the Balanced Portfolio, Continuous Process Improvement). (VII,3)

Portfolio Management: The Army's process for prioritizing and committing resources based upon validated requirements with the purpose

of creating a portfolio to align programs with the Army's strategic goals and objectives. Establishes business rules that ensure efficient and effective distribution of resources and capabilities. (VII,2)

Portfolio: A collection of investments (programs) that aims to maximize value while constraining risk. Source: U.S. Army Office of Business Transformation, <http://www.armyobt.army.mil/cpi-kc-glossary.html#p>. (VII)

Post Event Stage: The last stage in the Event Cycle. It coincides with the outcome of probable high risk behavior requiring institutional intervention. It results in investigative and reporting requirements for outcomes associated with attempted suicide, serious injuries, crimes or death. (VI,3)

Post Traumatic Stress Disorder (PTSD): An anxiety disorder that can occur after experiencing a traumatic event. Anyone who has gone through a life-threatening event can develop PTSD. These events can include combat or military exposure, sexual or physical abuse, terrorist attacks and natural disasters. Source: Defense Centers of Excellence for Psychological Health & Traumatic Brain Injury www.dcoe.health.mil/ForHealthPros/TipsforTreatingTBI_PTSD.aspx. (II,2)

Pre Event Stage: The first stage in the Event Cycle. Individuals in this stage are perceived as unaffected by stressors and demonstrate no indicators of increased risk. This stage may last indefinitely or transition to the next stage based on the individual's response to acute, recurring, or cumulative stress. (VI,3)

Privacy Act: Law governing the collection, maintenance, use and dissemination of personally identifiable information (PII) about individuals that are maintained in systems of records by federal agencies. The Privacy Act generally bars agency disclosure of PII without the individual's consent. Source: Public Law No. 93-579 (IX,3)

Productivity: One of the five metrics used in the Program Capabilities Assessment. A measurement of the efficiency and effectiveness of the program. (VI,2; VII,2)

Program Capabilities Assessment: A process in the *HP/RR/SP Portfolio Management Model* by which program capabilities are evaluated using specific, objective and standardized performance measures. (VII,2)

Program Governance Model: Establishes the governance and business management design for the *HP/RR/SP Program Portfolio*. It integrates the proponents, policy, structure, process and implementation functions for HP/RR/SP programs from HQDA to the garrison levels. It provides the recommended vertical and horizontal alignment of HQDA proponents, core enterprises, commands, subordinate commanders, garrisons, program/service providers, COMPOs and ASCCs across the Event Cycle and Care Continuum. (VI,3)

Program Portfolio: A refined group of programs produced by the *HP/RR/SP Portfolio Management Model* that maximizes the readiness of the force by providing comprehensive coverage and care for commanders, Soldiers and Families. Program Portfolio encourages responsible stewardship of resources by eliminating gaps, redundancies and inefficiencies and ensures quality services through performance analysis. (VI,2; VII)

Program Score Card: The proposed format to evaluate, compare, analyze and synchronize programs for inclusion in a specific portfolio. Uses, at a minimum, feasibility, cost, impact, balance and transition partners as metrics to optimize effectiveness and efficiency. (X3)

Q

Quality: One of the five metrics used in the Program Capabilities Assessment. A measurement of the program's ability to adhere consistently to measurable and verifiable standards and achieve uniform output that satisfies specific customer or user requirements. (VI,2; VII,2)

R

Rebalancing Cycle: A subsection of the Program Management Model. It represents Continuous Process Improvement and includes the "modification cycle" and the "initiatives cycle." (VII,2)

Requirements and Program Capabilities

Assessment: The first subsection of the Portfolio Management Model. It is comprised of five metrics to evaluate each program in the portfolio and to complete a Program Scorecard (Quality, Productivity, Cost, Access/Delivery, and Expeditionary). (VII,2)

Research Governance Model: A proposed Governance Model based on research. Designed to provide visibility of other related research; Provides a mechanism to prioritize research; Provides an enterprise forum to exchange information among other research communities; Maintains a centralized repository of research and results; and Ensures the transition of research findings for operational implementation. (X,1; X,2)

Research Portfolio: A proposed portfolio designed to maximize the value and constrain the risk associated with research. Requires an integrated governance model to ensure effectiveness and efficiency. (X1; X2)

Research Synchronization Forum: A proposed forum designed to ensure enterprise-wide coordination among researchers, maximize efficiency and deliver effective results to both senior leaders and program/service providers. (X,2)

Research: Consists of primary (basic science),

applied (translational), clinical and epidemiological study as well as surveys and program evaluation. This covers the spectrum of internal (ARL, ARI, CHPPM, MRMC, etc.) and external (NIMH, DARPA, RAND, VA, academia, etc.) sources, medical and non-medical, from discovery science to fielding programs. (II,1; II,2; V,3; X)

Resilience/Resiliency: A reaction to stress, transitions, or life events. A more resilient person feels less stress and is less negatively affected by transitions or life events. An increase in one's resiliency may be the result of preparedness or becoming adjusted to changes and events. (IV)

S

Serial Offender: A Soldier who has committed three or more felonies (separate cases at different times) or has had three or more positive drug tests. (III,3)

Silo: Refers to information flow that is not laterally shared with supporting individuals or organizations. Silo references the tube-like nature of a grain silo.

Situational Awareness:

— In the context of Army governance: the ability to generate actionable knowledge through the use of timely and accurate information about the Army enterprise, its processes and external factors.

— In the context of Information gathering: sharing relevant, timely, accurate and actionable information about units, Soldiers, Families and programs. (V; VI,2; IX,4)

Soldier Life Cycle Strand: Transitional events which focus on the professional yet personal transitions common to all Soldiers such as promotions, school, boards, etc. Events in the Unit Life Cycle Strand can drive events in the Soldier Strand and vice versa. (IV,2)

Stigma: The perception among leaders and Soldiers that help-seeking behavior will either be detrimental to their career (e.g., prejudicial to promotion or selection to leadership

positions) or that it will reduce their social status among their peers. (II,1; II,2)

Suicide Event: Events, acts, or thoughts associated with an intentional, self-inflicted death, injury, illness or poisoning. Includes suicides, suicide attempts, self-harm events and suicidal ideations. (II,2; V,2; VI,3)

Suicide: Self-inflicted death with evidence (either explicit or implicit) of intent to die. Source: AR 600-63, *Army Health Promotion, RAR 20 Sep 09*.

T

Track: The last of the three lines of efforts in the Army Warrior Mild Traumatic Brain Injury (mTBI) Campaign Plan. The focus is on developing effective tracking systems, mechanisms and business rules to track those Soldiers who have or may have sustained mTBI. Data collected, along with lessons learned, will inform future research priorities. (X,4)

Train and Educate: The first of the three lines of efforts in the Army Warrior Mild Traumatic Brain Injury (mTBI) Campaign Plan. The emphasis is on educating all Soldiers and leaders on the importance of seeking care for mTBI immediately after any concussive event. Soldiers learn that mTBI is a physical injury that must be identified and treated properly in an effort to avoid or mitigate persistent symptoms and long term health problems. (X,4)

Transition Partners: One of the metrics used to evaluate a specific portfolio program. A measurement of whether the research program has identified appropriate internal or external entities for implementing research results. (X,4)

Transitional Psychology: Study dedicated to life transitions and their impact as a part of life stage theory. Transitional Psychology recognizes and seeks to better understand the relationship between transitions and personal, career and life stress. Source: Dai Williams, www.eoslifework.co.uk/transprac.html. (IV,1)

Transitions: Changes to an individual's role or environment associated with significant life events such as entering the Army, death of a loved one, PCS, promotion, etc. (IV)

Traumatic Brain Injury (TBI):

The result of a blow or jolt to the head or a penetrating head injury that disrupts the function of the brain. Not all blows or jolts to the head result in a TBI. The different degrees of TBI include: Mild, Moderate and Severe TBI. Source: Defense Centers of Excellence for Psychological Health www.dcoe.health.mil/blog/article.aspx?id=1&postid=78 (II)

Treat: The second of the three lines of efforts in the Army Warrior Mild Traumatic Brain Injury (mTBI) Campaign Plan. The focus is on treating Soldiers who are diagnosed with mTBI. (X,4)

U

Undetermined Death: Death that occurs when the information pointing to the manner of death (e.g., accidental) is no more compelling than one or more other competing manners of death (e.g., natural or suicide). Source: CID Regulation 195-1, *Criminal Investigation Operational Procedures, 3 Jun 09*. See definition of Cause of Death and Manner of Death. (II,1; III,1; III,3)

Unit Integration: A planned transition associated with team building. Ensures Soldiers and Families achieve an immediate sense of purpose, worth and belonging upon arriving at a new unit or in preparation for pre-deployment and post-deployment phases. (IV,4)

Unit Life Cycle Strand: Part of the Composite Life Cycle model describing predictable and unpredictable unit rhythms/transitions such as predeployment, deployment, redeployment, reintegration/reset, compressed deployment cycles, or extensions in theater, etc. (IV,2)

V

Validating and Approving the Balanced Portfolio: The third subsection of the Portfolio Management Model. It is the oversight and review of a portfolio and validation of that portfolio against current Army Policy. (VII,2)

W

Worldwide Individual Augmentation System (WIAS): A system that fills critical personnel requirements not satisfied by unit deployments. (IV,2; VII,3)

Section III – Directives, Regulations Forms, Pamphlets, Manuals & Instructions

Army Directives

Army Directive 2009-03

Army Data Management

Army Directive 2010-01

Conduct of AR 15-6 Investigations Into Suspected Suicides and Requirements for Suicide Incident Family Briefs

Army Directive 2010-05

Shift of CONUS ASAP Counselors to U.S. Army IMCOM Control

Army Regulations (AR)

AR 15-6

Procedures for Investigating Officers and Boards of Officers

AR 190-45

Law Enforcement Reporting

AR 195-2

Criminal Investigation Activities

AR 350-1

Army Training and Leader Development

AR 600-63

Army Health Promotion Program

AR 600-85

The Army Substance Abuse Program

AR 635-200

Active Duty Enlisted Administrative Separations

Department of the Army Forms (DA Form)

DA Form 3975

Military Police Report

DA Form 4833

Commander's Report of Disciplinary or Administrative Action

DA Form 8003

Army Substance Abuse Program Enrollment

Department of the Army Pamphlets (DA PAM)

DA PAM 600-24

Health Promotion, Risk Reduction and Suicide Prevention

DoD Forms (DD Form)

DD Form 214

Certificate of Release or Discharge from Active Duty

DD Form 2064

Certificate of Death (Overseas)

DD Form 2795

Pre-Deployment Health Assessment Questionnaire

DD Form 2796

Post-Deployment Health Assessment Questionnaire

DD Form 2900

Post-Deployment Health Re-Assessment

DoD Directives (DoDD)

DoDD 1010.1

Military Personnel Drug Abuse Testing Program

DoDD 6490.1

Mental Health Evaluations of Members of the Armed Forces

DoD Instructions (DoDI)

DoDI 5154.30

Armed Forces Institute of Pathology Operations

DoDI 6025.18-R

DoD Health Information Privacy Regulation

DoD Manuals (DoD Manual)

DoD Manual 7730.47M

Manual for Defense Incident Based Reporting

Annex B – Conclusions & Recommended Actions/Research

The Conclusions within this report are derived from the experiential knowledge of Army HP/RR/SP programs/services, research and knowledge of Army governance, policy, infrastructure and process gained from more than 15 months of Army Suicide Prevention Task Force and Army leader action. Conclusions correlate to either Recommended Actions or recommendations for future research and apply to all levels of the Army from HQDA to field and garrison organizations. Implementation of the associated Recommended Actions offers the means to improve Army HP/RR/SP efforts. The Army Health Promotion Council (AHPC) will analyze and track implementation of this report's conclusions and recommendations via the *HP/RR/SP Synchronization Matrix* to integrate and synchronize recommended solutions.

Conclusions & Recommended Actions

All Conclusions and Recommended Actions are consolidated by chapter in the tables below. (There is no table for the report's Section I, "*Introduction to HP/RR/SP*"). A "★" is used to identify foundation Conclusions and Recommended Actions. Supporting Conclusions and Recommended Actions are marked by a "●" and complement the foundation set. Each Conclusion is followed by a page reference to its source within the report text. Each Recommended Action is followed by a page reference to its origin within the report.

Recommended Research

Many questions identified in the preparation of this report need additional exploration to expand the Army's understanding of HP/RR/SP issues. While the questions may have been identified, the answers remain obscure, incomplete, or elusive. As a result, Section II of this annex contains a series of recommended research topics, organized by their applicability to the eight phases of the Care Continuum.

Section I – Conclusions & Recommended Actions

SECTION II – THE REALITY OF SUICIDE

CONCLUSIONS

- ★ In FY 2009, more Soldiers died as a result of high risk behavior than died in combat. (page 11)
- ★ At any point along the Care Continuum there is an opportunity for the individual, Family, friends or leaders to intervene. Intervention requires an understanding of the high risk behavior often associated with suicide and equivocal deaths. (page 12)
- ★ It is difficult to directly compare and contrast the Army's suicide rate to the general (national) population due to differences in: reporting timelines and procedures, investigative protocols, manner of death determination, economic stressors, access to healthcare and access to behavioral healthcare. (pages 12-15)
- ★ High risk behavior (e.g., drug abuse, alcohol related incidents and suicidal behavior) is the leading cause of death for both the civilian and military populations for those under the age of 50. (page 15)
- ★ The self-selection bias of young adults who are willing to join the Army at a time of war may indicate a higher level of risk tolerance than their civilian counterparts. (page 15)
- ★ While the civilian suicide rate has remained relatively stable through 2007 (with 2008 and 2009 unknown), the Army rate has increased steadily through FY 2009 (see Figure 6). (page 16)
- ★ The greatest increase in military suicides have occurred in the Army and Marine Corps which have borne the greatest burden of ground combat in a protracted war. (page 16)
- ★ Job-related stress may be more acute among Reserve Component Soldiers. (page 17)
 - The "typical" suicide victim within the Army between 2005 and 2009 while on active duty was an Active Component, 23 year old, caucasian, junior enlisted male Soldier. (page 18)
 - The demographic profile for Soldiers who died by suicide while not on active duty between 2005 and 2009 were young, caucasian, junior enlisted male Soldiers who have never deployed. (page 19)
- ★ Manner of death determination may underreport a number of suicides by other means. This creates an artificial distinction between determination of suicide and other equivocal deaths. (page 20)
- ★ The American Institute of Pathology notes that "risk-taking behavior poses challenges when classifying manner of death... Injury or death, when it occurs during such [high risk] activities is not entirely unexpected, prompting the argument that such deaths may not truly be accidents." (page 20)
- ★ Despite the progress made in an attempt to better understand behavioral health issues related to suicide, research on suicide prevention still lacks definitive answers. (page 21)
- ★ The perceived stigma associated with seeking behavioral health treatment is a real barrier for those who would benefit from seeking professional care. (page 22)

SECTION II – THE REALITY OF SUICIDE

CONCLUSIONS

- ★ Those Soldiers who need behavioral health care the most are typically the least likely to seek care. (page 22)
- ★ Individual relationship stressors, life conditions, high risk behavior and medical conditions have been found to increase the likelihood of suicide. (page 23)
- ★ The individual stressors most frequently cited in suicide death investigations are relationship stress (58%) and work stress (50%), which may be catchall categories for other risk factors. (page 24)
- ★ Early recognition and intervention of legal, medical and disciplinary risk factors presents an opportunity for leaders, law enforcement personnel and program/service providers to prevent negative outcomes. (page 25)
- ★ Diagnosed cases of PTSD have steadily increased in the Army since 2003. Untreated PTSD can lead to suicidal behavior. (page 26)
- ★ Drug and alcohol abuse is a significant health problem in the Army. Almost 30% of the Army suicide deaths from CY03-CY09 and over 45% of the non-fatal suicidal behavior from CY05-CY09, involved the use of drugs or alcohol. (page 27)
- ★ The use of antidepressant, psychiatric and narcotic pain management medications has increased within the Army. Although the use of some types of antidepressants has been shown to increase suicidal behavior, they reduce depression and anxiety, which are known suicide behavior risk factors. (page 28)
- ★ Comorbidity is a challenge within the Army, both for the Soldiers affected and the health care providers who must sequence treatment of multiple conditions. (pages 29-30)
- ★ Early detection of behavioral health conditions results in increased willingness to begin treatment and better resolution of symptoms. (page 31)
- ★ Primary care represents the best opportunity to diagnose behavioral health issues in a population resistant to seeking behavioral health care. (page 32)

Refer to Section II – The Reality of Suicide – for associated discussion

SECTION II – THE REALITY OF SUICIDE

RECOMMENDED ACTIONS

- ★ [ALL] All leaders and program/service providers should review this report to better understand the nature of high risk behavior associated with suicide and equivocal deaths. (page 12)
- ★ [CDRs] Leaders should recognize that a potential self-selection bias indicating high risk tolerance, combined with service related transitions may result in high risk behavior – especially among first term Soldiers. (page 16)
- ★ [HQDA] Charter research to test the hypothesis that Soldiers who voluntarily enlist [self-select] during a time of war may be more willing to engage in high risk behavior. (page 16)

SECTION II – THE REALITY OF SUICIDE

RECOMMENDED ACTIONS

- ★ [HQDA] Fund suicide behavior surveys that span both civilian and military populations in order to make direct comparisons. (page 21)
- ★ [HQDA] Enhance research efforts for identifying at-risk Soldiers to provide effective and efficient programs/services. (page 23)
- ★ [CDRs] Ensure leaders at all levels encourage help-seeking behavior and convey anti-stigma messages as a routine matter of unit operations. (page 23)
- ★ [HQDA] Research the risk sub-factors that make up larger catchall stressor categories such as relationship and work stress to identify and target specific factors contributing to suicidal behavior. (page 26)
- ★ [HQDA] Coordinate with OSD to modify the DoDSER to implement future research findings regarding specific risk sub-factors associated with larger catchall stress categories. (page 26)
- ★ [ALL] Identify and mitigate stress during the critical window of legal/law enforcement encounters and subsequent adjudication actions. (page 26)
 - [HQDA] Ensure mTBI is evaluated, treated and tracked as close to the time of injury as possible following blast/concussive/overpressure exposure. (*Source: Army Campaign Plan for Warrior mTBI*). (page 26)
- ★ [MEDCOM] Implement standardized treatment protocols to identify other behavioral health issues in Soldiers who report or are diagnosed with mTBI/PTSD. (page 30)
- ★ [HQDA] Enhance policies to increase alcohol and drug reporting and referral for early detection and treatment of substance dependency and/or abuse. (page 30)
- ★ [HQDA] Conduct comprehensive research and analysis of the impact of increased use of antidepressant, psychiatric and narcotic pain management medications on the force. (page 30)
- ★ [HQDA] Conduct research to identify appropriate antidepressant medications that are beneficial to the treatment of depression and anxiety, but that will not increase risk for suicidal behavior. (page 30)
- ★ [MEDCOM] Clinicians need to carefully weigh the risks with potential benefits of using SSRIs when treating 18 to 29 year-old patients due to the increased risk for suicidal behavior. (page 31)
- ★ [HQDA] Initiate research to develop effective mitigation strategies to counter the effects of comorbidity on Soldiers and address the full spectrum of war-related health concerns. (page 31)
- ★ [MEDCOM] Expand Primary Care provider screening of patients for behavioral health issues (e.g., RESPECT-MIL). (page 33)

Refer to Section II – The Reality of Suicide – for associated discussion

SECTION III – THE LOST ART OF LEADERSHIP IN GARRISON

CONCLUSIONS

- In 2008, Army suicide numbers surpassed historical civilian averages for the first time since the Army began keeping suicide statistics in the early 1980s. (page 35)
- ★ The Army's professional development priorities and operational tempo have eroded the technical skills, communication skills and experiential knowledge needed to lead/manage effectively in the garrison environment. (page 36)
- Soldiers have become transient tenants of garrisons. They come and go in formations, groups and as individuals while they mobilize/demobilize, deploy/redeploy, serve under WIAS, PCS or travel TDY. (page 36)
- ★ Army Transformation and the creation of IMCOM have resulted in the decoupling of field commands from garrison management creating a permissive environment for high risk behavior. (page 36)
- ★ The demands of a protracted conflict have created a transient population with units and Soldiers on a constant move. Confused roles and responsibilities coupled with a loss of situational awareness have eroded accountability in the force. (page 37)
- Recurring combat rotational requirements have resulted in young and mid-level leaders whose only command experience is meeting the demands of deployment cycles. (page 37)
- Value of and appreciation for good order and discipline practices such as unannounced health and welfare checks in the barracks accompanied by Military Police Working Dog sweeps, unannounced 100% urinalysis tests, POV safety inspections, counseling, ceremonies, and accountability formations have been lost. (page 37)
- ★ The composition of the Army does not realistically reflect the society as a whole; individuals who "self select" during persistent conflict drive the makeup of the all-volunteer Army. (page 40)
- ★ By enforcing policy in a fair, judicious and equitable manner, leaders can determine Army culture through selective enlistment, retention and separation. (page 40)
- ★ There were 1,058 non-combat Soldier deaths investigated by CID from FY 2006 to FY 2009:
 - 916 deaths were the direct result of high risk behavior including murder, suicide, accidents or of an undetermined manner.
 - Of the 916 deaths, 417 involved drugs or alcohol use at the time of death.
 - 188 were the result of drug or alcohol overdose. (page 41)
- ★ Report data had to be extracted from several disparate databases from a small number of individuals who control and release these data. (page 42)
- ★ An increase in high risk behavior was caused by the loss of enterprise visibility due to a lack of data integration, reduced accountability for policy execution and an aversion to making often difficult decisions. (pages 42)
- ★ An increase in the high risk population is strongly supported by an overall increase in criminal and drug activity over the last five years. (page 43)
- ★ Behavior of the high risk population transfers risk to the population at large. (page 43)
- ★ Approximately 29% of suicides since FY 2005 included either drug or alcohol use. In addition, 25% were subjects of prior misdemeanor or felony investigations. (page 43)

SECTION III – THE LOST ART OF LEADERSHIP IN GARRISON

CONCLUSIONS

- ★ In FY 2009 alone, 15,074 cases of Soldier misconduct cannot be linked to any known disciplinary or corrective actions taken or recorded in law enforcement data. (page 43)
- ★ An increase in the number of prescriptions leads to potential masking of both drug addiction and distribution. (page 44)
- ★ Inadequate surveillance/detection of prescription drug abuse enables an increase in the high risk population. (page 44)
 - Last year, over 8,000 samples tested positive for a MRO reviewable drug with 21% found to be illicit. (page 44)
 - The real number of overall prescription positives may have been closer to 30,401 with close to 3,925 being illicit use. (page 44)
 - 45% of accidental or undetermined deaths over the last four years involved drugs or alcohol overdose. (page 45)
 - Currently, 14% of the entire Army population is prescribed some form of opiate. (page 45)
- ★ There is no other aspect of HP/RR/SP that is more important for preventing negative outcomes than the vigilance of the individual commander, supervisor, Soldier, law enforcement agent or program/service provider. (page 46)
- ★ Commanders, leaders, Soldiers and program/service providers have a specific duty to take action in response to high risk behavior. (page 46)
- ★ Commanders lack visibility of information revealed by any earlier investigations/adjudication to weigh the risk and make an informed decision regarding Soldier disposition (discipline/separation). (page 47)
- ★ Gaps in ASAP potentially have allowed approximately 40,000 Soldiers to illicitly use drugs without being detected. (page 48)
- ★ Investigations of single drug incidents indicate the social nature of illicit drug use; 25% of 34,962 CID drug investigations between FY 2001 and FY 2009 include multiple subjects. (page 50)
- ★ From FY 2001 – FY 2009, a total of 1.6 million individual Soldiers were tested for illegal drug use. Of those, 58,687 were positive for an illegal substance. (page 51)
- ★ 38% of those Soldiers who tested positive had actually tested positive as a multiple (two times) or a serial (three or more times) offender. (page 51)
- ★ As the force has grown, the number of samples taken per year has not adjusted accordingly. Last year over 78,517 Soldiers were not tested which may have left 1,311 drug offenders undetected. (page 51)
- ★ DoD requires a minimum number of samples (20%) be tested for controlled substances. The Army's testing rate for controlled substances last year was actually (18%). The Army has yet to meet the 20% standard set by DoD. (page 54)
- ★ There were 5,505 unresolved positive samples between FY 2001 – FY 2009, which equates to approximately 2,004 Soldiers who are illicitly using pharmaceuticals. (page 54)

SECTION III – THE LOST ART OF LEADERSHIP IN GARRISON

CONCLUSIONS

- ★ The amount of amphetamines being prescribed has more than doubled between FY 2006 and FY 2009. (page 55)
- ★ The combination of increased amphetamine prescription and the new oxycodone screening effectively doubled the rate of MRO reviews. (pages 55)
- ★ In FY 2009 alone, almost 80% of all MRO reviewable drugs were deemed “authorized use” compared to the low point in FY 2005 of 33%. This illustrates the amount of pharmaceuticals with serious abuse potential that are currently being prescribed across the force. (page 55)
 - There is concern, due to open-ended prescriptions with no expiration date, that MRO authorizations may mask opiate and other legal drug dependence and illicit drug use. (page 56)
- ★ Since UA positives are detected at low nanogram quantities, there should be some expectation as to normal pharmacological and therapeutic limits, which could discern legitimate from illicit use. (page 56)
- ★ Pharmaceutical drugs account for only 18% of the illicit drug use cases and make up 3.1% of felony use or possession cases but were involved in almost one third of the active duty suicides last year. (page 56)
- ★ Of the 188 accidental or undetermined deaths caused by drugs or alcohol from FY 2006 – FY 2009, 139 (74%) were caused by prescription drugs. (page 56)
- ★ It is often only in hindsight (post mortem) that we see indications of undocumented high risk behavior that provided opportunity for life saving intervention. (page 58)
- ★ Senior leaders determine when a DA Form 4833 should be command generated in order to establish a record of potentially criminal activity. The current language for “command referred” DA Form 4833 contained in ARs 190-30, 190-45 and 195-2 is ambiguous and does not provide commanders a clear indication of when initiation is required. (pages 58-60)
- ★ Commanders and law enforcement must report crimes to DIBRS for input into NIBRS as required by the Uniform Federal Crime Act. This includes active military personnel accused of:
 - Attempted or completed suicide.
 - Fraternalization, sexual harassment, a sex-related offense, a hate or bias crime or a criminal offense against a victim who is a minor and investigated by a commander, military officer or Civilian in a supervisory position (AR 15-6). (page 59)
- ★ Gaps in reporting felony drug offenses result in underreporting of drug crimes across the Army. If we examine the difference between DAMIS and ACI2 data, we find that in FY 2009 there were 1,415 illicit drug use positives never reported to law enforcement. (page 60)
- ★ There is no single database that commanders can examine to get a holistic picture of Soldier misconduct; they must depend on “silo’ed” databases (ASAP, COPS and ACI2). (page 60)
- ★ With no DA Form 4833 on file at the Crime Records Center, the founded offense cannot be closed and the final disposition remains unknown to law enforcement and the Army. (page 60)
- ★ The total number of DA Forms 4833 being sent to commanders for action has increased by almost 147% since 2004; the compliance percentage has leveled off at 64%. (page 61)
- ★ The gap between criminal offenses and reported adjudication is increasing year over year with 15,074 DA Forms 4833 not submitted in FY 2009. (page 61)

SECTION III – THE LOST ART OF LEADERSHIP IN GARRISON

CONCLUSIONS

- ★ With the exception of illicit drug use, policy does not establish clear thresholds for separation for most criminal offenses. (page 61)
- ★ When commanders believe their Soldiers have a drug or alcohol problem they must refer them to ASAP for clinical evaluation using DA Form 8003 (ASAP Enrollment). (page 63)
- ★ Use of DA Forms 8003 is not tracked and, therefore, there is no visibility of the number of command referrals. DAMIS data from FY 2009 indicate that while there were 7,907 Soldiers who tested positive for illicit drug use, only 4,111 were screened by ASAP. (page 63)
- ★ Army Regulation 600-85 directs commanders to initiate separation for Soldiers who test positive for illicit drug use. (page 64)
- ★ Soldiers who test positive for illicit drugs a **second** time or are convicted of driving while intoxicated a **second** time during their career, shall be administratively separated from the Service. (page 64)
- ★ Neither Chapter 9 nor 14 is ideally suited to respond to the Army's emerging drug use, high risk behavior and death trends. (page 65)
- ★ Use of Chapter 9 is at odds with how ASAP defines recidivism, which is an alcohol/drug relapse within one year of completing alcohol/drug rehab. On one hand the Army defines program failure as "recidivism" (rehab completion plus one year), while on the other, it brackets use of the chapter associated with program failure to the rehab program window only. (page 65)
- ★ Chapter 14 has become the catchall for a wide range of criminal activities, misconduct and disciplinary infractions; it masks the Army's ability to analyze and predict trends regarding drug use and the emerging high risk population (in covering everything, it signifies nothing). (page 66)
- ★ Chapter 9 is underutilized. Between FY 2001 – FY 2009 there was an average of 277 Chapter 9 separations per year compared to an average of 2,208 drug rehab failures in each year. (page 66)
- ★ Since FY 2004, Chapter 11 separations have significantly decreased while entry waivers have increased from FY 2004 – FY 2007. (page 68)
- ★ While the Army increased by 74,000 Soldiers, the total number of separations (all chapters) has decreased since FY 2001, likely resulting in the retention of 25,283 Soldiers who would not have been retained in previous years. (page 68)
- ★ Drug and misconduct waivers increased steadily from FY 2004 and peaked in FY 2007 at 11,766; although waivers declined in FY 2009, 6,137 waivers were granted (Figure 18). (page 69)
- ★ In FY 2009, first term Soldiers account for the vast majority of the 74,646 criminal offenses, 7,907 positive urinalysis for illicit drug use, and 1,713 reports of attempted suicide. (page 70)
- ★ From FY 2001 – FY 2009, only 69.9% of all DUIs and 60.7% of all positive urinalysis were referred to ASAP for evaluation. (page 70)
- ★ In FY 2009 alone there were 50,523 misdemeanor offenses committed by Soldiers. (page 72)
- ★ Misdemeanor crimes are on the rise since 2004 by almost 5,000 per year which indicates that good order and discipline are on the decline. (page 72)

SECTION III – THE LOST ART OF LEADERSHIP IN GARRISON**CONCLUSIONS**

- ★ In real terms of unit readiness and team cohesion misdemeanors affected over 59,000 fellow Soldiers and Families. (page 72)
- ★ There were 64,022 felony and death investigations conducted between FY 2001 – FY 2009, of which 72% were drug related. The 64,022 investigations involved 68,028 subjects and 109,903 victims. (page 73)
- ★ 40% of the illicit use drug UA positives were never referred for felony investigation. (page 73)
- ★ Gaps in silo'ed reporting prevent commanders from receiving accurate and timely information. (page 74)
- ★ Between FY 2001 – FY 2009, approximately 10,600 Soldiers committed two or more felony offenses (separate cases at different times) with 1,054 remaining in the Army. (page 75)
- ★ Between FY 2001 – FY 2009, 109 multiple and serial felony offenders and drug abusers died while still serving. Of these, 77 died from overdose, suicide or DUI. (page 76)
- ★ Retaining multiple criminal offenders is an unacceptable liability to the Army, their potential victims and the offenders themselves. (page 76)
- ★ 58,687 Soldiers tested positive for illicit drug use between FY 2001 – FY 2009. 36,470 were first time positives, 11,828 were multiple and 10,389 were serial offenders. (page 77)
- ★ There is a 90% chance a Soldier who tests positive a second time will test positive three or more times. (page 77)
- ★ By the end of next year it is expected there will be over 5,000 positive tests for amphetamine which will require an MRO review. (page 78)
- ★ It is predicted over 7,500 Guard Soldiers will test positive for THC this year. (page 78)
- ★ There is a clear and steady rise in the number of reported sexual offenses from FY 2001 – FY 2009, tripling from a low point of 265 in FY 2003 to a substantial 1,015 in FY 2009. (page 78)
- ★ 41% of the FY 2004 – FY 2009 reported and founded sexual offense cases involved drug or alcohol use. CID estimates this rate is actually closer to 60% based on an individual's reluctance to admit to underage drinking or General Order #1 violation associated with the incident. (page 79)
- ★ Law enforcement personnel may enter the offense code for assault rather than for spouse abuse, administratively reducing the total number of reported cases to law enforcement. (page 80)
- ★ There is a slow but steady rise in the number of non-combat Soldier deaths from FY 2001 – FY 2009. This increase is almost fully accounted for by the rise in both suicide numbers and accidental deaths. (page 80)
- ★ 25% of FY 2005 – FY 2009 suicide victims were prior subjects of a founded misdemeanor or felony investigation. 29% of FY 2005 – FY 2009 victims had drugs and/or alcohol in their systems at the time of death. (page 81)

SECTION III – THE LOST ART OF LEADERSHIP IN GARRISON

CONCLUSIONS

- ★ There were over 9,000 Soldiers (in the last nine years) who demonstrated substance abuse issues that were not referred to ASAP for evaluation. Drug and alcohol abuse can also be a sign of behavioral health problems. By not referring Soldiers to ASAP, we are potentially missing contact opportunities to provide program/service intervention. (page 82)
- ★ Current prescription medication policies may be masking abuse problems across the force. (page 83)
- ★ Failure to forward DA Forms 4833 to commanders results in a lack of command visibility of criminal and high risk behavior. This limits the commander’s ability to get the “whole picture” when adjudicating a course of action on an individual Soldier. (page 84)
- ★ We can expect that over 3,000 Soldiers will test positive for multiple or serial offenses at some time next year. (page 84)
- ★ A positive drug test only shows activity at or near the time of the test. There is no way to be certain of the number of times a Soldier, especially a serial abuser, used a particular drug before getting “caught.” (page 84)
- ★ The Soldiers who tested positive multiple or serial times (1,643 and 1,512 last year respectively) represent potentially more than 3,000 Soldiers who were candidates for discharge from the Army. The estimated number of such Soldiers over a nine year period would exceed 20,000. (page 84)
- Soldiers who have failed multiple drug tests (one as high as 17) are still serving in the Army. (page 85)
- ★ When cross-referencing the 10,389 SSNs of alleged serial drug users with the 2,405 SSNs of alleged serial criminal offenders from FY 2001 – FY 2009, data show 1,675 Soldiers are common to both lists. (page 85) (page 85)

Refer to Section III – The Lost Art of Leadership in Garrison – for associated discussion

SECTION III – THE LOST ART OF LEADERSHIP IN GARRISON

RECOMMENDED ACTIONS

- ★ [TRADOC/IMCOM] Ensure PME, pre-command course (PCC) and local CDR/1SG courses provide leaders with the requisite skills to mitigate the challenges of leading Soldiers in garrison. (page 38)
- ★ [All] Implement integration and reintegration programs at garrisons and units to ensure reception, integration and accountability of Soldiers and Families. Place special emphasis on the integration of young leaders and first term Soldiers. (page 38)
- ★ [CDRs] Implement programs to ensure accountability and discipline in the barracks including clear policies, non-commissioned officer (NCO) supervision and charge of quarters. (page 38)
- ★ [HQDA] Research the relationship between the “self selection” bias and the propensity to engage in high risk behavior to inform policy governing good order and discipline. (page 43)

SECTION III – THE LOST ART OF LEADERSHIP IN GARRISON

RECOMMENDED ACTIONS

- ★ [HQDA] Use the “Maze Model” to inform senior leaders at Star Conferences, PCCs, etc., as part of HP/RR/SP awareness education and training. (page 43)
- ★ [HQDA] Design integrated databases to account for Soldiers exhibiting high risk behavior to narrow gaps in the Army’s reporting, investigation, referral, discipline and separation policies. (page 43)
- ★ [HQDA] Require completion of DA Forms 4833 (including the 15,074 delinquent forms) to document critical information in law enforcement databases and provide Army-wide visibility of the high risk population. (page 46)
- ★ [HQDA] Revise policy to limit authorized use of prescription medication to one year after prescription issuance. For example, a Soldier with a prescription written in FY 2006 who tests positive for that drug in FY 2009 would not be medically cleared for authorized use. (page 46)
- ★ [HQDA] Periodically evaluate WTU Soldiers who test positive for pharmaceutical drugs to determine potential abuse/dependence. (page 46)
- ★ [CDRs] Ensure compliance with DA Form 4833 requirements to enhance situational awareness and the ability to track/trend high risk behavior. An accurate composite view of Soldier behavior (past and present) should be considered in weighing the risk and informing decisions regarding Soldier disposition (discipline/separation). (page 50)
- ★ [HQDA] Develop and field a central database (compatible with law enforcement databases) for AR 15-6 investigations of disciplinary infractions in support of the recommendation above. (page 50)
- ★ [HQDA] Revise policy to expedite urinalysis testing (on an expanded drug panel) of new/emerging pharmaceuticals with potential for abuse/dependence. (page 50)
- ★ [HQDA] Revise policy to test all panel drugs at 100% rather than DoD directed 20% for some pharmaceuticals. (page 50)
- ★ [HQDA] Prompt research to examine the social behavior of drug abuse with specific emphasis to identify the prevalent conditions (e.g., barracks introduction) that lead first term Soldiers to abuse drugs. (page 53)
- ★ [HQDA] Revise ASAP policy to require mandatory urinalysis testing of 100% of individual Soldiers annually as opposed to unit end strength testing or other metrics less than 100% of unique Soldiers (by Social Security Number). For example, mandate random testing of 4% of Soldier population weekly; require *random* 100% urinalysis testing twice annually. (page 53)
- ★ [HQDA] Revise policy to test all panel drugs at 100% rather than DoD directed 20% for some pharmaceuticals. (page 57)
- ★ [HQDA] Revise policy to limit authorized use of prescription medication to one year after prescription issuance to determine authorized use. For example, a Soldier with a prescription written in FY 2006 who tests positive for that drug in FY 2009 would not be medically cleared for authorized use. (page 57)
- ★ [HQDA] Research the normal therapeutic range for different prescription drugs to determine how to better assess potential abuse of pharmaceuticals. (page 57)

SECTION III – THE LOST ART OF LEADERSHIP IN GARRISON

RECOMMENDED ACTIONS

- ★ [CDRs] For positive drug tests, commanders must comply with current policy to initiate separation and refer the Soldier to ASAP and law enforcement. (page 57)
- ★ [HQDA] Issue an ALARACT or MEMO requiring use of the new MRO review system in DAMIS. Track utilization of the new system and improvement of MRO review rates. If there is no improvement, address the governing policy. (page 57)
- ★ [OPMG] Increase law enforcement training on the surveillance, detection and reporting of illicit pharmaceutical drug use. (page 57)
- ★ [HQDA] Implement an information campaign to inform leaders of the potential for prescription abuse within the force; include examples of Soldiers' abuse and subsequent deaths. (page 57)
- ★ [HQDA] Publish implementing guidance for DIBRS and NIBRS reporting in accordance with DoD policy. (page 62)
- ★ [HQDA] Revise AR 600-85 to direct ASAP to report all positive UAs for illicit drug use directly to both commanders and law enforcement; all positive UAs will be investigated as a criminal felony offense in accordance with AR 195-2. (page 62)
- ★ [HQDA] Consolidate criminal and misconduct databases into a single portal providing automatic feed to improve situational awareness for commanders, law enforcement and program/service providers. (page 62)
- ★ [AII] Implement DA Form 4833 reporting feedback forms/mechanisms at HQDA, IMCOM and garrison level to ensure 100% reporting compliance. Revise policy to limit reporting to 45 days upon receipt with extensions approved by the General Courts-Martial Convening Authority. (page 62)
- ★ [HQDA] Create a centralized repository for DA Forms 4833 that are generated as a result of AR 15-6 investigations to capture Soldiers' history of disciplinary infractions. (page 62)
- ★ [HQDA] Amend policy to require commanders to initiate separation proceedings for all major felonies (at a minimum, crimes against persons), not just for drug felonies (e.g., positive UAs). (page 63)
- ★ [AII] HQDA will require quarterly separation initiation/ASAP referral compliance reporting to ensure commanders initiate separation for positive drug test results and refer the Soldier to ASAP for clinical evaluation. (page 63)
- ★ [HQDA] Revise policy to provide commanders a clear indication of when "command initiation" of a DA Form 4833 is required (COPS, ACI2, DIBRS and NIBRS). (page 63)
- ★ [HQDA] Revise policy to mandate use of DA Form 8003 for all drug/alcohol referrals; track utilization at garrison, IMCOM and HQDA level. (page 68)
- ★ [HQDA] Track all Chapter initiations to differentiate between commander initiation and GO/separation board disposition. Ensure tracking closes the loop between chapter initiation and law enforcement/program visibility for final separation/disposition. (page 68)
- ★ [HQDA] Create a new misconduct code (drug and alcohol misconduct) so that the levels of drug and alcohol abuse can be tracked within the force. This should be coded as a 14a (alcohol misconduct), 14b (drug misconduct) and 14c (other misconduct). (page 68)

SECTION III – THE LOST ART OF LEADERSHIP IN GARRISON

RECOMMENDED ACTIONS

- ★ [HQDA] Expand Chapter 9 to include rehabilitation and recidivism period (rehabilitation plus one year). Additionally, add Other than Honorable as another option for characterization of service. (page 68)
- ★ [HQDA] Direct research to assess the adequacy of Army's definition of "recidivism" as one year rather than the more widely used convention of five years. (page 68)
- ★ [CDRs] Enforce separation actions for high risk behavior (felony and multiple misconduct). (page 71)
- ★ [HQDA] Revise policy to extend the amount of time during which a Soldier can be separated from the Army under Chapter 11 (from 6 months to 18 months). (page 71)
- ★ [HQDA] Reduce drug and misconduct enlistment waivers to reduce accessions of high risk recruits to ensure more resilient applicants. (page 71)
- ★ [HQDA] Direct research to assess the second and third order effects of increased waivers and relaxed separation standards in terms of crime and drug involvement and other high risk behavior. (page 71)
- ★ [HQDA] Hold commanders and ADCOs accountable for referral compliance to ASAP. (page 71)
- ★ [OPMG] Activate and/or increase Drug Suppression Team operations at all installations. (page 75)
- ★ [CDRs] Utilize military working dogs for health and welfare checks within the barracks and unit areas. (page 75)
- ★ [HQDA] Revise policy to ensure separation from the Army for all **second** felony criminal offenders. (page 77)
- ★ [HQDA] Revise Chapter 9 to extend the rehab window to include recidivism (drug rehab plus one year); revise Chapter 14 to provide specific data indicators for drug, alcohol use and other misconduct categories. Ensure separation code data is available at all levels of the Army. (page 78)
- ★ [CDRs] Process second time offenders for separation from the Army. (page 78)
- ★ [HQDA] Revise policy to separate first time sexual assault offenders from the Army. (page 79)
- ★ [CDRs] Educate leaders and Soldiers on the relationship between drug/alcohol involvement and sexual offenses. (page 79)
- ★ [HQDA] Coordinate policy revision to provide an opportunity for testimonial immunity of victims for violation of drug and alcohol policy in sexual assault cases. (page 79)
- ★ [OPMG] Prevent double reporting in COPS by making the "Referred to CID" field a mandatory populated field. (page 82)
- ★ [OPMG] Ensure assaults in cases of spouse abuse are coded appropriately for spouse abuse to provide accurate and consistent data reporting. (page 82)

SECTION III – THE LOST ART OF LEADERSHIP IN GARRISON

RECOMMENDED ACTIONS

- ★ [HQDA] Limit prescription duration so a script is not considered valid after one year without provider reevaluation and renewal. (page 83)
- ★ [IMCOM] Monthly reporting of ASAP referral rates to garrison commanders and higher headquarters to ensure compliance to existing policy. (page 83)
- ★ [HQDA] Revise policies to separate all Soldiers who commit two or more felony offenses, including drug and alcohol related offenses. (page 86)

Refer to Section III – The Lost Art of Leadership in Garrison – for associated discussion

SECTION IV – THE COMPOSITE LIFE CYCLE

CONCLUSIONS

- ★ Transitions within the Army are unavoidable and recurrent, representing extensive life stressors that affect the wellbeing of the units, Soldiers and Families. (page 89)
- ★ Compared to civilians, Soldiers experience multiple and more frequent transitions throughout their careers. (page 89)
 - These multiple transitions can produce a cumulative deterioration in Soldiers’ health, wellbeing and ability to recover before another transition. (page 89)
- ★ While stressful transitions are inevitable, their outcomes can enhance Soldier and Family wellbeing or degrade quality of life through acute, recurring or cumulative stress. (page 90)
- ★ The *Composite Life Cycle Model* is a holistic model that looks beyond the military unit to focus on the whole person through a composite view of three separate strands: the Unit Life Cycle, the Soldier Life Cycle and the Family Life Cycle. (pages 90-91)
- ★ Transitions and major life stressors often occur within a single life cycle strand. However, transitions and their associated stressors can accumulate across all three strands. (page 91)
- ★ Unit Strand transitions (e.g., pre-deployment, deployment, redeployment, reintegration and reset) recur and accumulate stress on Soldiers and Families over time. (page 91)
- ★ Stress upon units, Soldiers and Families will remain high as the Army continues to experience a high operational tempo. (page 92)
- ★ ARFORGEN is destabilized by BRAC, disaster responses, WIAS taskers and PCS; these can add stressors to the Unit Strand. (page 92)
- ★ Soldiers may incur additional stress as they PCS from one unit’s life cycle into another. (page 93)
- ★ While a 1:3 BOG:Dwell ratio is optimum to restore overall behavioral health, the current median BOG:Dwell ratio for all grades is just below 1:2. (page 93)
- ★ Since behavioral health wellbeing does not return to “baseline” until 24-36 months after a deployment, Soldiers and Families who experience shortened dwell cycles or other compressed transitions may continue to experience elevated stress levels for extended, if not indefinite, periods. (page 93)
 - Events in the Unit Life Cycle Strand can drive events in the Soldier Life Cycle Strand and vice versa. These two strands work in concert to elevate or amplify the amount of stress felt by the individual Soldier. (page 94)
- ★ The Unit Strand (ARFORGEN) is not synchronized with the Soldier Strand (ARPERGEN) and fails to accommodate normal Soldier life expectations, personal and/or career goals. (page 94)
 - The Soldier Life Cycle Strand highlights transitional events which focus on the professional yet personal transitions common to all Soldiers. This strand is less predictable than the Unit Life Cycle Strand. (page 94)
- ★ The combination of Soldier and Unit Strand transitions can result in the rapid accumulation of stress that adversely impacts the unit, Soldier and Family. (page 95)

SECTION IV – THE COMPOSITE LIFE CYCLE

CONCLUSIONS

- ★ It is unlikely that these stressors are merely additive (Unit Strand + [Soldier Strand X 2] = 3 stress units). It is more likely that as the time between these events compresses, one plus two really equals five. (page 95)
- Stressors associated with the Soldier are additive to those stressors associated with the unit. Taken together, the unit and Soldier transitions add more events and associated stressors affecting the individual by either compressing the time between transitions or by combining the stressful effects of transitions at any single point in time. (page 95)
- ★ Current HP/RR/SP policies and programs do not take into account critical aspects of Family separations/transitions within the Family Life Cycle. (pages 96-97)
- ★ Family transitional events are often generated by unit and Soldier transitions. Unit and Soldier transitions may also exacerbate naturally occurring Family transitions such as parenting and marital discord. (page 97)
- ★ The Family Life Cycle Strand is as relevant to single Soldiers and single-parent Soldiers as it is to Soldiers with Families since they receive nurturing and support from extended and “adopted” Families. (page 97)
- The Army Family has become an expeditionary element of the Soldier and unit. (page 98)
- ★ Critical aspects of unit separation preparation (e.g., Family Care Plans, Family Readiness Groups) do not fully penetrate the Family Life Cycle to address all aspects of Family transitions. (page 98)
- ★ Some children who are experiencing the repeated absence of their parents are displaying “clinically significant” mental and behavioral health problems. This, in turn, places additional stress on Soldiers trying to mitigate Family transitions. (page 98)
- ★ While electronic media and technological advances in communication networks makes connectivity feasible, too much connectivity and personal involvement with Families may distract and disrupt personal focus and team cohesion among deployed units. Prolonged or intense Family distractions may divide Soldiers who attempt to live two lives, straddling the expeditionary arch between home and the deployed location. (page 99)
- Pressure to reduce stress associated with Family transitions can often result in hard choices for Soldiers and their spouses. (page 99)
- Major events may occur singularly as a “transition,” or as a cluster of transitions as “stress windows.” Identifying individual transitions and stress windows is difficult. (page 101)
- ★ It is difficult to gain visibility of all Soldier and Family transitions. Army leaders do not have a systematic method for anticipating or identifying potential transition clusters across all three strands of their Soldiers’ lives. (page 102)
- ★ While the series of life cycle transitions continues unabated throughout a Soldier’s career and beyond, resiliency and maturity are often effective counterbalances. (page 102)

SECTION IV – THE COMPOSITE LIFE CYCLE

CONCLUSIONS

- ★ The lack of resiliency and maturity among “first termers” makes this population exceptionally vulnerable to the stress of initial transitions and may account for high risk behavior. First term Soldiers account for approximately 60% of Army suicides in FY 2009 – FY 2010. Of all Army suicides in FY 2009, 79% had one or no deployment. (page 102)
- ★ Soldiers and Families become more resilient/mature as well as more practiced/experienced in coping with transitions and less stressed with each recurring transition. (page 103)
- ★ The *Composite Life Cycle Model* provides a holistic view of transitional events occurring over time and simultaneously across the three life cycle strands. It is a critical tool to improve HP/RR/SP program/service access and delivery. (page 104)
- ★ The Army currently weighs efforts on the Unit Strand as part of its ARFORGEN cycle. However, the Army fails to balance efforts to accommodate and engage Soldier and Family transitions as part of an ARPERGEN cycle. (page 104)
 - The Army will not be able to reduce the OPTEMPO of ARFORGEN or ARPERGEN transitions. (page 106)
- ★ Army policy does not scope service entrance standards to assess Soldiers who demonstrate resiliency or maturity to withstand the transitions associated with their first term of service. (page 107)
- ★ Statistics suggest too many Soldiers entered the service on waivers. These Soldiers may be among a critical mass that engages in high risk behavior and may commit suicide. (page 107)
- ★ Unit integration is critical in ensuring Soldiers and Families achieve an immediate sense of purpose, worth and belonging upon arriving at a new unit or in preparation for pre-deployment and post-deployment. (page 107)
- ★ A commander who elects not to command-refer a Soldier for a positive urinalysis (Soldier Life Cycle Strand) in order to ensure the Soldier’s availability for deployment (Unit Life Cycle Strand) is in fact, contributing to the potential of adding stress to the unit, Soldier and Family, particularly if the Soldier’s high risk behavior continues. (page 107)
 - Transitions in the career of a Soldier add an element of stress separate from the Unit Life Cycle Strand. (page 108)
 - The Family Life Cycle Strand is affected by the Unit and Soldier Life Cycle Strands. (page 108)
- ★ The *Composite Life Cycle Model* serves as an awareness tool for surveillance, detection and mitigation of acute, recurring and cumulative stressors represented by each strand. (page 108)
- ★ As Soldiers and Families develop resiliency and maturity over time, they are better armed for continued growth through new challenges. (page 109)

Refer to Section IV – The Composite Life Cycle – for associated discussion

SECTION IV – THE COMPOSITE LIFE CYCLE

RECOMMENDED ACTIONS

- ★ [HQDA] Direct research to determine the optimum time for BOG:Dwell ratios to reduce stress levels and return Soldiers' and Families' overall behavioral health back to baseline. (page 94)
- ★ [HQDA] Direct research to examine the unique stressors associated with WIAS taskings (e.g., Soldiers deployed in isolation, double transition of integrating into a unit in a theater, etc.). (page 94)
- ★ [CDRs] Target HP/RR/SP programs and services in synchronization with major unit transitions (FAP during pre-deployment, ASAP during deployment, etc.). (page 94)
- ★ [HQDA] Use ARFORGEN and ARPERGEN in tandem to synchronize Soldier professional and personal transitions to ensure both the growth of the individual and the health of the unit. (page 96)
- ★ [CDRs] Conduct periodic informal assessments of Soldiers' wellbeing. Events seemingly "acceptable" to most may be overwhelming to some Soldiers (e.g., PCS, promotion, PME). (page 96)
- ★ [HQDA] Initiate an ARPERGEN forum to synchronize Soldier and Family life cycles with the ARFORGEN unit life cycle. (page 100)
- ★ [HQDA] Develop, measure and assess programs and services that take into account all three life cycles, both independently and interdependently. (page 100)
- ★ [HQDA] Direct program evaluation to determine the efficacy of existing policies, programs and structure (e.g., Family Care Plans, Soldier Readiness Program, Family Readiness Groups, and Family Readiness Support Assistants) in addressing aspects of Family transitions. (page 101)
- ★ [HQDA] Develop programs capable of building resiliency in Families; place special emphasis on children. (page 101)
- ★ [HQDA] Direct research to explore resiliency, coping skills and help-seeking behavior required by Soldiers and Families. (page 101)
- ★ [CDRs] Unit leaders and Soldiers must incorporate Family transition planning considerations into their pending deployment or separation planning. Incorporate those Families who do not intend to remain in the area. (page 101)
- ★ [CDRs] Include single Soldiers and single-parent Soldiers in the *Composite Life Cycle Model* when gauging Family transition mitigation efforts in policy and programs. (page 101)
- ★ [All] Incorporate the risks associated with communications technology (Continuous Partial Attention) in pre-deployment programs and services (e.g., FAP, FRGs, FRsAs, etc.). (page 101)
- ★ [HQDA] Develop a comprehensive first term Soldier integration program to reduce the onslaught of stressors associated with first term transitions including, entering the Army, first unit, first deployment; and typical transitions associated with young men and women (marriage, first child, etc.). (page 104)

SECTION IV – THE COMPOSITE LIFE CYCLE

RECOMMENDED ACTIONS

- ★ [HQDA] Examine first term Soldier suicides to identify common causes (i.e., stressors) and high risk behavior. Tailor strategies to reduce suicides within this vulnerable population. (page 104)
- ★ [HQDA] Develop an integrated portal/dashboard to enhance Army and leader situational awareness of stress windows. (page 104)
- ★ [HQDA] Synchronize and target HP/RR/SP programs and service delivery with recurring stress windows. (page 104)
- ★ [HQDA] Use the *Composite Life Cycle Model* to inform Army readiness and personnel policies, filter program evaluations and shape commanders' philosophy and guidance in implementing HP/RR/SP programs. (page 108)
- ★ [HQDA] Anticipate and facilitate Soldier and Family transitions as part of an ARPERGEN cycle and rebalance efforts between ARFORGEN and ARPERGEN. (page 108)
- ★ [HQDA] Create an ARPERGEN forum to elevate the importance of “generating personnel” readiness to that of “generating force” readiness to sustain campaign capabilities and provide a voice for Soldier and Family Life Cycle Strands. (page 108)
- [HQDA] Include the ARPERGEN cycle and the Composite Life Cycle Model in the Army Campaign Plan.
- ★ [HQDA] Prompt HP/RR/SP programs and services to target critical Soldier and Family transitions, build resiliency, instill coping skills, increase help-seeking behavior and reduce stigma associated with behavioral health care. (page 108)
- ★ [HQDA] Army policy must re-scope Service entrance standards to assess and vet Soldiers who demonstrate resiliency or maturity to withstand the transitions associated with their first term of service. Conduct research to identify recruit characteristics associated with early resilience and maturity. (page 108)
- ★ [CDRs] Commanders must consider each of the life cycle strands in relationship with the other along the time continuum and measured against the maturity and resiliency of the Soldier to mitigate risk to the Soldier, Family and unit. (page 108)
- ★ [HQDA] Create a complementary ARPERGEN forum to generate Soldier and Family readiness and produce a net increase on unit/ARFORGEN readiness. (page 109)
- ★ [CDRs] Identify and track the stressors related to all strands of the *Composite Life Cycle Model*, to understand their affect on Soldiers and Families. (page 109)
- ★ [CDRs/Garrisons] Plan for and approach “stress windows” systematically. Take measures to mitigate potential stressors before they occur. (page 109)

Refer to Section IV – The Composite Life Cycle – for associated discussion

SECTION V – THE ARMY SUICIDE PREVENTION CAMPAIGN**CONCLUSIONS**

- ★ The Army HP/RR/SP Campaign Plan was informed and developed by three concurrent efforts – (1) the collection of suicide data and research, (2) the comprehensive review of existing policy, doctrine, and all known HP/RR/SP related documents from HQDA and across DoD, and (3) the VCSA-led installation assessment of HP/RR/SP problems and solutions from the perspective of commanders, Soldiers, and Families. (page 113)
- ★ The Army's focus on suicide prevention up until 2009 was too narrow; the aperture needed to widen to a more comprehensive review to include all Soldier and Family risk reduction and wellness programs. (page 113)
- ★ There is a correlation between risk-taking behavior and suicide behavior. Risk-taking behavior is often overlooked within the Army due to the current operational tempo. (page 113)
- ★ Army Transformation created tension between the generating and operating force, resulting in the reduction of access and delivery of program/service providers to installations. (page 114)
- ★ There is an increase in the high risk population of Soldiers as evidenced by street and illicit drug use, criminal activity and higher levels of risk tolerance. (pages 114-115)
- ★ HP/RR/SP policy, programs and processes are fragmented and have not been effectively transferred to the Reserve Component or exported to ASCCs for bridging to deployed locations. Home grown programs and independent processes have proliferated as a result. (page 115)
- ★ HP/RR/SP databases are not integrated across the medico-legal, law enforcement and program/service systems and as a result do not provide adequate situational awareness to commanders. (page 115)
- ★ Critical shortages of care providers exist in the Army including behavioral health providers, chaplains, investigators, counselors and program staffs/service providers. (page 115)
- ★ The development of a synchronization matrix became the centerpiece of the Campaign Plan. As of 30 Jun 2010, 87% of the 242 tasks were complete. (page 120)
- ★ This report will generate additional tasks for incorporation into the Synchronization Matrix. (page 120)

Refer to Section V – The Army Suicide Prevention Campaign – for associated discussion

SECTION V – THE ARMY SUICIDE PREVENTION CAMPAIGN**RECOMMENDED ACTIONS**

- ★ [HQDA] Continue to utilize the P-DOTMLPF-R construct to evaluate the tasks associated with changes to Army HP/RR/SP. (page 118)
- ★ [HQDA] Analyze and implement this report’s conclusions and recommendations into the Campaign Plan *HP/RR/SP Sync Matrix*. (page 118)
- ★ [HQDA] Continue to utilize the P-DOTMLPF-R construct to evaluate the tasks associated with this report’s conclusions and recommendations for integration in the *HP/RR/SP Sync Matrix*. (page 122)
- ★ [HQDA] Continue to consult with external agencies and academia to research and study HP/RR/SP. (page 129)
- ★ [HQDA] Implement the new proposed *HP/RR/SP Program Governance Model* as presented in this report. (page 129)

Refer to Section V – The Army Suicide Prevention Campaign – for associated discussion

SECTION VI – PROGRAM GOVERNANCE FOR HP/RR/SP

CONCLUSIONS

- ★ The *HP/RR/SP Program Governance Model* could be based on proposed Army enterprise-based precepts with a view to integrating the proponents, policy, structure, process and implementation functions for HP/RR/SP programs from HQDA to the garrison level. (page 131)
- CE chairs and members occupy multiple roles with collaboration extending from HQDA through ACOMs, ASCCs, DRUs and FOAs to field and garrison levels. (page 136)
- ★ The VCSA, acting as the SecArmy’s presumptive delegate, and informed by the Army Health Promotion Council, provides HP/RR/SP management and oversight, whether in his role as an HQDA Principal Official or as a key figure in the notional AME. (page 137)
- ★ The ARFORGEN cycle is useful for managing the availability of units but is limited in its ability to manage the deployment of individual Soldiers. Soldiers experience many types of non-unit transitions that impact their deployment availability. (page 138)
- ★ Similar to ARFORGEN efforts to increase Army capacity of “ready” units, ARPERGEN efforts would strive to fill those ready units with ready Soldiers, supported by prepared Families. (page 138)
- ★ The ARPERGEN Synchronization Forum provides the mortar (Soldier and Family Readiness) to the ARFORGEN building blocks (Unit Readiness) to provide seamless and sustainable readiness across the Army. (page 139)
- ★ The *HP/RR/SP Program Governance Model* depicts the governing bodies responsible for implementing, sustaining and exporting HP/RR/SP programs throughout the Care Continuum. (page 139)
- ★ The *HP/RR/SP Program Portfolio* scorecard uses common metrics to measure program characteristics including quality, productivity, cost, access/delivery and expeditionary capabilities. (page 139)
- ★ The recommended *HP/RR/SP Program Governance Model* vertically aligns and horizontally integrates Army senior leaders, HQDA Principal Officials, functional proponents, the proposed CEs, commands, garrisons, program and service providers, and COMPOs and ASCCs across the Event Cycle and Care Continuum. (page 141)
- ★ The Event Cycle and Care Continuum are the hallmark of the *HP/RR/SP Program Governance Model*; together they uniquely define the *HP/RR/SP Program Portfolio* from other Army portfolios. (page 142)
- ★ The Event Cycle depicts the sequence of events affecting a person; the Care Continuum depicts the institution’s response to each event from the Event Cycle. (page 144)
- ★ The Event Cycle is separated into three distinct stages of Pre-Event, Inter-Event and Post-Event, which are delineated by the criteria listed on pages 144-145. (pages 144-145)
- ★ Because the Care Continuum represents an institutional response, it provides a focused methodology to align governance, policy and programs to efficiently meet HP/RR/SP requirements. (page 145)
- ★ The phases of the Care Continuum include: Recruit, Separate, Awareness/Resiliency, Assess, Train/Educate, Intervene, Treat and Inquiry. (pages 145-146)

SECTION VI – PROGRAM GOVERNANCE FOR HP/RR/SP

CONCLUSIONS

- ★ Commanders implement HP/RR/SP programs/services by directing or facilitating Soldiers participation based on demonstrated (or anticipated) behaviors or stated needs. (page 153)
- ★ Commanders lead/manage Soldiers across the pre-event, inter-event and post-event stages. Management becomes more difficult and resource intensive as Soldiers shift to the right in the Event Cycle. (page 153)
- ★ Maintaining unit members in the pre-event stage of the Event Cycle is the most effective and efficient means of optimizing Soldier/unit readiness. (page 153)
- ★ The commander's role during the inter-event stage is to determine the individual's status in relationship to the Care Continuum and identify which corresponding programs are appropriate. This integrative function – connecting the Soldier to the right program based upon the Soldier's current need – is critical. (page 153)
- ★ Commanders of Soldiers in the inter-event stage must act as the “implementer” of programs and services by performing three critical functions – referring Soldiers to appropriate program/service providers, facilitating and monitoring Soldier participation and reporting actions taken in response to high risk behavior. (page 153)
- ★ Commanders complete the *Commander's Report of Disciplinary or Administrative Action* (DA Form 4833) to inform higher headquarters of actions taken to reduce the population of high risk personnel. This data could be used to inform HP/RR/SP program governance of resource requirements or program efficacy. (page 154)
- ★ Garrison commanders, leaders and program/service providers perform several vital functions in governing HP/RR/SP programs/services. They implement and sustain program/service policy, structure and process. (page 155)
- ★ Garrison leaders sustain facilities, people and processes to implement HP/RR/SP programs/services to manage the Army's response to individual events across the Event Cycle. (page 155)
- ★ The sustainment function at the garrison level is overseen by the CHPC, the body responsible for coordinating and managing the *HP/RR/SP Program Portfolio* on an installation. (pages 156)
- ★ Garrisons, as a subset of the *HP/RR/SP Program Governance Model*, implement the continuous process improvement cycle to balance the *HP/RR/SP Program Portfolio*. (page 156)
- ★ HP/RR/SP programs are Soldier and Family focused and must be available to Soldiers and Families wherever they are located. (page 157)
- ★ ASCC commanders are responsible for generating requirements and coordinating with proponents to develop and export HP/RR/SP programs to support Soldiers while deployed. (page 157)

Refer to Section VI – Program Governance for HP/RR/SP – for associated discussion

SECTION VI – PROGRAM GOVERNANCE FOR HP/RR/SP

RECOMMENDED ACTIONS

- ★ [HQDA] Continue senior Army leader oversight and guidance regarding Army HP/RR/SP efforts. (page 133)
- ★ [HQDA] Use the recommended the *HP/RR/SP Program Governance Model* to integrate proponents, policy, structure, process and implementation functions of the program portfolio from HQDA to the garrison and forward operating base levels. (page 133)
- ★ [HQDA] While transitioning to the new HP/RR/SP governance, ensure change management does not create new gaps and redundancies in the quality and delivery of current programs and services to Soldiers and Families. (page 133)
- ★ [HQDA] Reconstitute the interim Army Suicide Prevention Council (ASPC) as the enduring Army Health Promotion Council (AHPC) to provide oversight, advice and recommendations on HP/RR/SP to senior Army leadership. (page 133)
 - [HQDA] Appoint military and civilian Flag-level Officer co-chairs to the AHPC. (page 133)
 - [HQDA] Direct the Army Suicide Prevention Program to provide administrative support to the AHPC. (page 133)
- ★ [AHPC] Use the *HP/RR/SP Sync Matrix* to integrate and synchronize recommended solutions for senior Army leadership approval. (page 133)
- ★ [AHPC] Advise senior Army leaders on the reintegration of HP/RR/SP governance, policy, structure and process. (page 133)
- ★ [ASPTF] Transition ASPTF staff functions to the Army Suicide Prevention Program (ASPP). (page 133)
- ★ [HQDA] Terminate and dissolve the ASPTF when transition of its staff functions to the ASPP is complete. (page 133)
- ★ [HQDA] Implement the *HP/RR/SP Program Governance Model* to synchronize HP/RR/SP policy, infrastructure, process, people and technology throughout the Care Continuum. (page 140)
- ★ [HQDA] Delegate to the VCSA the responsibility and authority to manage and oversee the HP/RR/SP Program. (page 140)
- ★ [HQDA] Convert the ASPC to the new enduring Army Health Promotion Council as an advisory body to the AME. (page 140)
- ★ [HQDA] Create the ARPERGEN Synchronization Forum, either as an HQDA Committee or as a cross-enterprise forum, to synchronize Soldier and Family readiness policy, programs and processes across the Army. (page 140)
- ★ [HQDA] Devise a scorecard for program evaluation based on the HP/RR/SP Program Portfolio Model. Use the standard process and metrics for both program and portfolio evaluation. (page 140)
- ★ [AHPC] Synchronize cross enterprise activities to inform the senior Army leadership on Army policy and programming across P-DOTMLPF-R domains. (page 143)
- ★ [AHPC] Nominate HP/RR/SP policy, structure and process for VCSA approval or referral to the HQDA Staff/AME and/or to the AEB. (page 143)

SECTION VI – PROGRAM GOVERNANCE FOR HP/RR/SP

RECOMMENDED ACTIONS

- ★ [HQDA] Use the Event Cycle and Care Continuum in tandem as a sequential methodology to align the appropriate authorities who have primary responsibility at each point along the Event Cycle and Care Continuum. (page 147)
- ★ [HQDA] Adjust policy and programs in accordance with the Care Continuum and based on (validated) downstream requirements originating with field and garrisons. (page 149)
- ★ [HQDA] Proponents will implement policy, structure and process solutions through the HQDA Staff or potentially through the CEs to ensure integrated, synchronized and standardized compliance. (page 149)
- ★ [HQDA/ARPERGEN] Utilize the Event Cycle and full Care Continuum to ensure top to bottom and end to end governance of HP/RR/SP policy, structure and process. (page 149)
- ★ [HQDA] Realign HQDA proponents by migrating the eight specific HP/RR/SP programs and program components identified in Table 13, Program Migration, on page 148. (page 149)
- ★ [HQDA] The Army must provide fully integrated, multidisciplinary coordination to reduce gaps and redundancies through the recommendations outlined on page 149. (page 150)
- ★ [HQDA] Direct education in PME/PCC to educate commanders on leading/managing Soldiers across the Event Cycle and Care Continuum. Training/awareness must inculcate in leaders an explicit understanding that the ***pre-event stage and corresponding Care Continuum provide optimum Soldier/unit readiness.*** (page 155)
- ★ [CDRs] Recognize and understand signals that indicate Soldiers are seeking help or engaging in high risk behavior and facilitate/direct their participation in appropriate programs/services. (page 155)
- ★ [CDRs] Implement the “inter-event stage” programs and services by performing three critical functions: refer Soldiers to appropriate program/service providers, facilitate and monitor Soldier participation and report actions taken in response to high risk behavior. (page 155)
- ★ [IMCOM] Use the CHPC to monitor HP/RR/SP policy, structure, process and program execution; validate requirements for existing and generate requirements for new/modified programs. (page 158)
- ★ [IMCOM] Garrison leaders sustain facilities, people and processes to implement HP/RR/SP programs/services to manage the Army’s response to individual events across the Event Cycle. (page 158)
- ★ [IMCOM] Use the CHPC to moderate and channel feedback from program customers to identify and generate new requirements for consideration by the HQDA Staff, and potentially by the CEs, if chartered. (page 158)
- ★ [NGB and OCAR] As members of the ARPERGEN forum, participate in the *HP/RR/SP Program Portfolio* management process to identify exportable program metrics in support of RC Soldiers not on active duty and their Families. (page 158)
- ★ [ASCCs] Coordinate with HQDA to export relevant programs from the *HP/RR/SP Program Portfolio* to support Soldiers while deployed (e.g., ASAP, FAP, SHARP, etc.). (page 158)

SECTION VI – PROGRAM GOVERNANCE FOR HP/RR/SP

RECOMMENDED ACTIONS

- ★ [HQDA] Implement the *HP/RR/SP Program Governance Model* as the organizing construct for oversight for HP/RR/SP programs/services (top to bottom, end to end). (page 159)
- ★ [HQDA] Implement customer-focus feedback on HP/RR/SP programs/services to ensure an individual (rather than the institutional) customer perspective by using the Event Cycle and Care Continuum. (page 159)

Refer to Section VI – Program Governance for HP/RR/SP – for associated discussion

SECTION VII – MANAGING THE HP/RR/SP PROGRAM PORTFOLIO

CONCLUSIONS

- ★ Portfolio management is the Army’s process for prioritizing and committing resources based upon validated requirements. The overall purpose of creating a portfolio is to align programs with the Army’s strategic goals and objectives. (page 161)
- ★ The management of programs under the portfolio concept promotes the shift of governance focus from the individual program proponents to the entire group of related programs – in this case, the group of programs that provide HP/RR/SP care and services. (page 161)
- ★ The central organizing construct of the *HP/RR/SP Program Portfolio* is the Care Continuum. Simply put, the Care Continuum defines the portfolio. (page 161)
- ★ The concept for *HP/RR/SP Program Portfolio* management changes the Army’s program management paradigm from a technical proponent-based, garrison-centric system to a strategic, holistic customer-focused model that delivers the needed support to today’s expeditionary Army. (page 161)
- ★ The traditional Army approach to delivering programs and services through narrowly focused technical channels from the policy proponent to implementing arm does not deliver the broad range of products and services required by our commanders, Soldiers and Families. (page 163)
- ★ A prerequisite of any effective management process is a systematic means for identifying its size and scope. In the HP/RR/SP context, the Care Continuum serves as the construct that captures the full range of requirements. (page 165)
- ★ The Report Team review identified 70 programs that would constitute the HP/RR/SP Potential Portfolio. (page 165)
- ★ Current program performance evaluation systems (where they exist at all) do not usually use common terminology and criteria that can be interpreted and analyzed by all users – they generally are developed and used only by the individual program proponents. (page 166)
- ★ An objective evaluative program scoring process by the core enterprise would mitigate the possible conflicts of interest and parochialism that may result from HQDA proponents’ self-evaluation of their respective HP/RR/SP programs. (page 166)
- ★ The ARPERGEN Forum (cross enterprise) is required to balance the portfolio across all core enterprises. (page 169)
- ★ Programs are adjusted in the portfolio (created, eliminated or modified) to ensure they are complementary but competitive to reduce both gaps and redundancies. (page 169)
- ★ The Army’s specific programmatic needs are dynamic and vary over time. CPI (enabled by LSS) is the management process to ensure that the *HP/RR/SP Program Portfolio* continuously evolves to meet customer requirements. (page 171)
- ★ The rebalancing cycle within the *HP/RR/SP Program Portfolio* has two components: a “modification cycle,” which represents a rapid rebalancing of existing programs to respond to emerging requirements, and an “initiatives cycle” in which CPI introduces new programs that require an initial capabilities assessment. (pages 171-172)

SECTION VII – MANAGING THE HP/RR/SP PROGRAM PORTFOLIO

CONCLUSIONS

- ★ The **modification cycle** is a short cycle that reduces management process cycle times to achieve **efficiencies** in program portfolio performance. The **initiatives cycle** is a long cycle that ensures new/major modifications in programs are thoroughly assessed to achieve **effectiveness** in program portfolio performance. (pages 171-172)
- ★ The increase in HP/RR/SP requirements to support readiness in the pre-deployment phase, coupled with the increase in requirements in the deployment and redeployment phases, has stretched the limits of HP/RR/SP programs and services in the generating force. (page 175)
- ★ The result of migrating generating force assets to the operating force has degraded generating force capability at the same time that the operating force has increased its demand for HP/RR/SP programs and services. This pressure – to provide more programs and services with fewer resources – is not likely to change. (page 176)
- ★ Numerous HP/RR/SP home grown or local initiatives have been implemented to address a variety of niche requirements but do not address critical issues such as predictable programming, resource sustainability, enterprise level program consistency or continuity of care. (page 176)
- ★ Portfolio management can mitigate an important effect of transformation – the migration of HP/RR/SP personnel and authorizations to the operating force to support the operational mission. Soldiers with dual roles in the operating and generating force (medical, legal, chaplain, etc.) who are assigned to operating force units are not systematically utilized to reinforce community capacity and relieve pressure on generating force providers while in garrison. (page 177)
- ★ Templates may be a more suitable tool to validate short-term operating force HP/RR/SP requirements but are not well suited to the longer-term variability of generating force requirements. (page 178)
- ★ The *Portfolio Management Model* could be used to determine HP/RR/SP force structure functional requirements, either via modeling or templates, and to support a bottom-up review of HP/RR/SP manpower by function. (page 178)

Refer to Section VII – Managing the HP/RR/SP Program Portfolio – for associated discussion

SECTION VII – MANAGING THE HP/RR/SP PROGRAM PORTFOLIO

RECOMMENDED ACTIONS

- ★ [HQDA] Proponents must screen their inventory of potential programs against the Care Continuum to identify those for inclusion in the HP/RR/SP Potential Portfolio. (page 168)
- ★ [HQDA] Complete the Program Capabilities Assessment for each individual program using the following metrics: Quality, Productivity, Cost, Access/Delivery and Expeditionary. (page 168)
- ★ [CEs] The core enterprise will incorporate individual program assessments into a Program Scorecard for comparative analysis and inclusion into the Potential Portfolio based on program efficiency and effectiveness. (page 168)
- ★ [CEs] Each core enterprise use the results of the Program Capabilities Assessment to adjust its portion of the Potential Portfolio by realigning and balancing HP/RR/SP programs and services against the applicable phases of the Care Continuum. The adjusted Potential Portfolio becomes the Interim Portfolio. (page 168)
- ★ [CEs] Recommend respective programs for inclusion into the Interim Portfolio for the Portfolio Capabilities Assessment. (page 170)
- ★ [ARPERGEN] Use the Care Continuum to validate the HP/RR/SP Portfolio Scorecard based on analysis of expected performance and risk. (page 170)
- ★ [ARPERGEN] Use the results of the Portfolio Capabilities Assessment to adjust the Interim Portfolio by realigning and balancing HP/RR/SP programs and services against the applicable phases of the Care Continuum. The adjusted Interim Portfolio is then nominated to the proposed AME as the Balanced Portfolio. (page 170)
- ★ [ARPERGEN] Present the Balanced Portfolio to the proposed AME for validation. (page 170)
- ★ [HQDA] The Balanced *HP/RR/SP Program Portfolio* is then validated against Army policy, structure and processes to readjust resource programming and garner resource offsets and savings. (page 170)
- ★ [HQDA] Utilize CPI (enabled by LSS) as the management process to ensure *HP/RR/SP Program Portfolio* continuously evolves to meet customer requirements. (page 173)
- ★ [IMCOM/MEDCOM] Provide feedback from the Balanced Portfolio's customers (commanders, Soldiers and Families) to program proponents. (page 173)
- ★ [HQDA] Use the *Portfolio Management Model* (with its emphasis on efficiency and effectiveness) to inform structure and force management decisions in this environment of increased demand and fewer resources. (page 180)
- ★ [HQDA] Use the *Portfolio Management Model* to evaluate and reduce home grown HP/RR/SP initiatives to achieve predictable programming, resource sustainability, enterprise level program consistency and continuity of care. (page 180)
- ★ [HQDA] The ARPERGEN Synchronization Forum should review and revise policy and process to balance structure between operating force and generating force assets while at home station (medical, legal, chaplain, military police, etc.). (page 180)

SECTION VII – MANAGING THE HP/RR/SP PROGRAM PORTFOLIO

RECOMMENDED ACTIONS

- ★ [ARPERGEN] Conduct a bottom-up review of HP/RR/SP manpower by function for the operating force and generating force to:
 - Determine which of the (~70) core HP/RR/SP programs need an expeditionary element.
 - Define the optimal mix of specialists needed to support both garrison and deployed populations.
 - Balance organic (operating force) and augmented (generating force) HP/RR/SP manpower. (page 180)

Refer to Section VII – Managing the HP/RR/SP Program Portfolio – for associated discussion

SECTION VIII – INVESTIGATIONS AND REPORTING**CONCLUSIONS**

- ★ Concurrent non-fatal investigations often occur as isolated processes with little coordination of final conclusions and reporting. (page 184)
- ★ Unit, law enforcement and medical reporting must be synchronized to prevent unnecessary duplication of effort, avoid miscommunication of the incident and provide visibility of an individual's past criminal behavior. (page 184)
- ★ The DA Form 4833 represents the primary communication commanders have with law enforcement agencies and higher headquarters. This report often is the only record regarding the disposition of a case. (page 184)
- ★ Program/service providers are required to report criminal misconduct to appropriate authorities. Any injury or illness that is the result of suspected criminal behavior must be reported to law enforcement. This includes suspected cases of spouse/child abuse, illicit drug use and injuries resulting from criminal misconduct (gunshot, knife wounds, underage drinking, etc.). (page 185)
- ★ Flaws in DoDSER processes result in reports that are not timely, accurate or actionable. (page 186)
- ★ Many non-fatal suicidal behaviors go unreported because they do not meet DoDSER criteria. This gap applies to DIBRS as well, which requires reporting of specified incidents (including attempted and completed suicides). (page 185)
- ★ Multiple agencies have responsibilities for investigating and reporting non-combat Soldier deaths, which require close coordination to ensure an accurate account of the facts and circumstances surrounding the death. (page 187)
- ★ DoD policy assigns investigative primacy to Military Criminal Investigative Organizations (e.g., CID) and primacy for determining cause and manner of death to the AFME for all non-combat Soldier deaths. (page 187)
- ★ It is the totality of CID's investigative findings combined with AFME's autopsy that ultimately determines manner of death. (page 187)
- ★ In all death investigations, CID conducts media forensic analysis of the Soldier's computer, cell phone, email accounts and other PDA to identify indicators of intent. This requires CID investigators to obtain preservation orders for private email accounts, serve search warrants, and locate and interview witnesses. (page 188)
- ★ Close coordination with CID during AR 15-6/LOD investigations is required to ensure that there is no unintended interference with CID's official criminal/death investigation. (page 189)
- ★ Deliberate coordination prior to communication with the victim's Family will ensure the accuracy of all official communications regarding the investigation. (page 189)
- ★ As law enforcement investigators conduct their due diligence to determine intent, medical examiners are under pressure to issue the death certificate. It is imperative that these two organizations work closely to preclude the misclassification of equivocal deaths. (page 189)
- ★ AFME often must select the manner of death while the results of the CID investigation are still pending to ensure the timeliness of issuance of a death certificate. Investigative evidence and findings may counter the documented manner of death determination. (page 189)

SECTION VIII – INVESTIGATIONS AND REPORTING**CONCLUSIONS**

- ★ Manner of death determination problems may conservatively account for 21% additional suicides in the military. (page 190)
- ★ Psychological autopsies can assist criminal investigators and medical examiners in determining the manner of death. (page 190)
- ★ The DoDSER provides a series of data categories including demographic (military information), event information and history (deployment, medical, behavioral health and Family) to provide comparative analysis among suicide victims. (page 191)
- ★ DoDSER's value can be enhanced by refinement of the survey methodology. Survey categories and potential risk factors may help identify suicide risk trends among the Services but still require further refinement to enhance the specificity of these data. (page 191)
- ★ DoDSER data are sent directly from a behavioral health provider to DoD without first coordinating with the Army's medical, law enforcement and commands to provide quality assurance in the submission of this report. (page 191)
- ★ AFME/CID collaboration is often adversely affected by the timing between issuance of the death certificate and resolution of all investigative leads. Conflicting conclusions may communicate inconsistent information to the victim's Family regarding manner of death. (pages 191-192)
- ★ There is no formal mechanism (e.g., manner of death review board) to reconcile differing conclusions regarding manner of death. It is essential to develop policy and processes to synchronize investigative conclusions regarding the victim's intent. (page 192)
- ★ Death investigations that occur outside of military jurisdiction add another layer of complexity in investigations, manner of death determination and reporting. Civilian law enforcement/ investigators may retain primacy for the investigation and determining cause and manner of death. (page 192)
- ★ CID routinely conducts joint and collateral investigations with their civilian counterparts. Additionally, AFME may coordinate with local medical examiners conducting medico-legal investigation of Soldier deaths. (page 192)
- ★ The death of an RC Soldier (not on active duty) is not always reported to military authorities. Civilian and military law enforcement must actively coordinate for death notification and investigative status. (page 193)
- ★ Families deserve to be notified of a Soldier's death in the most expeditious manner possible. Early coordination among multiple organizations is critical to ensure accurate and timely information is reported to the next-of-kin. (page 195)
- ★ The Army's requirement to provide timely and accurate information to the next-of-kin is often at odds with synchronizing a diverse set of organizations working worldwide under a high operational tempo. (page 195)
- ★ Current policy and processes are not ideally suited to control delivery of information among innumerable distractions associated with time, distance, extended Families, collateral reporting by the victim's friends and the proliferation of electronic communications. (page 195)

SECTION VIII – INVESTIGATIONS AND REPORTING

CONCLUSIONS

- ★ The next-of-kin notification process involves four organizations. Each has a complementary role in supporting the Family. The CMAOC's CAO provides administrative support and liaison; CID is responsible for reporting circumstances of death and investigative findings; AFME is responsible for medico-legal findings; and the unit is the focal point for conduct of military customs and accountability of personal effects. (page 196)
- ★ A revision to the current next-of-kin notification process is required to effectively coordinate and synchronize communications among reporting organizations. This change is essential to achieve unity of effort as a fluid situation involving investigations, reporting and other related activities evolve during the next-of-kin notification process. (page 197)

Refer to Section VIII – Investigations and Reporting – for associated discussion

SECTION VIII – INVESTIGATIONS AND REPORTING

RECOMMENDED ACTIONS

- ★ [HQDA] Revise policy to ensure medical program/service providers contact law enforcement regarding attempted suicides for reporting to DIBRS/NIBRS in accordance with DoD regulations. (page 187)
- ★ [HQDA] Develop and institutionalize a centralized database for collecting all substantiated AR 15-6 investigation results, accessible by commanders and law enforcement. (page 187)
- ★ [HQDA] Develop policy to promulgate DoD requirements for DIBRS/NIBRS reporting. (page 187)
- ★ [HQDA] Improve the DoDSER system by allowing MEDCOM oversight, Reserve Component data collection and mandating timely submission. (page 187)
- ★ [HQDA] Revise policy to reemphasize CID's investigative primacy for death investigations. Ensure the AR 15-6 and LOD investigations are coordinated under CID's investigative lead. (page 194)
- ★ [HQDA] Coordinate policy with OSD to sequence AFME determination of manner of death with CID's final investigative conclusions. Explore the feasibility of adopting "pending" as an option for manner of death on the certificate of death. (page 194)
- ★ [HQDA] Request psychological autopsy only after all other investigative leads have been exhausted or as appropriate. (page 194)
- ★ [HQDA] Establish an Army "manner of death review board" (may include external experts) to conduct a review/analysis of investigative conclusions to determine manner of death in equivocal cases. (page 194)
- ★ [HQDA] Coordinate with OSD to modify the DoDSER survey methodology to refine data categories including demographic (military information), event information and history (deployment, medical, behavioral health and Family) to provide comparative analysis among suicide victims. (page 194)

SECTION VIII – INVESTIGATIONS AND REPORTING**RECOMMENDED ACTIONS**

- ★ [HQDA] Coordinate with OSD to allow Service staffing/integration during the DoDSER reporting process. (page 195)
- ★ [HQDA] Establish a system/liaison for local, state and federal civilian law enforcement/ investigators to better inform military police of non-combat deaths of RC Soldiers (not on active duty). (page 195)
- ★ [OPMG] Direct CID to emphasize interagency coordination for joint and collateral investigations of all non-combat RC Soldier deaths. Develop a collaborative forum in the Law Enforcement Advisory Portal (LEAP) for law enforcement coordination of RC Soldier investigations. (page 195)
- ★ [HQDA] Reinforce policy to ensure all reporting agencies coordinate as one voice during next-of-kin notifications. All organizations/agencies must coordinate with one another prior to interacting, corresponding and sharing information with the next-of-kin. (page 198)
- ★ [HQDA] Develop a formal process to synchronize communication between the relevant agencies and the next-of-kin during the death investigation process using the “NOK Report Team” synchronization model. (page 198)
- ★ [HQDA] Revise policy to reinforce the CID CLO as the single point of contact for investigations and investigative reporting related to death investigations. (page 198)

Refer to Section VIII – Investigations and Reporting – for associated discussion

SECTION IX – INFORMATION SHARING AND RETRIEVAL

CONCLUSIONS

- ★ In order to oversee and manage HP/RR/SP efforts effectively, Army leaders and HP/RR/SP program/service providers need immediate access to relevant, timely, accurate and actionable information regarding individual Soldier behavior and program performance. (page 203)
- ★ Just as the Care Continuum defines HP/RR/SP governance and the *HP/RR/SP Program Portfolio*, it defines data requirements to support programs/services during each phase. (page 203)
- ★ Net-centric environment could provide leaders and HP/RR/SP program/service providers access to information to allow predictive analysis and inform proactive planning and mitigation measures. (page 203)
- ★ The Army's data infrastructure was created to support its current program structure. Just as the program infrastructure creates impediments to effective, enterprise-based governance, the Army's data infrastructure presents obstacles to comprehensive information sharing. (page 204)
- ★ The scope of data collected is often insufficient to meet the HP/RR/SP information requirements of leaders and HP/RR/SP program/service providers. Data-collecting organizations assemble and report information that serves their narrow programmatic objectives, generally without regard to information requirements across the Army Enterprise. (page 204)
- ★ Existing Army data systems are designed to restrict data access to a small number of gatekeepers, a characteristic which impedes efficient information sharing. (page 204)
- ★ The narrow programmatic focus of data systems causes impediments not only to collection of information, but also to its sharing. Impediments include data system design flaws and misperceptions of data "ownership," including the value of these data to "outsiders," possible data corruption and the effects of privacy laws on data sharing. (page 206)
- ★ Functional data managers often lack awareness of the value of their data to other potential data users. (page 207)
- ★ Army functional data managers, commanders and program/service providers frequently misunderstand the extent of privacy laws and the exceptions to those laws, causing unnecessary restriction of information flow. (page 207)
- ★ Information sharing solutions must address systemic design and accessibility obstacles to support the proposed transformation of HP/RR/SP governance. (page 210)
- ★ The goal of the ANCDs is to improve situational awareness through application of net-centric concepts, technologies and standards, institutionalized in a governance and technical framework, to enable net-centric data assets that are visible, accessible, understandable, trusted and interoperable to all users. (page 211)
- ★ Federated, enterprise-wide information sharing will be enabled resulting in increased flexibility and data sharing. ANCDs also enables the pulling of data from multiple authoritative sources to achieve Army-wide solutions. (page 211)
- ★ Until the ANCDs environment is fully developed, portals and dashboards could provide leaders and HP/RR/SP program/service managers with a means to utilize the available data to make informed decisions. (page 211)

SECTION IX – INFORMATION SHARING AND RETRIEVAL**CONCLUSIONS**

- ★ In an HP/RR/SP context, data portals provide leaders and HP/RR/SP program/service providers an authoritative source of information about Soldiers. (page 211)
- ★ A commanders' HP/RR/SP dashboard could provide timely, actionable knowledge of the overall health and risk factors affecting the command. The dashboard would permit oversight of actions taken to mitigate that risk as well as detection and analysis of help-seeking or risk-taking trends. (page 212)
- ★ The HP/RR/SP dashboard could be used to promote accountability by tracking resulting/corrective actions taken by commanders. (page 213)

Refer to Section IX – Information Sharing and Retrieval – for associated discussion

SECTION IX – INFORMATION SHARING AND RETRIEVAL**RECOMMENDED ACTIONS**

- ★ [HQDA] Design and implement an *HP/RR/SP Program Portfolio* portal integrating data from all HP/RR/SP programs/services as the interim bridge to the Army's net-centric environment. (page 204)
- ★ [HQDA] Update policy reflecting the requirement to share existing data and design interoperability into new data systems consistent with DoD net-centric data sharing policies. (page 210)
- ★ [HQDA] Update and implement policy and training to clarify the intent as well as legitimate exceptions to information sharing limitations of both the Privacy Act and HIPAA. (page 210)
- ★ [HQDA] Continue implementation of the Army's Net-Centric Data Strategy. (page 214)
- ★ [HQDA] Develop HP/RR/SP portals that aggregate databases to share critical data and create alerts or notifications ("red flags") based on predefined metrics. (page 214)
- ★ [HQDA] Develop and use HP/RR/SP dashboards for commanders and HP/RR/SP program/service providers to ensure timely and actionable knowledge of the health and accountability of their Soldiers. (page 214)

Refer to Section IX – Information Sharing and Retrieval – for associated discussion

SECTION X – HP/RR/SP RESEARCH GOVERNANCE AND CURRENT/FUTURE RESEARCH

CONCLUSIONS

- ★ A lack of HP/RR/SP research governance reduces visibility, coordination/synchronization and transition which results in silo'ed efforts and in the potential for research gaps and redundancies. (page 218)
- ★ Without full awareness of currently funded research projects, it is virtually impossible to know the current status of all HP/RR/SP research. This creates a series of problems with requirements validation, funding and implementation. (pages 219)
- ★ A standard centralized process for HP/RR/SP research coordination and synchronization is required to enable visibility, coordination and synchronization of programmed research. (page 219)
- ★ The *HP/RR/SP Research Portfolio* should be coordinated/synchronized similar to the *HP/RR/SP Program Portfolio*. (page 220)
- ★ The *HP/RR/SP Research Portfolio* addresses synchronization issues because it aligns research needs/opportunities, execution and transition to ensure that results are relevant, coordinated and can be applied to support Army goals. (page 220)
- ★ The *HP/RR/SP Research Governance Model* hinges upon a Chief Science Officer (CSO) who would provide coordination and synchronization for the *HP/RR/SP Research Portfolio* and other related Army research. (page 222)
- ★ The CSO, as a functional proponent, is the principal advisor to senior Army leadership for Army HP/RR/SP and related research (external and internal). The CSO should have situational awareness of all this research, regardless of funding source or recipient. (page 224)
- ★ The CSO should have visibility and understanding of Army research resource commitments, including Army, DHP, Congressional and extramural. (page 224)
- ★ The HP/RR/SP DSO as a member of the Health Promotion Council and the Research Synchronization Forum and is responsible for coordinating the *HP/RR/SP Research Portfolio*. The DSO provides the conduit for communicating findings from the individual HP/RR/SP Research Program Manager's (PMs) programs and integrates the *Research Portfolio* across the various Army research institutions. (page 224)
- ★ The application of the proposed Army enterprise concepts to the governance of Army HP/RR/SP research is intended to create an Army *HP/RR/SP Research Portfolio* that is holistic and multidisciplinary. (page 225)
- ★ The Care Continuum provides the lens through which all HP/RR/SP research is viewed and will eventually define the *Balanced Research Portfolio*. (page 225)
- ★ The *Potential Research Portfolio* includes identification and assessment of research that is potentially HP/RR/SP related. (page 226)
- ★ The *Interim Research Portfolio* is validated by the RSF and includes recommended adjustments to the portfolio. (page 227)
- ★ The *Balanced Research Portfolio* is then aligned horizontally and vertically for validation by the senior Army leadership. (page 228)
- ★ The CPI process identifies and validates new HP/RR/SP research requirements, recommends modification to existing programs, and facilitates transition to end users. (page 228)

Refer to Section X – HP/RR/SP Research Governance and Current/Future Research – for associated discussion

SECTION X – HP/RR/SP RESEARCH GOVERNANCE AND CURRENT/FUTURE RESEARCH

RECOMMENDED ACTIONS

- ★ [HQDA] Facilitate better efficiency/effectiveness of the *HP/RR/SP Research Portfolio* using the *HP/RR/SP Research Governance Model* (including the CSO, DSO and RSF). (page 225)
- ★ [HQDA] Authorize the CSO to serve as the functional proponent and principal advisor to the senior Army leadership in order to gain more situational awareness of all HP/RR/SP and related research, regardless of funding source. (page 225)
- ★ [HQDA] Assess the *HP/RR/SP Research Governance Model* as a pilot for potential expansion to all Army research. (page 225)
- ★ [HQDA] Utilize the *HP/RR/SP Research Portfolio Management Model* to provide top to bottom and end to end visibility, coordination and synchronization of all research efforts to close gaps and reduce redundancies. (page 229)

Refer to Section X – HP/RR/SP Research Governance and Current/Future Research – for associated discussion

Section II – Recommended Research

Current Army HP/RR/SP research efforts are primarily medically focused. In order to balance the Army HP/RR/SP research portfolio, research that informs Army efforts in all phases of the Care Continuum is required. Accordingly, the Task Force’s recommendations contained in this report that require research have been categorized by Care Continuum phases and aggregated below.

a. Recruit

RECOMMENDED RESEARCH

- ★ [HQDA] Survey the various types of risk-related behavior to develop a definition of “risk-related behavior” and, more importantly, a set of recognized high risk behaviors for use by recruiters as a screening tool.
- ★ [HQDA] Develop a statistical model to determine which risk-related behaviors present an unacceptable level of risk during service.
- ★ [HQDA] Conduct risk assessments to ascertain what constitutes an unacceptable level of risk during service.
- ★ [HQDA] Study the stress levels of first term soldiers (self-reported and otherwise) relative to their stress levels at the age at which they enlisted. We are potentially seeing an increase in the age of first term soldiers who commit suicide.
- ★ [HQDA] Research possible refinements to recruiting screens for pre-existing behavioral health conditions that are incompatible with military service.
- ★ [HQDA] Ascertain and define the character traits the Army desires in its recruits and whether certain traits align with certain MOS categories; recommend ways to recruit those that we want.
- ★ [HQDA] Conduct research and meta-research of the psychological measures and metrics that indicate increased resiliency.
- ★ [HQDA] Research whether junior Soldiers who have returned to service after lengthy breaks in service are more or less likely to engage in high risk behavior.
- ★ [HQDA] Research possible refinements to tailoring MOS assignments to the psychological profile of individual recruits.
- ★ [HQDA] Charter research to test the hypothesis that Soldiers who voluntarily enlist [self-select] during a time of war may be more willing to engage in high risk behavior. (page 16)
- ★ [HQDA] Research the relationship between the “self selection” bias and the propensity to engage in high risk behavior to inform policy governing good order and discipline. (page 43)
- ★ [HQDA] Direct research to assess the second and third order effects of increased waivers and relaxed separation standards in terms of crime and drug involvement and other high risk behavior. (page 71)

RECRUIT

(Continued)

- ★ [HQDA] Army policy must re-scope Service entrance standards to assess and vet Soldiers who demonstrate resiliency or maturity to withstand the transitions associated with their first term of service. Conduct research to identify recruit characteristics associated with early resilience and maturity. (page 108)

Conclusions & Recommendations 60 – Research for the Recruit Phase

b. Separate

RECOMMENDED RESEARCH

- ★ [HQDA] Ascertain factors that may help define an optimal (probability-based) timeline for medical separation proceedings to begin and end, tailored to particular diseases or injuries, the constellation of symptoms typical of varying degrees of disability (see 38 C.F.R. Part IV, VA schedule of disability ratings) and based on a survey of treatment outcomes and prognoses for both medical and socio-industrial rehabilitation.
- ★ [HQDA] Conduct medical and behavioral health research to define standard criteria for rehabilitation failures for both medical rehabilitation and substance abuse rehabilitation.
- ★ [HQDA] Determine the effect of serial substance abusers on the good order and discipline in units.
- ★ [HQDA] Determine warning signs of high risk behavior, including suicidal behavior, that are commonly displayed early in the career of a young Soldier.
- ★ [HQDA] Identify the best predictors of failure/success in performance of Army duties. Researchers may wish to break this out by particular duties or MOS categories.
- ★ [HQDA] Identify the best predictors of drug and alcohol rehabilitation failure/success.
- ★ [HQDA] Direct research to assess the adequacy of Army's definition of "recidivism" as one year rather than the more widely used convention of five years. (page 68)
- ★ [HQDA] Direct research to assess the second and third order effects of increased waivers and relaxed separation standards in terms of crime and drug involvement and other high risk behavior. (page 71)

SEPARATE

Conclusions & Recommendations 61 – Research for the Separate Phase

c. Awareness/Resiliency

RECOMMENDED RESEARCH

- ★ [HQDA] Research the best means for increasing awareness (both self-awareness and leadership awareness) of at-risk behavior. Improved awareness will allow targeted resilience education and training.
- ★ [HQDA] Update Holmes and Rahe's Social Readjustment Rating Scale to reflect the current operating environment, family stressors, financial indicators and their effects on Soldiers and Families.
- ★ [HQDA] Study the role and impact of Comprehensive Soldier Fitness (CSF) on building and maintaining resilience across the force.
- ★ [HQDA] Continue to promote NIMH's role in the resilience study as part of STARRS.
- ★ [HQDA] Perform a research study to examine the physiological levels of different opiates and amphetamines that can be expected to be found in an individual who is taking these drugs as part of their normal drug regimen. Can we then use pharmacokinetics to determine those that are moving from normal treatment to abuse?
- ★ [HQDA] Research the effect (if any) of having family members with special needs on stress and readiness.
- ★ [HQDA] Fund suicide behavior surveys that span both civilian and military populations in order to make direct comparisons. (page 21)
- ★ [HQDA] Enhance research efforts for identifying at-risk Soldiers to provide effective and efficient programs/services. (page 23)
- ★ [HQDA] Research the risk sub-factors that make up larger catchall stressor categories such as relationship and work stress to identify and target specific factors contributing to suicidal behavior. (page 26)
- ★ [HQDA] Direct research to determine the optimum time for BOG:Dwell ratios to reduce stress levels and return Soldiers' and Families' overall behavioral health back to baseline. (page 94)
- ★ [HQDA] Direct program evaluation to determine the efficacy of existing policies, programs and structure (e.g., Family Care Plans, Soldier Readiness Program, Family Readiness Groups, and Family Readiness Support Assistants) in addressing aspects of Family transitions. (page 101)
- ★ [HQDA] Direct research to explore resiliency, coping skills and help-seeking behavior required by Soldiers and Families. (page 101)

d. Assess

RECOMMENDED RESEARCH

- ASSESS**
- ★ [HQDA] Improve Soldier assessments to better identify those who may be at-risk to allow early treatment and maximize the potential for full recovery.
 - ★ [HQDA] The phenotypic presentation of behavioral health conditions within the Army population may vary from that of the civilian populations. Conduct a research study to determine what presentations are most prevalent within the Army population so that primary care doctors can assess individuals for behavioral health issues during routine visits.
 - ★ [HQDA] Research the most accurate and effective ways to assess the force.
 - ★ [HQDA] Direct research on post-deployment opium addiction/abuse problems.
 - ★ [HQDA] Conduct medical testing to determine if Soldiers are taking therapeutic medications appropriately.
 - ★ [HQDA] Explore methods to prevent illicit drug use while Soldiers are taking narcotic medication.
 - ★ [HQDA] Continue ongoing research on optimized screening for suicide risk.
 - ★ [HQDA] Continue ongoing MHAT research to improve the Army's understanding of behavioral health issues in theater.
 - ★ [HQDA] Refine reporting protocols to capture and analyze information on the root causes of the relationship between stress and military/work. Both of these (relationship and work) are too broadly scoped to provide targeted training and education to the at-risk Soldier.
 - ★ [HQDA] Conduct surveys, research and meta-research to determine best practices for mitigating risky behavior once detected during service.
 - ★ [HQDA] Prompt research to examine the social behavior of drug abuse with specific emphasis to identify the prevalent conditions (e.g., barracks introduction) that lead first term Soldiers to abuse drugs. (page 53)
 - ★ [HQDA] Research the normal therapeutic range for different prescription drugs to determine how to better assess potential abuse of pharmaceuticals. (page 57)

e. Educate/Train

EDUCATE/TRAIN	RECOMMENDED RESEARCH
	<ul style="list-style-type: none"> ★ [HQDA] Examine previous anti-stigma campaigns that were successful and model the Army's after these campaigns. ★ [HQDA] Research the best means to educate Soldiers on both how to improve buddy "overwatch" as well increasing their own self-awareness for early signs of at-risk behavior. Emphasis should be on improving willingness to seek assistance, be it behavioral health, ASAP, family counseling or other assistance program. ★ [HQDA] Continue ongoing research on linkages between OIF/OEF deployment history and suicidal behavior risk.

Conclusions & Recommendations 64 – Research for the Educate/Train Phase

f. Intervene

INTERVENE	RECOMMENDED RESEARCH
	<ul style="list-style-type: none"> ★ [HQDA] Research into how and when to best intervene, documentation of intervention, and performance feedback on the effectiveness of intervention. ★ [HQDA] This report theorizes that stress windows are an important part of the triggers especially for the first term Soldier. Perform a research study to look at true indicators of stress (i.e., cortisol levels, HPA axis activation, etc.) and correlate these with the individual stressors as reported by the Soldiers (relocation anxiety, financial, relationship). ★ [HQDA] Research how major life events (marriage, death, birth, cancer, etc.) affect the deployability of the individual soldier. ★ [HQDA] Perform a study on the effects of data gaps on awareness of individual and unit readiness or stress. How does not having real-time access effect leadership decisions?

Conclusions & Recommendations 65 – Research for the Intervene Phase

g. Treat

RECOMMENDED RESEARCH

- ★ [HQDA] Research the effectiveness of the medical home model to ensure behavioral health is seen as primary care prevention and not as a referral without follow up.
- ★ [HQDA] Research the best means of treating to maximize full return to duty and minimize chances for reoccurrences.
- ★ [HQDA] Determine the best “order of operations” for treatment of co-morbid conditions including PTSD, TBI and depression.
- ★ [HQDA] Examine the true recidivism rate of those that go into ASAP even after they have left the service to determine the effects of this intervention on the Army.
- ★ [HQDA] Continue ongoing research for treatment interventions.
- ★ [HQDA] Research limitations caused by Protected Health Information (PHI).
- ★ [HQDA] Update manpower models to reflect current workload demands and appropriate manpower “credit” for prevention efforts.
- ★ [HQDA] Continue ongoing research on drug-related overdoses and blister packaging to reduce suicidal behavior.
- ★ [HQDA] Continue ongoing research on treatment modalities (brief cognitive therapy, dialectical behavior therapy, etc.).
- ★ [HQDA] Continue ongoing research on antidepressants and the risk of self-harm behavioral.
- ★ [HQDA] Research into the effect of antidepressants, psychiatric and or narcotics on readiness both pre-deployment and during deployment. Do some help while others hinder?
- ★ [HQDA] Conduct comprehensive research and analysis of the impact of increased use of antidepressant, psychiatric and narcotic pain management medications on the force. (page 30)
- ★ [HQDA] Conduct research to identify appropriate antidepressant medications that are beneficial to the treatment of depression and anxiety, but that will not increase risk for suicidal behavior. (page 30)
- ★ [HQDA] Initiate research to develop effective mitigation strategies to counter the effects of comorbidity on Soldiers and address the full spectrum of war-related health concerns. (page 31)

TREAT

h. Inquire/Investigate/Report

INQUIRY**RECOMMENDED RESEARCH**

- ★ [HQDA] Research how to improve the “lessons learned” process, expand to include non-fatal suicide behavior and standardize the means for conducting both the legal investigation and the medical inquiry (DoDSER).
- ★ [HQDA] Improved clarity on the DoDSER for “relationship failure.”
- ★ [HQDA] Explore potential dashboard metrics – what are the most significant factors that identify an at-risk unit or Soldier?
- ★ [HQDA] Examine first term Soldier suicides to identify common causes (i.e., stressors) and high risk behavior. Tailor strategies to reduce suicides within this vulnerable population. (page 104)
- ★ [HQDA] Coordinate with OSD to modify the DoDSER survey methodology to refine data categories including demographic (military information), event information and history (deployment, medical, behavioral health and family) to provide comparative analysis among suicide victims. (page 194)

Conclusions & Recommendations 67 – Research for the Inquiry Phase

Annex C – HP/RR/SP Policy Review and Synchronization

This report makes numerous specific and general recommendations for changes to Army HP/RR/SP policies and programs. Effective implementation of these recommendations will require a comprehensive review of existing DOD and Army policy by the AHPC in order to synchronize and integrate these revisions. Just as each proponent reviews its inventory of programs to assemble its potential *HP/RR/SP Program Portfolio*, it should also review its inventory of policies to identify those that may require review and revision.

This annex is intended to provide a comprehensive list of DOD and Army policies for review and synchronization in order to implement the recommendations in this report. Table 1 represents the inclusive (insofar as the Report Team review could determine) list of HP/RR/SP policies. The remaining tables list groups of policies by related area (e.g. Accessions/Separations, Law Enforcement, etc.) as a starting point for the AHPC for their analysis.

Table 13 – DOD and Army Policies Potentially Affected by Recommendations in the Report

	Policy	Date	Proponent
1	Army Directive 2010-01 (<i>Conduct of AR 15-6 Investigations Into Suspected Suicides and Requirements for Suicide Incident Family Briefs</i>)	26 Mar 10	SA
2	Army Directive 2010-02 (<i>Guidance for Reporting Requirements and Redacting Investigation Reports of Death and Fatalities</i>),	26 Mar 10	SA
3	AR 10-87, <i>Army Commands, Army Service Component Commands, and Direct Reporting Units</i>	4 Sep 07	DAS
4	AR 600-34, <i>Fatal Training/ Operational Accident Presentations to the Next of Kin</i>	2 Jan 03	DAS
5	AR 70-6, <i>Management of the Research, Development, Test, and Evaluation, Army Appropriation</i>	16 Jun 86	RDT&E
6	AR 70-8, <i>Soldier-Oriented Research and Development in Personnel and Training</i>	31 Jul 90	G1
7	AR 135-175, <i>Separation of Officers (RAR)</i>	27 Apr 10	G1
8	AR 135-178, <i>Enlisted Administrative Separations (ARNG/RC) (RAR)</i>	27 Apr 10	G1
9	AR 340-21, <i>The Army Privacy Program</i>	5 Jul 85	G1
10	AR 600-8-1, <i>Army Casualty Program</i>	30 Apr 07	G1
11	AR 600–8–2, <i>Suspension of Favorable Personnel Actions (FLAGS)</i>	23 Dec 04	G1
12	AR 600-8-4, <i>Line of Duty Policy, Procedures, and Investigations</i>	4 Sep 08	G1
13	AR 608-8, <i>Mortgage Insurance for Service Members</i>	5 Oct 84	G1
14	AR 600-8-24, <i>Officer Transfers and Discharges (RAR)</i>	27 Apr 10	G1

	Policy	Date	Proponent
15	AR 600-8-101, <i>Personnel Processing (In-, Out-, Soldier Readiness, Mobilization, and Deployment Processing)</i>	18 Jul 03	G1
16	AR 600-15, <i>Indebtedness of Military Personnel</i>	14 Mar 86	G1
17	AR 600-20, <i>Command Policy (RAR)</i>	27 Apr 10	G1
18	AR 600-100, <i>Army Leadership</i>	8 Mar 07	G1
19	AR 600-63, <i>Army Health Promotion Program (RAR)</i>	20 Sep 09	G1
20	AR 600-85, <i>The Army Substance Abuse Program (RAR)</i>	2 Dec 09	G1
21	AR 601-270, <i>Military Entrance Processing Station (MEPS) (RAR)</i>	26 Feb 10	G1
22	AR 635-200, <i>Active Duty Enlisted Administrative Separations (RAR)</i>	27 Apr 10	G1
23	DA PAM 600-24, <i>Health Promotion, Risk Reduction, and Suicide Prevention</i>	17 Dec 09	G1
24	AR 165-1, <i>Army Chaplain's Corps Activities</i>	3 Dec 09	OCCH
25	AR 608-1, <i>Army Community Service Center</i>	19 Sep 07	ACSIM
26	AR 608-18, <i>The Army Family Advocacy Program</i>	30 Oct 07	ACSIM
27	AR 930-4, <i>Army Emergency Relief</i>	22 Feb 08	ACSIM
28	AR 15-6, <i>Procedures for Investigating Officers and Boards of Officers</i>	2 Oct 06	SA
29	AR 27-10, <i>Military Justice</i>	16 Nov 05	OTJAG
30	AR 190-30, <i>Military Police Investigations</i>	1 Nov 05	OPMG
31	AR 190-45, <i>Law Enforcement Reporting</i>	30 Mar 07	OPMG
32	AR 195-2, <i>Criminal Investigation Activities</i>	15 May 09	OPMG
33	AR 40-5, <i>Preventive Medicine</i>	25 May 07	OTSG
34	AR 40-31, <i>Armed Forces Institute of Pathology and Armed Forces Histopathology Centers</i>	4 Jun 93	OTSG
35	AR 40-57, <i>Armed Forces Medical Examiner System</i>	2 Jan 91	OTSG
36	AR 40-66, <i>Medical Record Administration and Healthcare Documentation (RAR)</i>	4 Jan 10	OTSG
37	AR 40-68, <i>Clinical Quality Management (RAR)</i>	22 May 09	OTSG
38	AR 40-400, <i>Patient Administration</i>	27 Jan 10	OTSG
40	AR 40-501, <i>Standards of Medical Fitness (RAR)</i>	10 Sep 08	OTSG
41	AR 350-1, <i>Army Training and Leader Development</i>	18 Dec 09	G3/5/7
42	AR 385-40, <i>Army Accident Investigations and Reporting (RAR)</i>	25 Feb 10	CSA
43	AR 385-10, <i>The Army Safety Program (RAR)</i>	14 Jun 10	CSA
44	DODD 1030.1, <i>Victim and Witness Assistance</i>	23 Apr 07	USD, (P&R)
45	DODI 1300.18, <i>Department of Defense (DoD) Personnel Casualty Matters, Policies, and Procedures</i>	14 Aug 09	USD, (P&R)
46	DoDI 3210.1, <i>Administration and Support of Basic Research by the Department of Defense</i>	16 Sep 05	USD (AT&L)

	Policy	Date	Proponent
47	DoDD 3216.02, <i>Protection of Human Subjects and Adherence to Ethical Standards in DoD Supported Research</i>	24 Apr 07	USD (AT&L)
48	DODI 5154.30, <i>Armed Forces Institute of Pathology Operations</i>	18 Mar 03	ASD (HA)
49	DODI 5505.3, <i>Initiation Of Investigations by Military Criminal Investigative Organizations</i>	21 Jun 02	DoDIG
50	DODI 5505.10, <i>Investigation of Noncombat deaths of Active Duty Members of the Armed Forces</i>	31 Jan 96	DoDIG
51	DoDI 6025.18, <i>Privacy of Individually Identifiable Health Information in DoD Health Care Programs</i>	2 Dec 09	USD (P&R)
52	DODI 6055.5, <i>Occupational and Environmental Health (OEH)</i>	11 Nov 08	USD (AT&L)
53	DODI 6055.7, <i>Accident Investigation, Reporting, and Record Keeping</i>	24 Apr 08	USD (AT&L)
54	DODD 7730.47, <i>Defense Incident-Based Reporting System (DIBRS)</i>	15 Oct 96	USD (P&R)
55	DOD Manual 7730.47M, <i>Manual for Incident-Based Reporting System</i>	25 Jul 07	USD (P&R)
56	Joint Army Regulation 40–56, <i>Introduction, Requirements Determination, and Publication of New Standardized Medical Items into the Department of Defense (Supplementation is prohibited.)</i>	14 May 86	None Listed

The following Tables provided groups of related policies which may require review, synchronization, and or revision to implement report recommendations.

	Policy	Date	Proponent
1	AR 135-175, <i>Separation of Officers (RAR)</i>	27 Apr 10	G1
2	AR 135-178, <i>Enlisted Administrative Separations (ARNG/RC) (RAR)</i>	27 Apr 10	G1
3	AR 600–8–2, <i>Suspension of Favorable Personnel Actions (FLAGS)</i>	23 Dec 04	G1
4	AR 600-8-24, <i>Officer Transfers and Discharges (RAR)</i>	27 Apr 10	G1
5	AR 600-20, <i>Command Policy (RAR)</i>	27 Apr 10	G1
6	AR 600-85, <i>The Army Substance Abuse Program (RAR)</i>	2 Dec 09	G1
7	AR 635-200, <i>Active Duty Enlisted Administrative Separations (RAR)</i>	27 Apr 10	G1
8	AR 601-270, <i>Military Entrance Processing Station (MEPS) (RAR)</i>	26 Feb 10	G1
9	AR 40-501, <i>Standards of Medical Fitness (RAR)</i>	10 Sep 08	OTSG

Table 14 – Policies Related to Accessions and Separations

	Policy	Date	Proponent
1	DODD 1030.1, <i>Victim and Witness Assistance</i>	23 Apr 07	USD (P&R)
2	DODI 5505.3, <i>Initiation Of Investigations by Military Criminal Investigative Organizations</i>	21 Jun 02	DoDIG
3	DODD 7730.47, <i>Defense Incident-Based Reporting System (DIBRS)</i>	15 Oct 96	USD (P&R)
4	DOD Manual 7730.47M, <i>Manual for Incident-Based Reporting System</i>	25 Jul 07	USD (P&R)
5	AR 27-10, <i>Military Justice</i>	16 Nov 05	OTJAG
6	AR 190-45, <i>Law Enforcement Reporting</i>	30 Mar 07	OPMG
7	AR 195-2, <i>Criminal Investigation Activities</i>	15 May 09	OPMG
8	AR 600-20, <i>Command Policy (RAR)</i>	27 Apr 10	G1
9	AR 600-85, <i>The Army Substance Abuse Program (RAR)</i>	2 Dec 09	G1
10	AR 608-1, <i>Army Community Service Center</i>	19 Sep 07	ACSIM
11	AR 608-18, <i>The Army Family Advocacy Program</i>	30 Oct 07	ACSIM

Table 15 – Policies Related to Commander Discipline/Law Enforcement Reporting and Information Sharing

	Policy	Date	Proponent
1	DODI 1300.18, <i>Department of Defense (DoD) Personnel Casualty Matters, Policies, and Procedures</i>	14 Aug 09	USD (P&R)
2	DODI 5154.30, <i>Armed Forces Institute of Pathology Operations</i>	18 Mar 03	ASD (HA)
3	DODI 5505.10, <i>Investigation of Noncombat deaths of Active Duty Members of the Armed Forces</i>	31 Jan 96	DoDIG
4	Army Directive 2010-01 (<i>Conduct of AR 15-6 Investigations Into Suspected Suicides and Requirements for Suicide Incident Family Briefs</i>)	26 Mar 10	SA
5	Army Directive 2010-02, (<i>Guidance for Reporting Requirements and Redacting Investigation Reports of Death and Fatalities</i>)	26 Mar 10	SA
6	AR 600-34, <i>Fatal Training/ Operational Accident Presentations to the Next of Kin</i>	2 Jan 03	DAS
7	AR 15-6, <i>Procedures for Investigating Officers and Boards of Officers</i>	2 Oct 06	SA
8	AR 600-8-1, <i>Army Casualty Program</i>	30 Apr 07	G1
9	AR 600-8-2, <i>Suspension of Favorable Personnel Actions (FLAGS)</i>	23 Dec 04	G1
10	AR 600-8-4, <i>Line of Duty Policy, Procedures, and Investigations</i>	4 Sep 08	G1
11	DA PAM 600-24, <i>Health Promotion, Risk Reduction, and Suicide Prevention</i>	17 Dec 09	G1
12	AR 195-2, <i>Criminal Investigation Activities</i>	15 May 09	OPMG
13	AR 40-31, <i>Armed Forces Institute of Pathology and Armed Forces Histopathology Centers</i>	4 Jun 93	OTSG
14	AR 40-57, <i>Armed Forces Medical Examiner System</i>	2 Jan 91	OTSG
15	AR 385-40, <i>Army Accident Investigations and Reporting (RAR)</i>	25 Feb 10	CSA
16	AR 385-10, <i>The Army Safety Program (RAR)</i>	14 Jun 10	CSA

Table 16 – Policies Related to Death Investigations and Next-of-Kin Notifications

	Policy	Date	Proponent
1	DoD 8320.02-G, <i>Guidance for Implementing Net-Centric Data Sharing</i>	12 Apr 06	DoD CIO
2	Army Net-Centric Data Sharing Guidance Document	15 Nov 07	CIO/G6
3	Initial Army Duty Transformation Plan	10 May 10	CIO/G6
4	DoDI 6025.18, <i>Privacy of Individually Identifiable Health Information in DoD Health Care Programs</i>	2 Dec 09	USD (P&R)
5	AR 40-66, <i>Medical Record Administration and Healthcare Documentation (RAR)</i>	4 Jan 10	OTSG
6	AR 40-68, <i>Clinical Quality Management (RAR)</i>	22 May 09	OTSG
7	AR 40-400, <i>Patient Administration</i>	27 Jan 10	OTSG
8	AR 190-45, <i>Law Enforcement Reporting</i>	30 Mar 07	OPMG
9	AR 195-2, <i>Criminal Investigation Activities</i>	15 May 09	OPMG
10	AR 340-21, <i>The Army Privacy Program</i>	5 Jul 85	G1
11	AR 600-20, <i>Command Policy (RAR)</i>	27 Apr 10	G1
12	AR 600-63, <i>Army Health Promotion Program (RAR)</i>	20 Sep 09	G1
13	AR 600-85, <i>The Army Substance Abuse Program (RAR)</i>	2 Dec 09	G1
14	AR 608-1, <i>Army Community Service Center</i>	19 Sep 07	ACSIM
15	AR 608-18, <i>The Army Family Advocacy Program</i>	30 Oct 07	ACSIM
16	DA PAM 600-24, <i>Health Promotion, Risk Reduction, and Suicide Prevention</i>	17 Dec 09	G1

Table 17 – Policies Related to Information Sharing

	Policy	Date	Proponent
1	AR 600-15, <i>Indebtedness of Military Personnel</i>	14 Mar 86	G1
2	AR 608-8, <i>Mortgage Insurance for Service Members</i>	5 Oct 84	G1
3	AR 608-1, <i>Army Community Service Center</i>	19 Sep 07	ACSIM
4	AR 608-18, <i>Army Family Advocacy Program</i>	30 Oct 07	ACSIM
5	AR 930-4, <i>Army Emergency Relief</i>	22 Feb 08	ACSIM

Table 18 – Policies Related to Financial Assistance for Soldiers

	Policy	Date	Proponent
1	DoDI 3210.1, <i>Administration and Support of Basic Research by the Department of Defense</i>	16 Sep 05	USD (AT&L)
2	DoDD 3216.02, <i>Protection of Human Subjects and Adherence to Ethical Standards in DoD Supported Research</i>	24 Apr 07	USD (AT&L)
3	AR 70-6, <i>Management of the Research, Development, Test, and Evaluation, Army Appropriation</i>	16 Jun 86	RDT&E
4	AR 70-8, <i>Soldier-Oriented Research and Development in Personnel and Training</i>	31 Jul 90	G1
5	Joint Army Regulation 40–56, <i>Introduction, Requirements Determination, and Publication of New Standardized Medical Items into the Department of Defense (Supplementation is prohibited.)</i>	14 May 86	None Listed

Table 19 – Policies Related to Research

Annex D – Revised Report for Suicide or Equivocal Death Investigated as Possible Suicide

DA Pam 600-24, *Health Promotion, Risk Reduction and Suicide Prevention*, requires commanders to submit, in addition to the SIR, a “34 Line Report” to the ASPP within 30 days of a Soldier suicide or equivocal death being investigated as a suicide. The contents of each line of the report are specified, and the report is prepared using information gathered during the AR 15-6 inquiry process. This report format is also used by investigators from CID in support of the ASPTF and to inform Army Senior Leadership of the details surrounding suicide events. This report will be continuously modified based on requirements for additional data. This Annex contains recommended changes to the “34 Line Report” that will be staffed through the Army Health Promotion Council for validation by the VCSA.

Table 20 – Commander's Revised 37 Line report

Commander's Report of Suicide or Equivocal Death Investigated as Possible Suicide	
Line 1	Name:
Line 2	Rank:
Line 3	MOS: <ul style="list-style-type: none"> • Assigned duty at time of event:
Line 4	Time in Service: <ul style="list-style-type: none"> • Previous break in service? (Y/N): <ul style="list-style-type: none"> – If yes, specify the dates:
Line 5	Age:
Line 6	Education: (check all that apply) <input type="checkbox"/> GED <input type="checkbox"/> High School diploma <input type="checkbox"/> Two-year college degree <input type="checkbox"/> Four-year college degree <input type="checkbox"/> Master's degree <input type="checkbox"/> Doctoral degree
Line 7	Marital/Significant Other Relationship and Status: (check all that apply) <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally separated <input type="checkbox"/> Married but living apart <input type="checkbox"/> Single <input type="checkbox"/> Significant Other
Line 8	Family Members Relationships (Spouse, Children, Mother, Father, Sister(s), Brother(s)): <input type="checkbox"/> Single parent? Y/N – If yes, number, sex, and age of children: <input type="checkbox"/> Dual military? Y/N <input type="checkbox"/> Significant health issues for Family member(s)? Y/N – If yes, identify member(s) and issue(s) for each: <input type="checkbox"/> Significant legal issues for Family member(s) (e.g., impending bankruptcy, divorce or child custody proceeding)? Y/N – If yes, identify member(s) and issue(s) for each: <input type="checkbox"/> Significant disputes among Family member(s)? Y/N – If yes, identify member(s) dispute(s) for each:

Line 9	<p>Living Arrangements at time of incident (indicate all that apply)</p> <p><input type="checkbox"/> Living alone</p> <p><input type="checkbox"/> Living with spouse</p> <p><input type="checkbox"/> Living with significant other</p> <p><input type="checkbox"/> Living with Family member(s) – Identify Family member(s):</p> <p><input type="checkbox"/> Living with friend(s) – Identify friend(s):</p>
Line 10	<p>Unit and Duty Status</p> <ul style="list-style-type: none"> • Unit of assignment: <p>Duty status at time of event ((check all that apply):</p> <p><input type="checkbox"/> AD</p> <p><input type="checkbox"/> ADT/IDT/AGR</p> <p><input type="checkbox"/> Mobilized Guard or Reserve</p> <p><input type="checkbox"/> Trainee (Basic Training/AIT)</p> <p><input type="checkbox"/> Released from active duty within 120 days Scheduled for release from active duty within 120 days</p> <p><input type="checkbox"/> Retired Guard or Reserve not on AD or drill status</p>
Line 11	<p>PCS/leave issues</p> <ul style="list-style-type: none"> • Date of last PCS: • Relevant stressors during PCS move? Y/N – If yes, identify date(s) of last leave: • Any leave disapproved within last 48 hours? Week? Month?
Line 12	Arrival Date to Current Unit:
Line 13	<p>Status of Unit at time of Incident</p> <ul style="list-style-type: none"> • Deployed? Y/N • Redeployed? Y/N
Line 14	<p>Deployment History</p> <ul style="list-style-type: none"> • Number of deployments: • Date(s) of last deployment:
Line 15	Pending Deployment (date):
Line 16	Identify Suicide Prevention Training received within the last 12 months:
Line 17	DTG Completed Suicide Stand-Down/Training (Phase #1): (Still ongoing? If not, omit?)
Line 18	DTG Completed Suicide Chain-Teach/Training (Phase #2): (Still ongoing? If not, omit?)
Line 19	DTG and location of incident (On/Off Post):
Line 20	Details of Suspected Suicide Event, including suspected method of death (e.g., hanging, drowning, overdose):

Line 21	Drug or Alcohol Involvement (e.g., bottles/pills found at Scene/Witness Reports, etc.):
Line 22	Evidence of prior planning for suicide (Settling Affairs, etc.):
Line 23	Triggering Event (Argument, Breakup, Admonishment, etc):
Line 24	<p>Pre-Death Signals/Indicators (indicate all that apply)</p> <input type="checkbox"/> Threatening to kill himself/herself <input type="checkbox"/> Threatening to hurt himself/herself <input type="checkbox"/> Evidence of looking for ways to kill himself/herself (e.g., seeking access to pills, weapons, or other means of death) <input type="checkbox"/> Talking or writing about death, dying, or suicide <input type="checkbox"/> Suicide Note <input type="checkbox"/> Evidence of: <ul style="list-style-type: none"> – rage – anger – seeking revenge <input type="checkbox"/> Use or purchase (within last 3 months) of motorcycle or high-performance vehicle <input type="checkbox"/> Engagement in other reckless or risky activities (describe) <input type="checkbox"/> Increase in drug use over the prior 48 hours? Past year? <input type="checkbox"/> Increase in alcohol use over the prior 48 hours? Past year? <input type="checkbox"/> Evidence of: <ul style="list-style-type: none"> – dramatic mood change – anxiety – agitation – inability to sleep – sleeping more than normal <input type="checkbox"/> Giving away personal property <input type="checkbox"/> Changes in personal habits (eating, smoking, stopping PT) <input type="checkbox"/> Other possible evidence of intent to kill himself/herself:
Line 25	Previous Ideations/Gestures/Attempts:
Line 26	Does suicide date coincide with other anniversary dates (Suicide or Deaths of Relatives, Divorce, Birthdays, etc):
Line 27	<p>Mental/Physical Health History:</p> <input type="checkbox"/> Mental Health History <ul style="list-style-type: none"> – Within 24 hours prior to event – Within 48 hours prior to event – Within 1 week prior to event – Within 1 month prior to event

	<ul style="list-style-type: none"><input type="checkbox"/> Physical Health History<ul style="list-style-type: none">– Within 24 hours prior to event– Within 48 hours prior to event– Within 1 week prior to event– Within 1 month prior to event
Line 28	<p>Current Medications and History of Compliance:</p> <ul style="list-style-type: none"><input type="checkbox"/> Medications used<ul style="list-style-type: none">– Within 24 hours prior to event– Within 48 hours prior to event– Within 1 week prior to event– Within 1 month prior to event<input type="checkbox"/> Compliance with prescription (e.g., taken as prescribed? Skipped? In excess of prescription? In different manner (e.g., crushed instead of in capsule)?<ul style="list-style-type: none">– Within 24 hours prior to event– Within 48 hours prior to event– Within 1 week prior to event– Within 1 month prior to event
Line 29	<p>Illegal Use of Drug/Addiction to Alcohol History:</p> <ul style="list-style-type: none"><input type="checkbox"/> Prescription drugs<ul style="list-style-type: none">– Within 24 hours prior to event– Within 48 hours prior to event– Within 1 week prior to event– Within 1 month prior to event– Past year– Prior to past year<input type="checkbox"/> Non-prescription (“street”) drugs<ul style="list-style-type: none">– Within 24 hours prior to event– Within 48 hours prior to event– Within 1 week prior to event– Within 1 month prior to event– Past year– Prior to past year<input type="checkbox"/> Alcohol<ul style="list-style-type: none">– Within 24 hours prior to event– Within 48 hours prior to event– Within 1 week prior to event– Within 1 month prior to event– Past year– Prior to past year

Line 30	Adverse Actions/Pending Adverse Actions:
Line 31	<p>Financial Status issues (indicate all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Mortgage exceeding value of property (“underwater” mortgage)? Y/N <input type="checkbox"/> Amount of monthly obligations exceed amount of monthly income from all Sources? Y/N <input type="checkbox"/> RC Soldiers unemployed? Y/N <ul style="list-style-type: none"> – Duration of unemployment: – Underemployed/part time employment only? Y/N <ul style="list-style-type: none"> ▪ Duration of underemployment/part time employment: – Service connected disability? Y/N <ul style="list-style-type: none"> ▪ If yes, percent rating? – Involuntarily separated from civilian employment within last 6 months? Y/N <ul style="list-style-type: none"> ▪ If yes, <ul style="list-style-type: none"> ○ Laid off? Y/N ○ Fired? Y/N ○ Other? (describe): ○ Circumstances: – Evidence of frustration in obtaining employment? Y/N <ul style="list-style-type: none"> ▪ If yes, describe: – Homeless? Y/N
Line 32	<p>Legal Issues/Adverse Actions (indicate all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> AWOL/dropped from rolls <input type="checkbox"/> Positive urinalysis <input type="checkbox"/> Arrest <input type="checkbox"/> Incarceration <input type="checkbox"/> Under investigation <input type="checkbox"/> Charged with crime (civilian or military) <ul style="list-style-type: none"> – DUI – Reckless driving – Drug use/possession – Drug distribution – Abuse of spouse/significant other/child – Other violent crime – Other – Unknown <input type="checkbox"/> Administrative separation action <input type="checkbox"/> MEB/PEB <input type="checkbox"/> Other involuntary separation action <input type="checkbox"/> Article 15 <input type="checkbox"/> Article 32 <input type="checkbox"/> Court-martial <input type="checkbox"/> Civilian criminal proceeding

	<input type="checkbox"/> Non-selection for advanced schooling, promotion, or command <input type="checkbox"/> DA Form 4187 reflecting denial of requested schooling within last 3 months <input type="checkbox"/> Security clearance issue <input type="checkbox"/> Divorce <input type="checkbox"/> Child custody proceeding <input type="checkbox"/> Other administrative proceeding <input type="checkbox"/> Lawsuit <input type="checkbox"/> Bankruptcy
Line 33	Work Related Issues (indicate all that apply) <input type="checkbox"/> Dispute with supervisors, peers or subordinates <input type="checkbox"/> Substandard performance ratings <input type="checkbox"/> RC Soldiers: impending layoff, firing, demotion, work reduction or reduction in benefits <input type="checkbox"/> Work-related accidents in the last 2 years
Line 34	Supervisor/peer hazing or maltreatment:
Line 35	Lifestyle, Personality: • Non-work related accidents in the last 2 years?
Line 36	Gun Ownership/Type:
Line 37	GT Score:

Annex E – Confirming Data: The Lost Art of Leadership

The data in this annex provide additional details supporting the calculations, statistics, conclusions, and recommendations presented in Section III of this report, “*The Lost Art of Leadership in Garrison.*”

Army Separation Actions (FY2001-2009)

Separation data from FY 1997–2000 demonstrate a steady state rate of separations (Chapters 5-13, 9, 10, 11, 13, 14) averaging **3.2%** per year.

- This **3.2%** baseline **Separation Rate** was then multiplied by the **End Strength** for each year from FY01–09 to derive the expected separation totals if the separation rate had not changed.
- The actual yearly **Separation Totals** (for the same Chapters, 5-13, 9, 10, 11, 13, 14) were then subtracted from the expected yearly totals to derive the yearly difference.
- The **Yearly Difference** was then added to derive the surplus bolus of Soldiers retained through FY 01–09.

Or:

$$\text{Sep Rate}_{(\text{ave } 97-00)} * (\text{EndSt}_{01} + \text{EndSt}_{02} \dots + \text{EndSt}_{09}) - (\text{SepN}_{01-09}) = \text{Surplus Retained}$$

Figure 71 – Army Separation Actions (FY01-09)

Active Duty Suicide Deaths (CY 2003-2009)

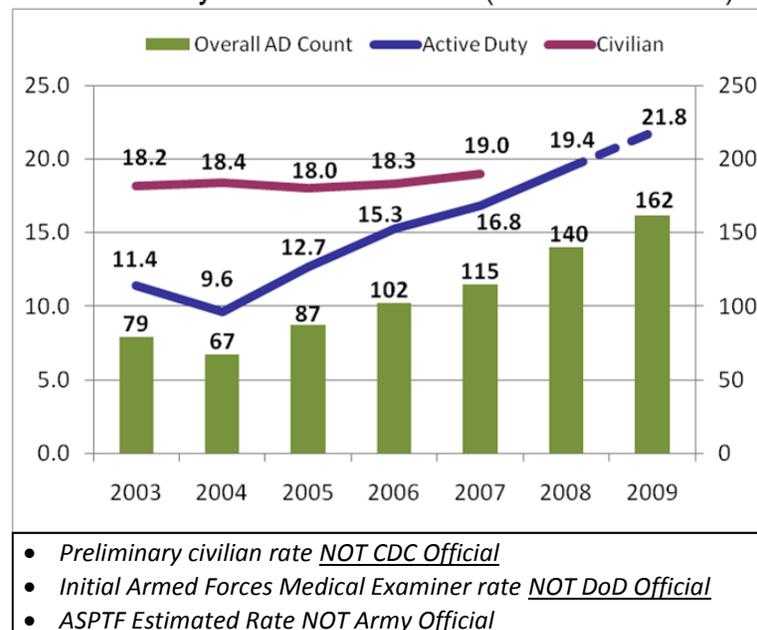


Figure 72 – Active Duty Suicide Deaths (CY 2003-2009)

Non-Combat Soldier Deaths (FY06-FY09)

Fiscal Year	Accidental	Murder	Suicide	Undetermined	Totals
FY06	79	44	82	13	218
FY07	84	52	90	12	238
FY08	72	49	122	14	257
FY09	107	59	160	19	345
				FY 06-09 Total:	1058

Table 21 – 1058 Non-Combat Soldier Deaths Investigated by CID

Suicide Data: Priors and Drug/Alcohol Use

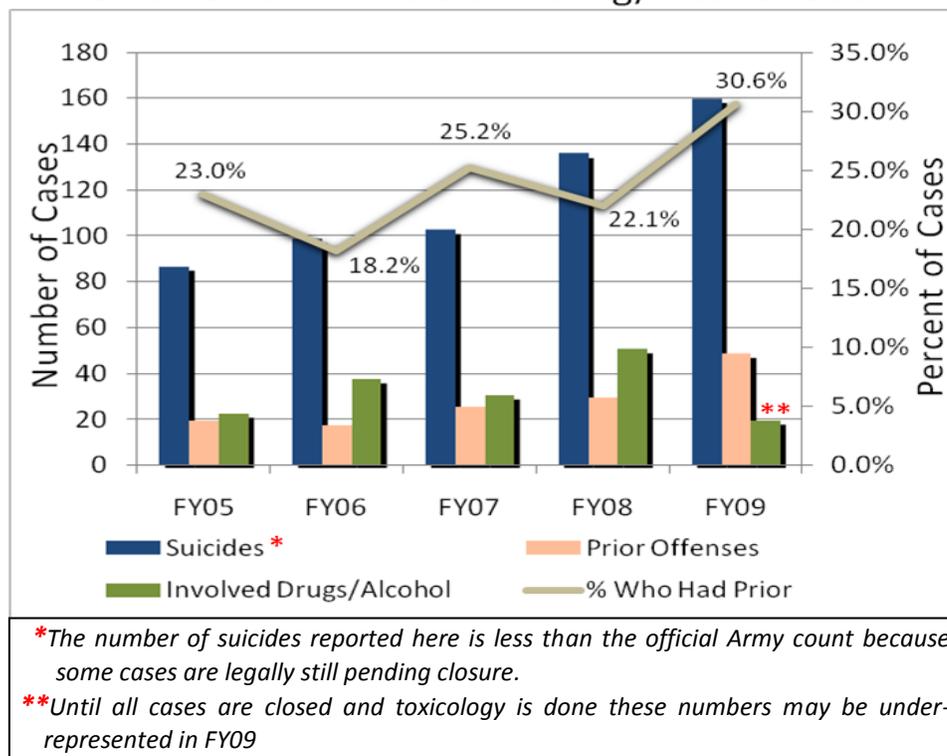


Figure 73 – Suicide Data: Prior Offenses and Drug/Alcohol Abuse

MRO Evaluations: (Un)Resolved/(Un)Authorized Use (FY01-FY09)

FY	Total MRO Evaluation Required by Drug Positive	Unresolved	Resolved	% Authorized	% Unauthorized	% MRO Reviews Unresolved	Authorized Use	Unauthorized Use	Admin Close	Soldier Unavailable	Pending
FY01	2,964	1,137	1,827	66.8%	33.2%	38%	1,221	606	627	510	0
FY02	3,514	1,150	2,364	54.8%	45.2%	33%	1,296	1,068	320	830	0
FY03	3,099	872	2,227	55.9%	44.1%	28%	1,246	981	186	686	0
FY04	2,693	732	1,961	47.7%	52.3%	27%	935	1,026	96	636	0
FY05	3,292	474	2,818	32.7%	67.3%	14%	921	1,897	2	467	5
FY06	5,359	338	5,021	56.9%	43.1%	6%	2,857	2,164	1	330	7
FY07	5,801	226	5,575	61.9%	38.1%	4%	3,453	2,122	2	186	38
FY08	6,916	188	6,728	74.3%	25.7%	3%	5,002	1,726	0	171	17
FY09	8,390	388	8,002	78.6%	21.4%	5%	6,291	1,711	0	189	199
Totals	42,028	5,505	36,523	63.6%	36.4%	13%	23,222	13,301	1,234	4,005	266

Table 22 – MRO Evaluations: (Un)Resolved/(Un)Authorized Use (FY01-09)

Drug Testing: 1st Time, 2nd Time, and Serial Positives (FY01-FY09)

Fiscal Year	Total Soldiers Tested	Soldiers Tested Positive for Illicit use	Illicit Use Rate	# of Soldier 1st Time Positives	# of Soldier 2nd Time Positives	# of Soldier Serial Positives
FY01	453,073	7,260	1.60%	4,698	1,388	1,174
FY02	467,967	8,236	1.76%	5,081	1,623	1,532
FY03	459,064	7,304	1.59%	4,542	1,538	1,224
FY04	423,951	6,243	1.47%	4,070	1,256	917
FY05	429,352	7,381	1.72%	4,678	1,501	1,202
FY06	426,570	7,527	1.76%	4,760	1,468	1,299
FY07	456,316	8,080	1.77%	5,283	1,507	1,290
FY08	446,498	7,860	1.76%	4,877	1,627	1,356
FY09	474,526	7,907	1.67%	4,752	1,643	1,512
Totals	1,662,004	58,687	3.53%	36,470	11,828	10,389

Table 23 – DAMIS Drug Testing: 1st Time, 2nd Time, and Serial Positives (FY01-FY09)

Drug Testing: Individual Soldiers vs. Total Force (FY01-FY09)

Fiscal Year	Soldiers Tested at least Once	Army End Strength	# Soldiers Not Tested	% Soldiers Tested	Specimens Tested	Soldier Testing Rate
FY01	445,993	480,801	34,808	92.76%	1,100,701	228.93%
FY02	460,162	486,542	26,380	94.58%	1,179,855	242.50%
FY03	452,940	499,301	46,361	90.71%	1,040,388	208.37%
FY04	424,021	499,543	75,522	84.88%	968,016	193.78%
FY05	429,378	492,728	63,350	87.14%	1,094,781	222.19%
FY06	426,683	505,402	78,719	84.42%	1,095,880	216.83%
FY07	457,445	522,017	64,572	87.63%	1,092,402	209.27%
FY08	446,502	543,645	97,143	82.13%	1,119,832	205.99%
FY09	474,527	553,044	78,517	85.80%	1,216,032	219.88%
Totals	1,653,289*		565,372	87.79%	9,907,887	216.41%

- Soldier testing data was queried against individual social security numbers to identify the number of unique Soldiers never tested. The final column demonstrates that those tested tended to be tested on average more than once.
- Multiplying the number of Soldiers not tested in FY09 (78,517) by the FY09 Illicit use rate (1.67%) reveals there were likely 1,311 Soldiers who abused drugs but were never detected.

* This column is not a total of all years, because the total line represents the total number of unique Soldiers tested over the nine year time period

Table 24 – DAMIS Drug Testing: Individual Soldiers vs. Total Force (FY01-FY09)

Prescription Drug Testing Data (FY06-FY09)

Fiscal Year	Total Specimens	Total Oxy	% Oxy	Total Opiates	% Opiates	% Tested*
FY06	1,095,880	128,672	11.74	191,824	17.50	14.62
FY07	1,092,402	158,412	14.50	177,676	16.26	15.38
FY08	1,119,832	194,637	17.38	192,487	17.19	17.28
FY09	1,216,032	196,738	16.18	240,476	19.78	17.98

* If every sample were tested for the panel of prescription drugs, then the total for Oxy and Opiates would be the same (1:1) ratio.

Table 25 – Prescription Drug Testing Data (FY06-FY09)

Data on DA Form 4833 (FY 04-09)

Fiscal Year	Required	# Completed	% Completed	Incomplete	Drug Offenses	Referred to Drug/Alcohol
FY04	25,613	11,703	46%	13,910 (54%)	6391 (25%)	468 (7%)
FY05	32,498	20,814	64%	11,684 (36%)	7836 (24%)	718 (9%)
FY06	33,443	22,111	66%	11,332 (34%)	7681 (23%)	1,204 (4%)
FY07	34,494	21,774	63%	12,720 (37%)	7439 (22%)	1,160 (3%)
FY08	36,413	22,723	62%	13,690 (38%)	7874 (22%)	1,123 (3%)
FY09	37,633	22,559	60%	15,074 (40%)	7559 (20%)	1,262 (3%)
Totals	200,094	127,684	64%	78410 (36%)	44,780 (22%)	5935 (3%)

Table 26 – Data on DA Form 4833 (2004-2009)

Chapter Action Data by Year (FY01-FY09)

Fiscal Year	Chapter 9	Chapter 10	Chapter 11	Chapter 13	Chapter 14	Chapter 5	Totals
FY01	330	3,088	5,234	1,498	5,009	8,608	23,767
FY02	432	6,437	4,998	1,280	5,738	8,283	27,168
FY03	325	2,461	3,658	1,302	6,928	9,554	24,228
FY04	228	1,549	4,449	1,305	5,411	10,525	23,467
FY05	215	1,961	3,194	794	5,781	9,910	21,855
FY06	194	2,252	833	314	5,658	7,268	16,519
FY07	225	2,979	1,058	382	6,118	8,978	19,740
FY08	244	2,562	1,708	428	6,464	9,828	21,234
FY09	297	2,297	2,105	670	7,254	8,867	21,490

This represents the first data call which is not consistent with the second data call as reflected in section III. This table was retained due to the unknown consistency between both data calls. The difference between the numbers in the two data calls represents variation in total columns. A third pull also resulted in a variation in the data despite the same criteria (chapter actions by year) being used.

Table 27 – Chapter Action Data by Year (FY01-FY09)

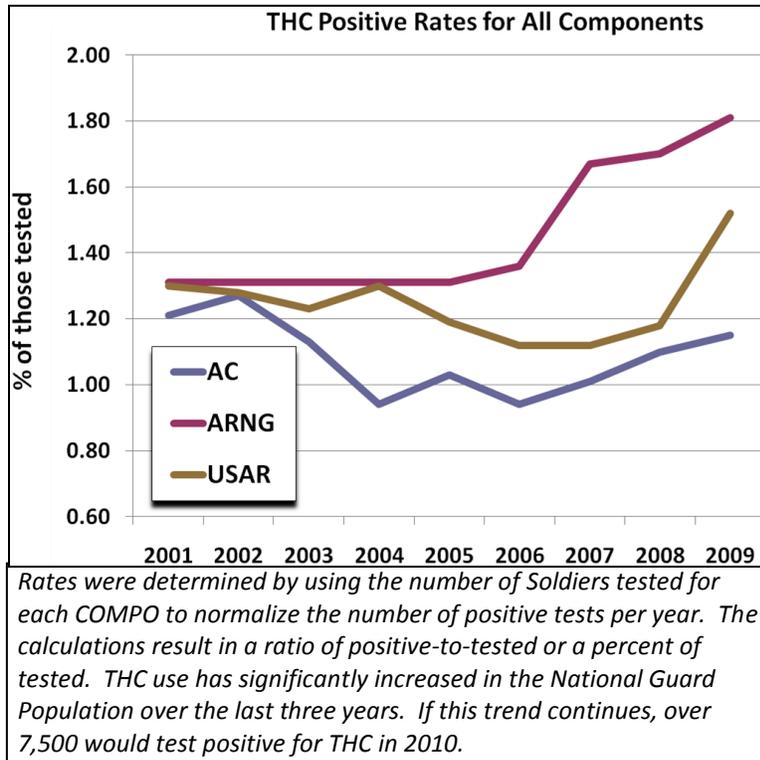


Figure 74 – THC Positive Rates for All Components (FY01-09)

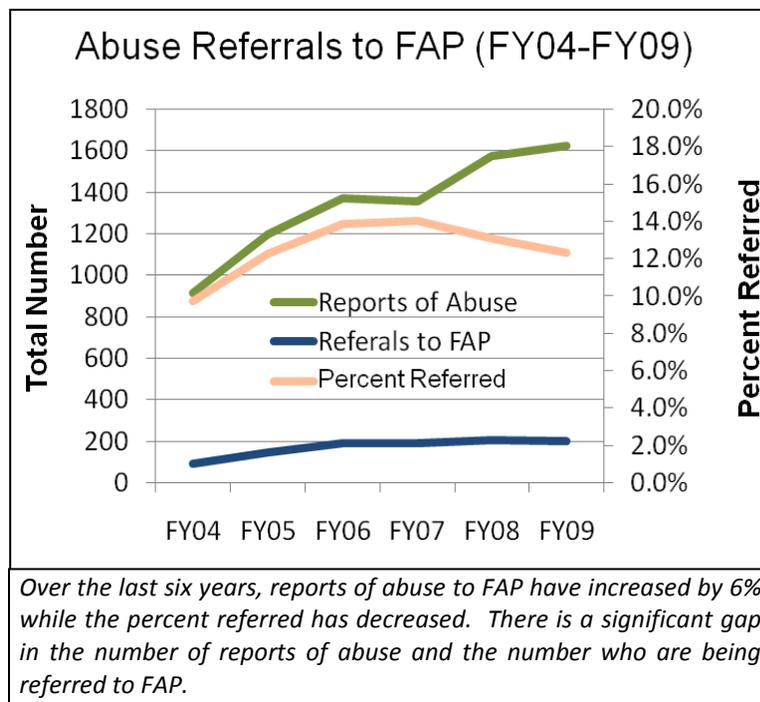


Figure 75 – Abuse Referrals to FAP (FY04-09)

DUI and UA Positive Referral Data (FY01-FY09)

Fiscal Year	Total DUIs	Referred to ASAP	Rate	Total UA Positive	Referred to ASAP	Rate
FY01	850	553	65.1%	1,976	1,166	59.0%
FY02	1,507	1,057	70.1%	3,458	2,115	61.2%
FY03	2,354	1,625	69.0%	5,388	3,089	57.3%
FY04	2,630	1,727	65.7%	5,599	3,404	60.8%
FY05	3,012	1,845	61.3%	7,765	4,283	55.2%
FY06	3,802	2,703	71.1%	9,769	5,841	59.8%
FY07	4,009	2,856	71.2%	9,880	6,850	69.3%
FY08	3,933	2,917	74.2%	9,195	6,231	67.8%
FY09	3,543	2,651	74.8%	8,882	4,648	52.3%
Totals	25,640	17,934	69.9%	61,912	37,627	60.8%

Table 28 – DUI and UA Positive Referral Data (FY01-FY09)

Potential Total & Illicit Drug Positives

Potential Positives:

$$(388_{\text{unresolved}} + 22_{\text{missing}}) * (.214_{\text{illicit rate}}) = 87.74 \text{ Total Additional}$$

Opiates:

$$(618_{\text{opiate reviews}}) = (.1978_{\text{sample rate}}) * (N_{\text{total positives}}), N = 3,124$$

$$3,124_{\text{total positives}} * (.267_{\text{positive rate}}) = 834.1 \text{ Total Opiates}$$

Oxycodone:

$$3,756_{\text{oxy reviews}} = (.1618_{\text{sample rate}}) * (N_{\text{total positives}}), N = 23,214$$

$$23,214_{\text{total positives}} * (.0942_{\text{positive rate}}) = 2,186.75 \text{ Total Oxycodone}$$

Amphetamine:

$$3,135_{\text{amp reviews}} = (.858_{\text{sample rate}}) * (N_{\text{total positives}}), N = 3,653$$

$$3,653_{\text{total positives}} * (.2236_{\text{positive rate}}) = 816 \text{ Total Amphetamine}$$

$$\text{Grand Total: } N = 410_{\text{Unresolved}} + 3,124_{\text{Opiates}} + 23,214_{\text{Oxy}} + 3,653_{\text{Amp}} = 30,401 \text{ Total Positives}$$

$$\text{Illicit Total: } N = 88_{\text{Additional}} + 834_{\text{Opiates}} + 2,187_{\text{Oxy}} + 816_{\text{Amp}} = 3,925 \text{ Illicit Positives}$$

Figure 76 – Potential Total and Illicit Drug Positives

Annex F – Navigating the Event Cycle & Care Continuum

Any Soldier's movement along the eight phases of the Care Continuum and three stages of the Event Cycle can be traced using the illustration in Figure 77. The Pre-Event stage of the Event Cycle corresponds with the *Recruit*, *Separate* and *Awareness/Resiliency* phases of the Care Continuum. Ideally, the commander's goal would be to keep every Soldier in the *Awareness/Resiliency* phase of the Care Continuum whenever possible. Commanders should recognize when a Soldier demonstrates a need for specific care through high risk or help-seeking behaviors, and refer the Soldier to programs and services in the Inter-Event stage, which encompasses the *Assess*, *Educate/Train*, *Intervene*, and *Treat* phases of the Care Continuum. Movement through the Inter-Event stage is not always linear; there are many possible turns that lead either to low risk behaviors with continuous assessment or unchecked high risk behavior that could result in accidental death or suicide. During the Post-Event stage the Army measures success when it neutralizes high risk behaviors; it conducts inquiries when death or other negative outcomes occur.

Pre-Event

Recruiting and accession standards act as an initial filter for potentially at-risk Soldiers – not everyone who wants to become a Soldier can. The blue diagonal arrows during the *Recruit* phase represent that portion of the target recruit population which does not successfully pass entry-level requirements for Army service due to previous behavioral health (BH) history. For a range of reasons, including BH, some Soldiers who cannot or will not meet Army standards are separated through legal or administrative processes. Additional blue diagonal arrows represent this further culling of the force.

The Army promotes HP/RR/SP *Awareness* to everyone (Soldier, Family, and Civilian) in the Army through training and builds *Resilience* in its people to promote general wellbeing across the force. *Awareness* also provides opportunities to identify and address individual issues before a Soldier moves into the Inter-Event stage where the consequences could become irreversible.

Programs in this stage of the Event Cycle focus on providing general information (i.e., Family Advocacy parenting classes, ASAP prevention/education training and skill building).

Inter-Event

The goal of the Inter-Event stage is to assess a Soldier as at-risk and provide appropriate education and training before intervention becomes necessary. This affords the commander and at-risk Soldier the largest window of opportunity to resolve the behavior or stressor before reaching a negative outcome.

The *Assess, Educate/Train, Intervene, and Treat* phases of the Care Continuum occur within the Inter-Event stage of the Event Cycle. Program effectiveness at each phase within the Inter-Event stage determines the at-risk Soldier's path along the Care Continuum. The intent is to work with each at-risk Soldier towards a positive outcome such as the neutralization of high risk behavior. Actions that lead to negative outcomes (e.g., continued high risk behavior, accidental death, and completed suicide) should be avoided. Green boxes represent positive outcomes; red boxes represent negative outcomes.

The 'low risk loop' in Figure 77 represents the ideal sequence of events for achieving a positive outcome. The Soldier is correctly assessed as at-risk. The Soldier then receives specific training and education on the stressor or high risk behavior identified. The Soldier successfully uses the training to cease the high risk behavior and no further intervention or treatment is needed. A Soldier will experience the *Awareness/Resiliency* stage continuously (green arrows) throughout a career. The 'high risk loop' in the figure represents an at-risk Soldier's worst case scenario. The Soldier engages in high risk behavior which may or may not be identified (or signaled). This behavior continues until an effective intervention occurs or a negative outcome is reached.

Programs in this stage of the Event Cycle address a specific behavior/need such as Army Emergency Relief, tele-TBI treatment or Warrior Adventure Quest.

Post-Event

Post-Event is the final stage of the Event Cycle and correlates with the *Inquiry* phase of the Care Continuum. Investigation and reporting of negative outcomes (grey arrows) combine with measures of success from positive outcomes (grey arrows) to provide feedback and inform predictive modeling efforts.

This stage follows an event that yields either a positive or negative outcome experienced by the at-risk Soldier and is used to determine specific details surrounding the event. Common investigations conducted in this stage include AR 15-6 and Line of Duty (LOD) investigations; reports include Serious Incident Reports (SIR) and the Report for Suicide or Equivocal Death Investigated as Suicide ("34 Line Report").

A commander's primary responsibility is to ensure the readiness, health, morale, welfare and discipline of the unit. In the HP/RR/SP context, this responsibility means to manage unit members across the Event Cycle (pre-event, inter-event and post-event) and the Care Continuum (from Recruit through Inquiry).

Individual Progress through the Care Continuum Cycle

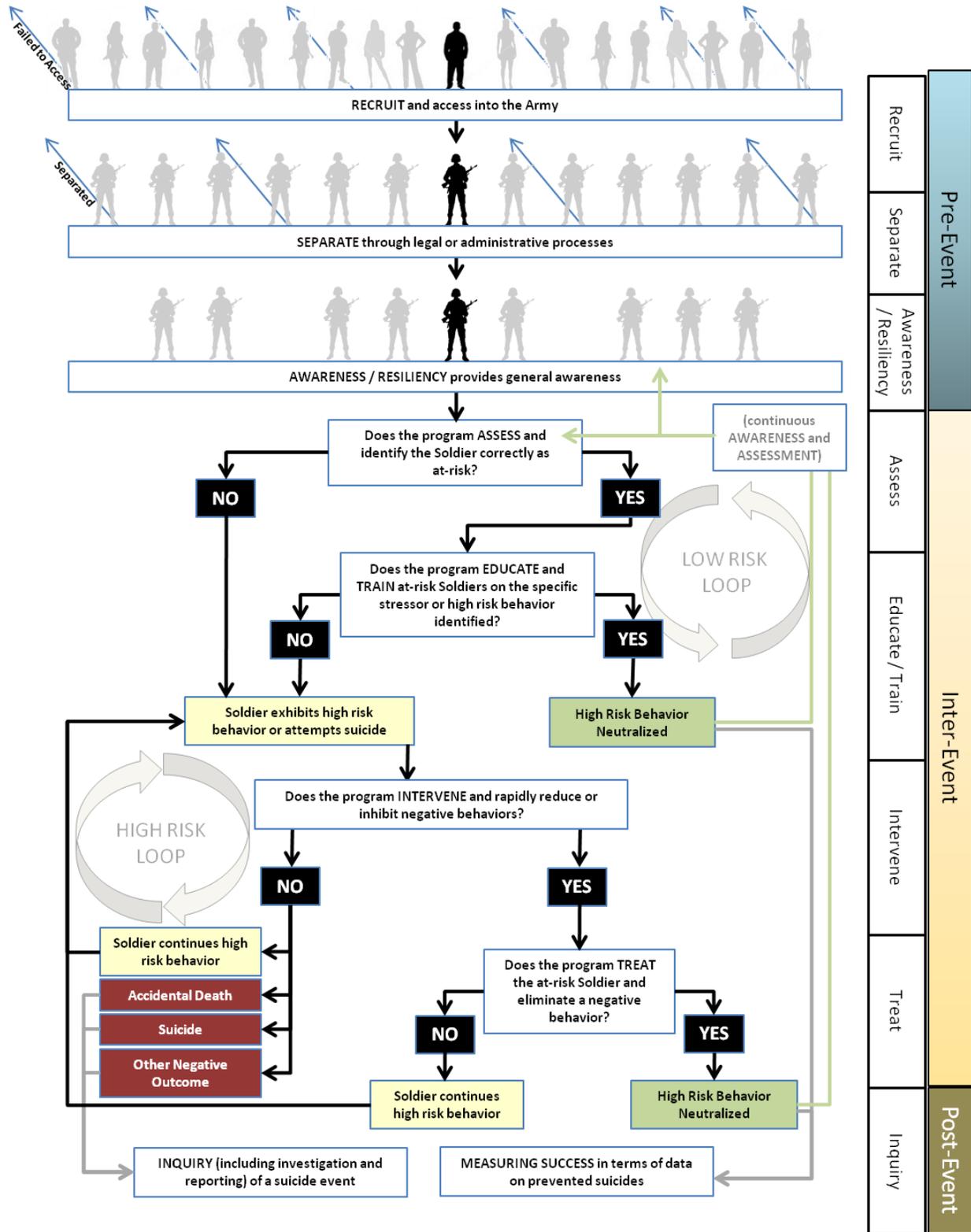


Figure 77 – Individual Progress through the Care Continuum

Annex G – HP/RR/SP Potential Portfolio

On 15 Dec 09 the Vice Chief of Staff, Army (VCSA) issued a memorandum with implementing guidance for an Army-wide program assessment in support of the Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention (ACPHP). The implementing guidance outlined the need for a comprehensive and integrated review and assessment of all programs and initiatives in support of the ACPHP. The VCSA memorandum outlined the requirements, suspenses, method and expectations associated with a program assessment to identify gaps, overlaps, seams and appropriate levels of support in HP/RR/SP related programs that mitigate Soldier, Family member and Civilian stressors.

The data call included a standard Program Assessment Tool (PAT) data sheet to be completed by program owners at echelons from HQDA to the local unit level. Program owners were asked to conduct a self-analysis and submit data sheets containing basic program and initiative data. The collected PATs would permit a general, collective evaluation of HP/RR/SP related programs. Between December 2009 and January 2010, the Army Suicide Prevention Task Force received 622 PAT data sheets in response to the VCSA memorandum.

The Report Team screened the 622 data sheets and identified 269 duplicative programs and initiatives; that is, the PATs included multiple responses for an identical program or identified a common program by a unique, locally-determined name (e.g., the “Fort Courage Daddy’s Program” as opposed to the Army “New Parent Support Program”). A review of the remaining 353 programs identified 283 that were either unrelated or not directly related to health promotion, risk reduction and suicide prevention. The result of the analysis yielded 70 programs and initiatives directly related to HP/RR/SP that collectively could constitute the HP/RR/SP Potential Portfolio (refer to “Building the Potential Portfolio” in Section VII of the main report, “*Managing the Program Portfolio*”(page 165)).

Figure 78 presents the 70 programs, program components and services identified by the Report Team as they relate to the Event Cycle and the phases of the Care Continuum – the latter defining whether a program or component is associated with HP/RR/SP and how its features complement the other elements of the program portfolio. The brown arrows thread HP/RR/SP programs from top to bottom (from the Event Cycle through the Care Continuum to the proponent and at least one of the three proposed core enterprises (CE). The programs are grouped by proponent and proposed CE. Programs listed in the yellow boxes are primarily associated with the proposed Services and Infrastructure CE, the pink boxes identify those closely related to the proposed Human Capital CE, and the blue boxes highlight programs connected to the proposed Readiness CE.

The services provided by many of the programs may span multiple phases of the Care Continuum (e.g., ASAP); however, each is listed under the phase associated with its primary purpose. For example, the “ACS Financial Readiness” program is listed under the Awareness/Resiliency phase even though the program also provides education and training. The Family Advocacy Program (FAP) extends from the pre-event stage to the inter-event stage of the Event Cycle and from the Awareness/Resiliency phase through the Assess to the Treat phase. MEDCOM, as the action agent of the FAP (Treatment) program, may involve the local garrison to increasing program awareness. ACSIM, as the program proponent, may engage OTSG, through the Army Health Promotion Council process to ensure appropriate information is shared with the ACS FAP service providers.

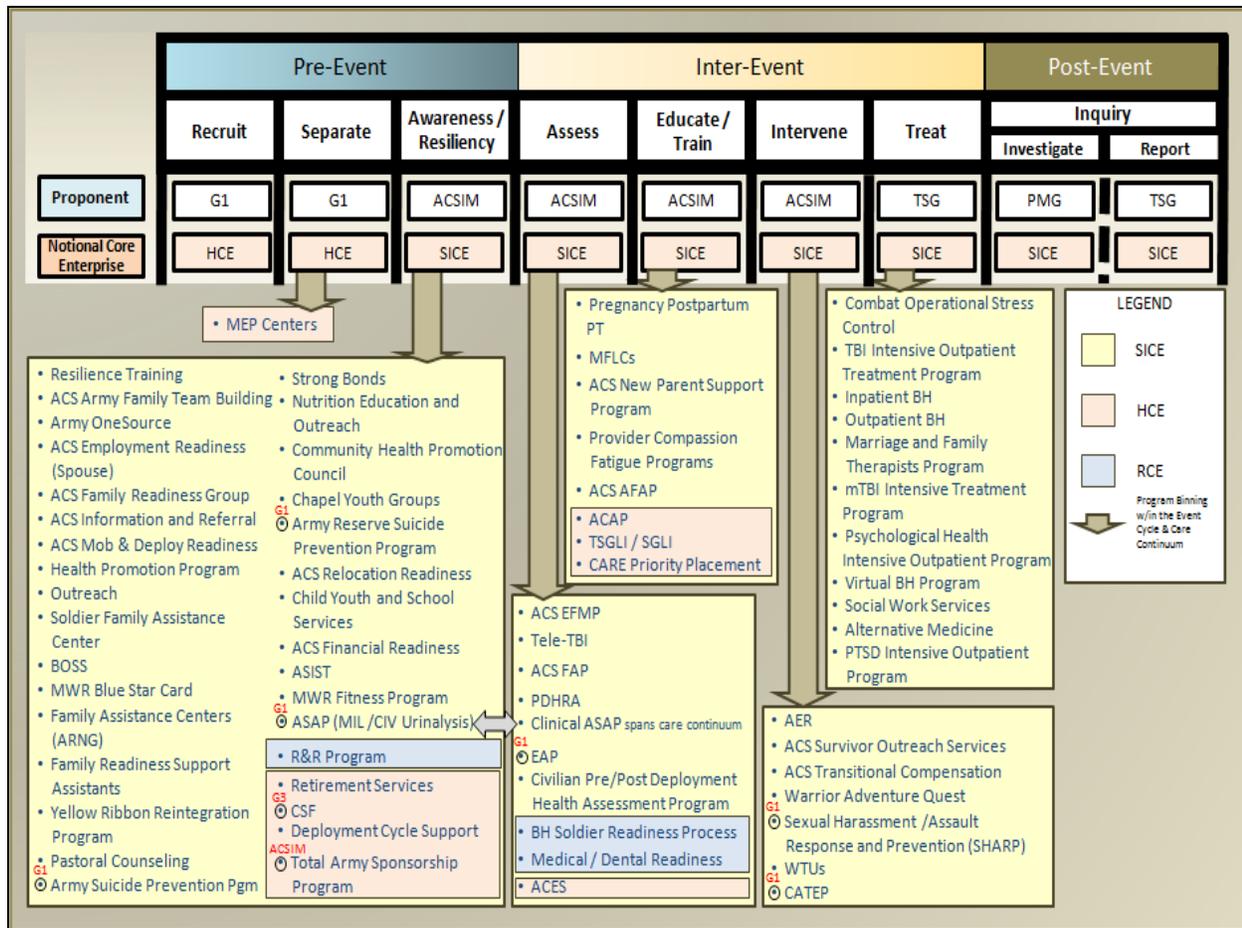


Figure 78 – HP/RR/SP Potential Portfolio of 70 Programs/Initiatives

Figure 78 shows the interrelationships among the core enterprises and reinforces the need for the core and cross enterprise approach to HP/RR/SP efforts. Finally, the VCSA may engage the HCE, RCE and SICE through the ARPERGEN cross enterprise forum, to ensure appropriate policies governing the reassignment, deferment, or deletion and reporting of specific FAP enrollments.

The 70 HP/RR/SP programs and services identified by the Report Team program analysis are listed in Table 30 along with their corresponding regulatory guidance.

Table 29 – HP/RR/SP Related Programs Identified by the Initial Program Assessment

HP/RR/SP Related Program	Program Regulations/Guidance
ACS Army Family Action Plan (AFAP)	AR 608-47, <i>Army Family Action Plan (AFAP) Program</i>
ACS Army Family Team Building (AFTB)	AR 608-48, <i>Army Family Team Building (AFTB) Program</i>
ACS Employment Readiness (Spouse)	AR 608-1, <i>Army Community Service Center</i>
ACS Exceptional Family Member Program (EFMP)	AR 608-75, <i>Exceptional Family Member Program</i>
ACS Family Advocacy Program (FAP)	AR 608-18, <i>The Army Family Advocacy Program</i>
ACS Family Readiness Groups (FRG)	AR 608-1, <i>Army Community Service Center</i>
ACS Financial Readiness	AR 608-1, <i>Army Community Service Center</i>
ACS Geographically Dispersed Outreach	AR 608-1, <i>Army Community Service Center</i>
ACS Information and Referral	AR 608-1, <i>Army Community Service Center</i>
ACS Mobilization and Deployment Readiness (Support)	AR 608-1, <i>Army Community Service Center</i>
ACS New Parent Support Program (NPSP)	AR 608-18, <i>The Army Family Advocacy Program</i>
ACS Relocation Readiness	AR 608-1, <i>Army Community Service Center</i>
ACS Soldier Family Assistance Center (SFAC)	AR 608-1, <i>Army Community Service Center</i>
ACS Survivor Outreach Services (SOS)	AR 608-1, <i>Army Community Service Center</i>
ACS Transitional Compensation	AR 608-1, <i>Army Community Service Center</i>
Alternative Medicine	Army Campaign Plan for Pain Management (pending)
Applied Suicide Intervention Skills Training (ASIST) ¹⁵⁷	AR 600-63, <i>Army Health Promotion</i>
Army Career and Alumni Program (ACAP)	AR 600-8-7, <i>Retirement Services Program</i>
Army Continuing Education System (ACES)	AR 621-5, <i>Army Continuing Education System</i>
Army Emergency Relief (AER)	AR 930-4, <i>Army Emergency Relief</i>
Army OneSource	AR 608-1, <i>Army Community Service Center</i>
Army Reserve Suicide Prevention Program	AR 600-63, <i>Army Health Promotion</i>

¹⁵⁷ Although not an Army program, it is documented in AR 600-63 with implied Army coordination and requires portfolio management until modified or deleted as a result of the portfolio management process.

HP/RR/SP Related Program	Program Regulations/Guidance
Army Substance Abuse Program (ASAP)(Military/Civilian Urinalysis)	AR 600-85, <i>The Army Substance Abuse Program</i>
Army Suicide Prevention Program (ASPP)	AR 600-63, <i>Army Health Promotion</i>
Better Opportunities for Single Soldiers (BOSS)	AR 215-1, <i>Military Morale Welfare, and Recreation Programs and Nonappropriated Fund Instrumentalities</i>
Behavioral Health Soldier Readiness Processing	AR 600-8-101, <i>Personnel Processing (In-, Out-, Soldier Readiness, Mobilization, and Deployment Processing)</i>
Care PPP (Civilian Assistance and Re-employment)	AR 600-85, <i>The Army Substance Abuse Program</i>
CATEP (Confidential Alcohol Treatment and Education Program)	AR 600-85, <i>The Army Substance Abuse Program</i>
Chapel Youth Groups	AR 165-1, <i>Army Chaplain Corps Activities</i>
Child, Youth and School Services	AR 608-10, <i>Child Development Services</i>
Civilian Pre/Post Deployment Health Assessment Program	AR 40-66, <i>Medical Record Administration and Health Care Documentation</i>
Clinical Substance Abuse Program (ASAP)	AR 600-85, <i>The Army Substance Abuse Program</i>
Combat Operational Stress Control (COSC)	AR 40-5, <i>Preventive Medicine</i>
Community Health Promotion Council	AR 600-63, <i>Army Health Promotion</i>
Comprehensive Soldier Fitness (CSF)	www.army.mil/csf
Deployment Cycle Support	AR 600-20, <i>Army Command Policy</i> Army Directive 2007-02, <i>Deployment Cycle Support</i>
Employee Assistance Program (EAP)	AR 600-85, <i>The Army Substance Abuse Program</i>
Family Assistance Centers (ARNG)	AR 608-1, <i>Army Community Service Center</i>
Family Readiness Support Assistants (FRSA)	AR 608-1, <i>Army Community Service Center</i>
Health Promotion Program	AR 600-63, <i>Army Health Promotion</i>
Inpatient Behavioral Health (BH)	AR 10-87, <i>Army Commands, Army Service Component Commands, and Direct Reporting Units</i>
Marriage and Family Therapist Program	AR 600-63, <i>Army Health Promotion</i> AR 10-87, <i>Army Commands, Army Service Component Commands, and Direct Reporting Units</i>

HP/RR/SP Related Program	Program Regulations/Guidance
MEB Processing Centers	AR 635-40, <i>Physical Evaluation for Retention, Retirement, or Separation</i>
Medical/Dental Readiness	AR 40-35, <i>Dental Readiness and Community Oral Health Protection</i>
Mild Traumatic Brain Injury (mTBI) Intensive Treatment Program	AR 10-87, <i>Army Commands, Army Service Component Commands, and Direct Reporting Units</i>
Military Family Life Consultants (MFLC)	DA PAM 600-24, <i>Health Promotion, Risk Reduction, and Suicide Prevention</i>
MWR Blue Star Card Program	AR 215-1, <i>Military Morale Welfare, and Recreation Programs and Nonappropriated Fund Instrumentalities</i>
MWR Fitness Program	AR 215-1, <i>Military Morale Welfare, and Recreation Programs and Nonappropriated Fund Instrumentalities</i>
Nutrition Education and Outreach	AR 40-25, <i>Nutrition Standards and Education</i>
Outpatient Behavioral Health	AR 600-63, <i>Army Health Promotion</i>
Pastoral Counseling	AR 165-1, <i>Army Chaplain Corps Activities</i>
Post Traumatic Stress Disorder (PTSD) Intensive Outpatient Program (IOP)	AR 10-87, <i>Army Commands, Army Service Component Commands, and Direct Reporting Units</i>
Post Deployment Health Reassessment Program (PDHRA)	AR 40-66, <i>Medical Record Administration and Health Care Documentation</i>
Pregnancy Postpartum Physical Training (PPPT)	AR 40-501, <i>Standards of Medical Fitness</i>
Provider Compassion Fatigue Program	www.behavioralhealth.army.mil/prt/index.html
Psychological Health Intensive Outpatient Program (IOP)	AR 10-87, <i>Army Commands, Army Service Component Commands, and Direct Reporting Units</i>
Rest and Recuperation (R&R) Program	AR 600-8-10, <i>Leaves and Passes</i>
Resilience Training (formerly Battlemind)	www.resilience.army.mil
Retirement Services	AR 600-8-7, <i>Retirement Services Program</i>
Sexual Harassment/Assault Response and Prevention (SHARP)	AR 600-20, <i>Army Command Policy</i>
Social Work Services (SWS)	AR 10-87, <i>Army Commands, Army Service Component Commands, and Direct Reporting Units</i>

HP/RR/SP Related Program	Program Regulations/Guidance
Strong Bonds	AR 165-1, <i>Army Chaplain Corps Activities</i>
TBI Intensive Outpatient Treatment Program	AR 10-87, <i>Army Commands, Army Service Component Commands, and Direct Reporting Units</i>
Tele-Traumatic Brain Injury (TeleTBI)	http://www.tatrc.org/
Total Army Sponsorship Program	AR 600-8-8, <i>The Total Army Sponsorship Program</i>
Traumatic Service Members Group Life Insurance/Service Members Group Life Insurance (TSGLI/SGLI)	AR 600-8-1, <i>Army Casualty Program</i>
Virtual Behavioral Health (BH) Program	AR 10-87, <i>Army Commands, Army Service Component Commands, and Direct Reporting Units</i>
Warrior Adventure Quest (WAQ)	AR 215-1, <i>Military Morale Welfare, and Recreation Programs and Nonappropriated Fund Instrumentalities</i>
Warrior Transition Unit (WTU)	http://wtc.armylive.dodlive.mil/about-wtu/
Yellow Ribbon Reintegration Program	DoD DTM 08-029, <i>Implementation of the Yellow Ribbon Reintegration Program</i>



