OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG 26 2010

The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This report responds to House Report 110-652 of the National Defense Authorization Act for Fiscal Year 2009. The House Report requests the Secretary of Defense to study the possibility of providing a referral for a second opinion to potentially suicidal Service members in a combat theater.

Thank you for your continued support of the Military Health System.

Sincerely,

Charles L. Rice, M.D.
President, Uniformed Services University of the Health Sciences
Performing the Duties of the Assistant Secretary of Defense (Health Affairs)

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

AUG 26 2010

HEALTH AFFAIRS

The Honorable Ike Skelton
Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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Enclosure:
As stated

cc:
The Honorable Howard P. "Buck" McKeon
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

AUG 26 2010

HEALTH AFFAIRS

The Honorable Susan Davis
Chairwoman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Madam Chairwoman:

This report responds to House Report 110-652 of the National Defense Authorization Act for Fiscal Year 2009. The House Report requests the Secretary of Defense to study the possibility of providing a referral for a second opinion to potentially suicidal Service members in a combat theater.

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Enclosure:
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cc:
The Honorable Joe Wilson
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG 26 2010

The Honorable Daniel K. Inouye
Chairman, Subcommittee on Defense
Committee on Appropriations
United States Senate
Washington, DC 20510

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Charles L. Rice, M.D.
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Enclosure:
As stated

cc:
The Honorable Thad Cochran
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

AUG 26 2010

HEALTH AFFAIRS

The Honorable David R. Obey
Chairman, Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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Enclosure:
As stated

cc:
The Honorable Jerry Lewis
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

AUG 26 2010

HEALTH AFFAIRS

The Honorable Norm Dicks
Chairman, Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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cc:
The Honorable C. W. Bill Young
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

AUG 26 2010

HEALTH AFFAIRS

The Honorable James H. Webb
Chairman, Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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cc:
The Honorable Lindsey O. Graham
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

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Enclosure:
As stated

cc:
The Honorable Thad Cochran
Ranking Member

# SUICIDE PREVENTION IN THE ARMED FORCES
# STUDY ON REFERRAL FOR SECOND OPINION

## REPORT TO CONGRESS

## HOUSE REPORT 110-652 OF THE NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2009

**FEBRUARY 2010**

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## Introduction

This report responds to House Report 110-652, page 384, of the National Defense Authorization Act for Fiscal Year 2009 that directs the Secretary of Defense to study the possibility of providing a referral for second opinion to potentially suicidal Service members in the combat theater. In April 2009, OASD (HA) established the Suicide Prevention and Risk Reduction Committee (SPARRC). The SPARRC is chaired by the Defense Centers of Excellence (DCoE) and has representatives from the Army, Navy, Air Force, Marine Corps, Coast Guard, the National Guard Bureau Director of Psychological Health and Reserve Affairs, the Armed Forces Medical Examiner, the Armed Forces Chaplains Board, the DCoE Telehealth and Technology center, as well as, Veterans Affairs, Centers for Disease Control and Substance Abuse and Mental Health Administration. To provide an informed response, the SPARRC formed a working group to examine the topic. The following organizations participated in the working group:

| Organization |
|---|
| Air Force |
| Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury |
| Uniformed Services University of Health Sciences |
| Substance Abuse and Mental Health Services Administration |

The main focus of this report is the possibility of providing a second opinion for potentially suicidal Service members. The reviews and evaluations have resulted in ongoing discussions and changes to suicide prevention efforts. The working group believes professional consultation rather than second opinion is the preferred and more appropriate approach to clinical suicide risk assessment and management. The working group agreed that provider training and judgment should dictate when consultation is necessary. Consultation is already a common practice among providers. At this time, DoD has decided not to develop a policy to mandate consultation for suicidal patients in theater. However, the DoD Instruction on Combat Operational Stress Control will be modified to include language encouraging providers to consult their colleagues in evaluating patients who present a threat to self/others in the deployed environment. We will use this report to help guide and inform our current programs and policies.

## Second Opinion and Consultations: Definition of Terms

Different definitions of consultation and second opinion may apply in various settings. For the purposes of this report, the working group adopted the following definitions (referenced throughout the report) to pertain specifically to communications among mental health providers. The primary objective of clinical communication is to make the most appropriate clinical care decisions for our Service members recognized at risk for suicide behavior.

A **Consultation** within the military mental health field is a provider request for input from another knowledgeable health professional, based on the clinical provider's clinical description of a case. In the mental health field, consultation usually occurs when the primary mental health provider confers with a professional colleague about the patient. The clinical consultant may or may not interact directly with the patient in the course of the professional consultation. The provider seeking consultation is usually fully responsible for the handling of the case in terms of diagnosis and treatment. In the community, the provider usually carries the professional liability for the case, but in the military this can depend on the relationship and qualifications of the consultant. Requests for consultations may occur when a provider seeks to enhance the assessment and treatment he or she is providing to a patient. Consultations are often sought in both medical settings for a variety of reasons to ensure optimal assessment and treatment for a given individual. In some cases, the consultation may result in a request for a second opinion.

In the field of mental health, a **second opinion** differs from consultation and is generally a patient-initiated, full and independent evaluation by a second provider who directly interacts with the patient. Responsibility for clinical care determined by the patient's choice of the professional opinion. A request for a second opinion, for instance, may occur if an individual is given a psychiatric diagnosis and subsequently, chooses to request an independent evaluation by a second provider for confirmation, or refutation of the initial diagnosis. In this vein, a second opinion may be sought after diagnosis to confirm a recommended course of treatment or generate possible alternative treatments. Thus, second opinions are often sought in both medical settings to confirm or clarify a diagnosis and/or possible courses of treatment.

**Discussion of Consultation versus Second Opinion in Suicide Risk Assessment**

Based on collaboration with subject matter experts and several group discussions involving both civilian and military mental health providers, the working group recognizes that, in general, professional consultation is the preferred, more appropriate, and the less intrusive approach to clinical suicide risk assessment and management. Seeking a timely or contemporaneous clinical consultation is widely accepted in clinical suicidology practice for providers who work with suicidal individuals, and will ultimately help to ensure proper and appropriate medical and psychiatric decisions.

It is important to note the benefits of professional consultation, especially in the assessment, management, and treatment of suicidal behaviors. First, consultation presents the opportunity to further examine the details of a given case with another colleague. This helps to minimize further trauma to the Service member who would have to re-live the experience in the case of seeking a second opinion. Second, consultation provides reassurance to the suicidal individual and his/her family members and commands that the best possible care is being provided in order to prevent any potential

harm. It provides the Service member and his or her family a more informed medical opinion on issues such as return to duty, evaluation, hospitalization, and treatment options. There is no guarantee providers can assess the risk of suicide with 100 percent certainty, but nonetheless the diagnosis is their responsibility. Consultations enable providers to share experiences and gain an improved understanding of suicide risk to help them more accurately assess and mitigate risk. Third, a consultation has fewer logistical difficulties because it can be obtained in an easier manner, particularly in very rural or rugged terrains (i.e., telephone, chat or video teleconference). Since a consultation does not require the consulting provider to have an interaction with the patient, there are fewer scheduling constraints that would delay the provision of care. In comparison, a referral for a second opinion in theater has various logistical challenges that make it a more complicated option than consultation.

Given the factors outlined above, the working committee decided it was more logical to focus on determining the feasibility of consultation rather than second opinion in theater. However, in circumstances when the primary treatment provider does not have the expertise to adequately diagnose or treat the Service member's illness, a second opinion may be more appropriate than a consultation.

**Conclusion**

Based on the review, DoD recognizes that while a consultation is often more feasible, there may be situations where a second opinion is called for. DoD believes that second opinion should still remain an option for patients to initiate as they feel necessary, however the working group at this time believes consultation is the recommended approach to clinical suicide risk in theater assessment but a provider's training and judgment should dictate when consultation is appropriate and necessary. Consultation is already a common practice among providers. At this time, DoD has decided not to develop a policy to mandate consultation or second opinion for suicidal patients in theater. However, the DoD Instruction on Combat Operational Stress Control will be modified to include language encouraging providers to work with their colleagues in evaluating patients who present a threat to self/others in the deployed environment.

## Overview of the Literature

The working group collected recent literature including information about consultation and second opinion in order to identify current practices, as well as possible models or programs that could be used in theater to reduce suicide. These references are listed below.

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