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A model for the assessment, care, and treatment of suicidal risk within the military intelligence community

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ABSTRACT

This paper describes the development of a behavioral health and wellness model into the US Army Intelligence and Security Command (INSCOM) to address concerns about suicide within this community. In response to stresses existing within the intelligence community (IC), INSCOM partnered with the Army Public Health Center (APHC) to assess the health and wellbeing of Command personnel. A Community Health Assessment (CHA) survey was conducted (N = 2,704 Soldiers; N = 959 Civilians) that included focus groups across three installations and secondary source data. Six key areas were prioritized: suicide behavior, behavioral health access to care and health promotion, behavioral health stigma and maintaining clearances, workplace environment, sleep health, and overall fitness. Several actions were implemented to address the report's findings and recommendations. A Command Surgeon office was established within INSCOM. An INSCOM Health Assessment and Readiness Team (I-HART) was established. The Deputy Undersecretary of the Army provided support to address suicide within INSCOM by approving 4 highly qualified experts (HQE's) in behavioral health and clinical suicidology to provide research oversight and make recommendations. The Command General approved 8 behavioral health providers. There are planned research efforts within the command focusing on scalable and technology enabled care delivery to improve mental well-being and decrease suicides.

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Suicide; INSCOM; community health assessment

What is the public significance of this article?— To address concerning trends in suicide within the military intelligence community, a behavioral health and wellness model into the US Army Intelligence and Security Command (INSCOM) was developed. A Community Health Assessment (CHA) provided a systematic way to determine the health and quality of life-related needs and strengths of the Command's Soldier and Civilian personnel. Actionable health and wellness needs are identified and future research and support are described with the goal of improving wellness and decreasing suicides.

Introduction

The United States Army's Intelligence Security Command (INSCOM) is a two-star Army Command that conducts intelligence, security, and information operations for Army, Joint services, and our Coalition partners. Headquartered at Fort Belvoir, Virginia, INSCOM is comprised of 18 Brigade-size subordinate commands worldwide, 17 of which are under the Command's direct control. Personnel assigned to INSCOM include approximately 17,500 Active Duty Soldiers, Civilians, and contractors located at nearly 200 locations. The military intelligence (MI) community has been called upon to provide increased global support to fight terrorism and to mitigate national security threats. These threats are broad and our forces are continuously tasked with providing protection under increasingly challenging circumstances including high operation tempo (OPTEMPO), operation control (OPCON) and administrative control (ADCON) conflicts, shift work and sleep challenges, and deployed-in place personnel sustaining 365 24/7 operations (Prince et al., 2015).

The psychological wellbeing of the MI warfighter is a critical factor in successfully implementing the mission and goals of this community and in mitigating adversaries' attempts to undermine the moral and psychological conditioning of Soldiers. As the frontlines are

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increasingly cyber-oriented operations, research has shown that a different kind of warfare is now emerging. This new form of warfare is intensely psychological in nature, and the impact and effects of this activity are not fully known. As we enter into a new domain of remote and cyber operations, how do we as mental health care professionals take care of those who will be adversely affected by the work they do on our country's behalf?

A specific concern regarding the health of the Command, has been the incidence of suicide, a problem of concern across DoD (2010). The United States Military has a growing incidence of suicide among active duty personnel. In 2018, the active duty suicide rate was 24.8 per 100,000 service members, up from 21.9 in 2017 and 18.7 in 2013, with Intelligence and Security Command (INSCOM) personnel at highest risk. INSCOM's rates of suicide have increasingly risen the past 5 years (Figure 1). In addition to the rates of suicide behavior there were also serious incident reports that included arrest, AWOL, domestic/child abuse (accused), DUI/DWI, misconduct, narcotics related, and sexual harassment/assault (accused) incidents.

INSCOM personnel, in the context of performing their duties, encounter various types of exposures that are unpleasant, distressing, and that can have prolonged effects that carry over to personal and family relations. These may include exposure to remote combat experiences, graphic media, and abhorrent material including those associated with child victims of sexual crimes. Research has shown a direct relationship between symptoms of distress and exposure to remote combat and graphic media (Armour & Ross, 2017; Ogle & Young, 2016; Prince et al., 2015). There is also evidence that cases involving child victims, specifically abuse and child pornography, have a significant impact on psychological functioning either in isolated instances or through repeated exposure (Krause, 2009; Ludick & Figley, 2017). These effects can be cumulative (Ogle, Reichwald, & Rutland, 2018; Reardon et al., 2015) and may cause strain to family relationships, reduce resilience and negatively impact readiness (Van Dillen, Brown, Ogledzinski, Deleeuw, & Neal, 2019). Exposure to repeated stressors may be exacerbated by shift-work, long hours, operational tempo, intra-individual factors or other related environmental and/or human factors. Furthermore, a study conducted by Ogle et al. (2018), found that nearly half (49.8%) of intelligence, surveillance, and reconnaissance (ISR) personnel surveyed had potentially traumatic experiences (PTE) unrelated to remote combat and/or graphic media exploitation operations.

INSCOM Soldiers and Civilians are a special force on the front lines fighting intelligence and security-based threats every day to ensure the Army community is safe and the force remains ready. They routinely encounter extreme and abhorrent situations. Similar to other warfighters in "big Army," members of the IC may deal with trauma, distress, and legal matters that may substantially impact their lives (Cieslak et al., 2014). MI Warfighters thus carry the emotional burdens of their duties and are strictly forbidden to discuss mission related information with spouses or loved ones. Moreover, many compartmentalize their thoughts and reactions to stress and trauma so as to avoid any negative emotional impact on job performance. Stigma associated with seeking any kind of psychological help is prevalent and comprised of many layers including Army and MI cultural factors, and fear of losing clearances resulting in loss of access to work areas.

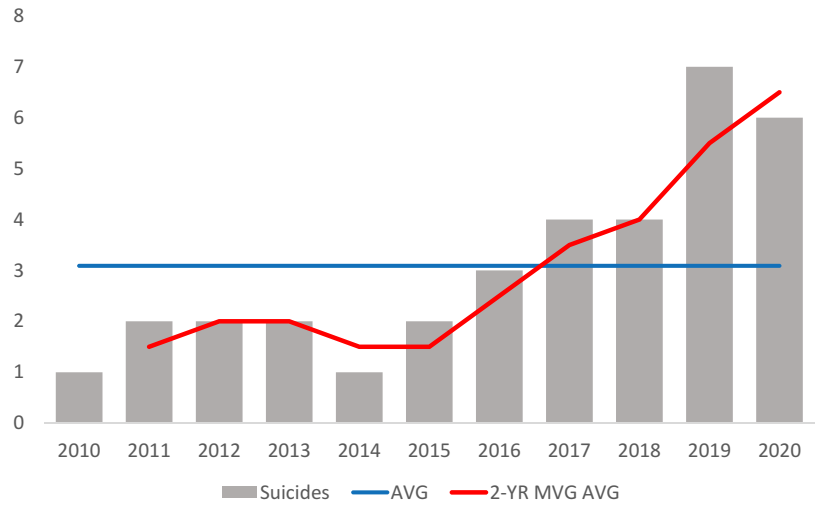

Figure 1. INSCOM suicide incidents between 1 January 2010 through 06 August 2020.
Suicides were tracked using serious incident reports (SIR's) and include Soldiers and Civilians.

Both small and large Army and IC agencies have devoted behavioral health resources to screen, evaluate and provide counseling to MI personnel. The need for behavioral health services is recognized across MI and Federal agencies (NSA, DIA, USAF, USN, FBI, ATF, DEA, etc.). Until recently, INSCOM leaders had not been afforded equivalent resources. The majority of INSCOM units primarily rely upon military treatment facility (MTF) providers, whose lack of security clearances place limits on their ability to engage with INSCOM MSC command teams and unit members. Furthermore, there exists a stigma associated with seeking behavioral health services. Complicating the sole reliance on traditional mental health intervention is the fact that MI community members remain concerned they will be viewed as weak, ineffective, or in a worst-case scenario, stripped of their credentials or clearances if they participate in behavioral health programs.

In response to these problem behaviors, INSCOM hired a psychologist in 2016 with the primary task of determining the nature of these problems and how to address them. In 2017, INSCOM requested support from the APHC to systematically determine the needs and strengths of their Soldier and Civilian personnel so that INSCOM leadership could make data-informed decisions about policies, programs, and/or services that could be improved or implemented to ensure a ready and resilient INSCOM. To obtain additional data not covered in the initial report and to assess potential changes over time, APHC collaborated with INSCOM HQ to complete a Command-wide Community Health Assessment (CHA) to obtain data to inform improvements to personnel health, quality of life, readiness, and resilience, and to inform suicide mitigation efforts. This paper presents the results of that survey, recommendations, and subsequent actions taken.

Method

The INSCOM Community Health Assessment (CHA) survey (N = 2,704 Soldiers; N = 959 Civilian personnel) included fifteen focus groups across three installations (N = 45 Soldiers; N = 15 Civilians) as well as secondary source data. Six areas were prioritized for assessment: suicide behavior, behavioral health access to care and health promotion, behavioral health stigma and maintaining clearances, workplace environment, sleep health, and overall fitness. Between April 2017 and January 2018, APHC and INSCOM leadership met to clarify the intent of the INSCOM CHA. In these meetings, a list of health and wellness domains that were seen as a priority for INSCOM were compiled, plans were discussed for data collection including survey administration, focus group conduct, and the sequence of these activities. The team determined the best way to communicate the process and findings to INSCOM key leaders beyond those at INSCOM HQ. Communication plans included briefing an overview of the process at the INSCOM Commander's Conference in September 2017 and to the INSCOM Commander's Ready and Resiliency Council (CR2C) in November 2017.

To ensure the most useful and actionable product for INSCOM, the assessment team engaged with key INSCOM staff in a prioritization process to narrow the domains and indicators for inclusion in the CHA. First, the assessment team compiled a list of all relevant domains (e.g., health status, health behaviors, demographics) and indicators (e.g., unintentional injuries, current tobacco use) typically used in community health work and that are established as important to the Army (APHC, 2017). After compiling the list and mapping the potential domains to data sources, the team provided a prioritization matrix to INSCOM leaders for them to rank the concepts most critical to learn about in their Command. INSCOM prioritized these domains and indicators between August and October 2017.

To address the prioritized domains and indicators, the execution of the INSCOM CHA included both primary and secondary data collection. Where feasible, the assessment team obtained existing information from secondary, "corporate" sources (e.g., DOD, Army systems), to alleviate the burden on the INSCOM population of answering additional questions. However, some prioritized indicators, such as social support and quality of life, do not exist at the corporate level and needed to be collected directly. The assessment team collected primary data from both Soldiers and Civilians via an electronic survey and a set of in-person focus group discussions.

Data from each of these methods and a variety of data sources were sought to effectively pinpoint the health and wellness status and needs of the INSCOM workforce. INSCOM leadership tasked all Soldier and Civilian personnel via INSCOM OPORD 18–047 (published 11 January 2018) and FRAGORD 1 to the OPORD (published 16 February 2018) to complete the survey and, for those meeting specific criteria, to participate in focus groups (at three locations).

Descriptions of each of these three data collection methods used in the CHA, along with the timeframe they were completed within, are as follows:1) INSCOM CHA Survey, distributed electronically to all INSCOM Soldiers and Civilian personnel from 20 February to 20 March 2018; 2) Focus Groups with key groups of personnel at three installations with significant INSCOM presence. Focus groups were conducted between 21 February and 19 March 2018 at Fort Belvoir, Virginia; Fort Gordon, Georgia; and Fort

Meade, Maryland; and 3) Secondary data compilation from existing DOD databases. Initial data requests were made in December 2017 and all data were received by April 2018.

A combination of the three data collection methods was used to answer each of the five guiding questions. The DOD and the Department of the Army keep records of health information and resource access in various databases available upon request. For example, the Medical Operational Data System (MODS) contains Medical Readiness Classification for Active Duty Soldiers. The number of musculoskeletal injuries in the past 12 months exists in a number of databases including the Defense Medical Surveillance System (DMSS).

The assessment team created the survey to gather additional data that may not be available from secondary sources. Like all Federal agencies, the APHC is only authorized to collect certain data from Civilian personnel without additional approvals; therefore, the team developed and administered two versions of the survey: one for Soldiers (Active Duty and Activated Reservists) and one for Civilians. The Civilian survey was a shorter version of the Soldier survey and included only those survey items that were specific to work experiences at INSCOM.

The assessment team organized both surveys according to a series of domains, where each domain included items – and in some cases entire scales – from validated measures. The Soldier survey contained 138 items, and was organized according to all 10 domains. The Civilian survey contained 74 items and was organized according to 8 of the 10 domains (i.e., Physical Training and Health Status domains were not included). Both surveys included a short answer open-ended response item at the end of each domain section to provide participants the opportunity to explain their responses as needed or desired.

Survey participation was voluntary for both surveys and participants could opt out of the survey after completing the two initial survey questions (i.e., identifying their unit and/or indicating whether they accept or decline to participate in the survey). Furthermore, survey items were optional so that participants could skip questions they were not comfortable answering, and skip logics were included where appropriate to minimize survey burden.

Focus group

Guided focus group discussions addressed all CHA guiding questions. The assessment team conducted 15 focus groups between 21 February and 19 March 2018, at the three above noted locations. These three installations contain nearly half of INSCOM's major subordinate commands and provide a diversity of people, organizations, career fields, and missions. Points of contact at each of the locations were asked to identify participants that met the criteria and who were willing to participate (i.e., voluntary participation). Overall, 60 Soldiers and Civilians participated in the focus group discussions.

The assessment team used a semi-structured focus group guide to facilitate each discussion with the goal of understanding current INSCOM health and quality of life needs from participants' perspectives. Observers were not permitted in the focus groups, thus protecting participants from the influence of higher levels of leadership.

The methods of data collection were designed to address data from different perspectives. Data from the survey and secondary sources allow for reporting of discrete, specific information in a quantifiable format. For example, the assessment team can report percentages of Soldiers and Civilians with anxiety symptoms. In the survey, participants were invited to type in additional information to provide context to their responses, but this field was optional. Data from focus groups, on the other hand, were much less quantifiable but assessed overall perspectives, experiences, and opinions of personnel. For example, across focus groups, the assessment team may be able to report on common factors that may relate to anxiety. The different orientation of the data sources is important in creating a holistic picture of the INSCOM Soldier and Civilian personnel experiences.

The assessment team combined the data from the secondary, survey, and focus group sources to provide comprehensive answers to the guiding questions. For each guiding question, the team analyzed data from each source by the prioritized domains and then integrated relevant information to provide answers within each question. The team began with descriptive analysis (e.g., frequencies, means) of secondary and survey data for each guiding question and, where available, supplemented this quantitative information with context from the survey and focus groups. Where quantitative data were unavailable, the assessment team answered the guiding questions using qualitative data from both the survey and focus groups.

Results

Overall, 28.1% of INSCOM Soldiers and Civilians (N = 3,663) completed the INSCOM CHA Survey. The gender ratio, age distribution, and rank/grade proportions of Soldier and Civilian survey participants, respectively, were highly aligned with the data from the demographic breakdown of personnel provided by INSCOM. The alignment between these demographics, and the fairly consistent survey response rate across units, support the generalizability of the survey results across INSCOM.

The INSCOM Soldier and Civilian health status indicators revealed several positive health attributes (e.g., low rate of chronic conditions, positive ratings of resilience), and Soldiers and Civilians reported multiple assets and resources available to them to support health and quality of life (e.g., medical/dental services, chaplain services, fitness facilities). Additionally, Soldiers and Civilians reported both positive perceptions (e.g., their immediate supervisor is fair and reliable) and negative perceptions (e.g., difficulty in de-conflicting priorities) of the work environment and quality of work life. Collectively, Soldiers and Civilians provided specific recommendations that INSCOM should consider as it works to address key health and quality of life issues.

In regard to behavioral health, data from Patient Health Questionnaire (PHA) screenings indicated that one in three Soldiers were experiencing moderate to severe symptoms of depression, one in five Soldiers and Civilians indicated symptoms of mild or moderate anxiety and over half of Soldiers were experiencing moderate to severe symptoms associated with PTSD. Data from INSCOM's serious incident reports (SIR's) that include suicides from Soldiers and Civilians annually, indicated rates of deaths from suicides increasing from 2 in 2010 to 7 in 2019 and present-day rate of 5 this year (Figure 1).

Survey and focus group results on the health and quality of life in the environment suggests organizational environment factors that negatively impact their health due to their workspaces such as backaches, eye issues, and headaches. Soldiers and Civilians also reported health impacts attributable to the organizational environment to include, but not limited to mental fatigue/exhaustion, depression, isolation, chronic stress, sleep deprivation, and lack of physical fitness.

Approximately one in five INSCOM Soldier and Civilian participants reported that their current OPTEMPO makes it more difficult to perform their duties. Burnout was commonly discussed as were concerns with shift work, a lack of work/life balance, and limited opportunities during the workday to mentally reset or step away from their workspace. Additional barriers to meeting mission included ever-changing priorities, communication challenges, pulled from MOS-related work to perform other duties and lack of Soldiering skills.

Based on their findings, the APHC identified five primary recommendation categories with a total of 21 specific recommendations, in order of importance and urgency, based on the CHA results. The specific recommendations are presented in Table 1 within each primary category and demonstrate the comprehensiveness of data collected to assess and improve the health and readiness of the command and that would mitigate risk factors for suicide.

Discussion

The APHC survey demonstrated the complexity of the command and the various challenges faced by Soldiers and civilians engaged in and supporting various intelligence and security operations. Issues of stigma and clearances and the need to focus on behavioral health has prompted the Command to integrate a wellness model to make focusing on mental health as easily accepted as focusing on physical health. To further explore factors affecting force health and readiness, the command established an INSCOM Health Assessment and Readiness Team (I-HART) to visit units, conduct focus groups and interviews, and to further define ways in which stresses can be address and access to care increased. To guide efforts in a datacentric way, the Deputy Undersecretary of the Army provided support to address suicide within INSCOM by approving four highly qualified experts (HQE's) in behavioral health and clinical suicidology to provide research oversight and make recommendations. Efforts to enhance health and readiness to be effective need to be ongoing. The HQE's will help guide the development of programs and research to further assess behavioral health issues and interventions and to address the issue of suicide. Part of the effort of the Command and the HQEs will be to evaluate ways in which technology can assist with behavioral health and provide tools to help individuals mange stress, sleep, and make use of crisis response plans during periods of increased suicidal risk. To facilitate access to behavioral health care, the Commanding General approved 8 behavioral providers, some of whom will be embedded at specific locations and others available through telehealth and who will focus on implementing wellness checks.

There were some limitations to the APHC effort. The variety of data sources used in this assessment each carry their own set of limitations. Across sources, the sensitive nature of some positions within INSCOM may have limited responses to the CHA. Personnel may have resisted answering questions of a sensitive nature in the secondary sources. Similarly, participants in the survey and focus group data collection may have been hesitant to discuss how their work affects them or any concerns they may perceive as negatively affecting their position. The assessment team tried to ensure that participants were aware their individual responses were confidential and data would only be reported in aggregate. Although provided this assurance; some participants expressed concern that their responses would become identifiable from the amount and nature of demographics collected. Data from any demographic subcategories with fewer than 40 individuals were not reported.

Table 1. APHC identified five primary recommendation categories with a total of 21 recommendations.

(I)	**Clearly Communicate Policies and Support Behavioral Health**
(a)	INSCOM HQ and unit leadership should write, distribute, and execute clear and consistent policies about how seeking behavioral health support could impact careers and ensure consistent interpretation and application of these policies.
(a)	INSCOM HQ and unit leadership should ensure personnel have an accurate understanding of what they can and cannot disclose to behavioral health providers. In many cases, providers can provide effective diagnosis and treatment without personnel revealing classified information. In other cases, HQ and unit leadership may want to consider embedding licensed therapists with the appropriate clearance into units for behavioral health prevention and support. Similarly, leadership should also encourage personnel to identify other teammates who have the appropriate clearance with whom they can confide in when needed.
(a)	Unit leaders and their subordinates should explicitly encourage personnel to reach out for help and advice when they need it. Many Soldiers and Civilians report having a support network to turn to; reminders of support networks are important for behavioral health concerns and should be consistent in their messaging and regular in frequency.
(II)	**Foster a Culture of Respect and Support**
(a)	INSCOM HQ and unit and installation leadership should take decisive action and work with discrimination and sexual harassment SMEs to address these behaviors effectively at INSCOM worksites.
(a)	INSCOM HQ should review the experiences of INSCOM personnel with parental leave and associated policies for Soldiers and Civilians. INSCOM HQ should encourage unit leadership to support new parents in their use of leave and transition back to the work environment.
(a)	Unit leaders should work with personnel to identify and execute regular unit-specific activities, inclusive of all personnel (i.e., Soldiers, Civilians, and Contractors), aimed at improving camaraderie and morale. This may include activities such as lunch outings, organizational days, potlucks, or unit-specific PT. These were discussed as benefits for many, but not all, INSCOM units.
(a)	INSCOM HQ and unit leadership should directly inform Soldiers of on-post resources/services and through their own channels than relying on outreach from the garrison or services themselves. Findings suggested that many personnel do not directly engage with on-post resources and information may not reach them through garrison channels.
(III)	**Ensure Optimal Workflow and Mission Execution**
(a)	Unit leaders should work with subordinates carefully considering workflow in terms of OPTEMPO, job duties/roles, and mandatory training to distribute work as appropriately and evenly as possible; thus, avoiding burnout of particular personnel.
(a)	INSCOM HQ and individual units should encourage communication between different chains of command (e.g., OPCON and ADCON) to de-conflict competing priorities or redundant tasks and ensure personnel at lower levels are focused on the most critical mission actions.
(a)	INSCOM HQ and unit leaders should identify and address major barriers to ensure optimal manning of positions. These include filling open positions as soon as possible and identifying ways to expedite the security clearance process to address delays in personnel performing their duties. One solution may be to identify alternative processes for personnel who already have the appropriate clearance and are moving to a new duty station. Delays in processing new or transitioning personnel are considered a key factor in causing insufficient manning and staff burnout.
(a)	Unit Commanders and leaders should coordinate shift-work schedules to allow these personnel to access required and needed services and, if necessary, allow for adequate time for other personal needs during their duty hours. Additionally, INSCOM HQ should work with garrisons, MTFs, and/or installation Community Health Promotion Councils (CHPC)/Commander's Ready and Resilient Councils (CR2C) to identify potential on-post policies or activities that will help address the needs of shift workers during their varying duty hours or non-duty days.
(a)	INSCOM unit leadership should provide and/or encourage staff training, as it is critical to mission success and job satisfaction. This may include training to keep up with the intelligence community outside the military that is MOS-specific, or other training for Soldiers such as preparing for their next assignment.
(IV)	**Change Work Environment to Improve Health of Personnel**
(a)	INSCOM HQ, unit leadership, and installation leadership should allocate fitness space (e.g., for push-ups or sit-ups) and/or equipment near INSCOM personnel workspaces to encourage physical activity during the workday. This space may serve to mitigate the impact of the largely sedentary nature of most personnel's work and allow personnel to seek the benefits of exercise (e.g., stress reduction, mood enhancement).
(a)	Unit and garrison leadership should engage installation and other occupational health, industrial hygiene, and public works personnel to address concerns or perceptions of unsafe and unhealthy work environments such as mold problems, HVAC issues, and pest infestations as immediately and effectively as possible.
(a)	INSCOM HQ, unit leadership, and installation programs and resources, including the CHPC/CR2C, should identify ways to increase the availability of healthy eating options for personnel. Methods could include collaborating with Army and Air Force Exchange Service (AAFES) and Morale, Welfare, and Recreation (MWR) to identify points of change or providing common areas with seating and kitchenettes to encourage bringing prepared food from home. It will be especially important to consider the options available for personnel doing shift work and who may need access to the DFAC or other on-post dining options during nonstandard business hours.
(a)	INSCOM HQ and/or individual unit leadership, in collaboration with the CHPCs/CR2Cs and other installation resources, should determine root causes of alcohol use and binge drinking, and develop and execute multi-pronged solutions to address concerns.
(a)	INSCOM HQ and/or individual unit leadership should develop and disseminate clear guidance on both Soldier PT and Civilian Fitness Program rules and/or regulations to eliminate unnecessary variation and confusion.
(a)	INSCOM HQ and/or individual unit leadership should help Soldiers explore healthcare access options, with the understanding that installation MTFs may not be the primary option at all locations where INSCOM units are located.
(V)	**Design Workspaces to Promote Well-Being**
(a)	Unit and garrison leadership should investigate and implement ergonomic solutions, such as sit-to-stand workspaces and glare shields, to mitigate effects of personnel who spend the majority of their duty day at a computer. Focus group participants made this recommendation and is supportive of the assessment team's conclusions.
(a)	Unit and garrison leadership should collaborate to effectively address challenges of open-office environments including providing adequate meeting spaces for private meetings or for staff to take "mental breaks" as needed. When planning new workspaces, leadership should fully explore possibilities of eliminating open office environments or specifically planning to mitigate disadvantages of this workspace design.
(a)	Unit and garrison leadership should design new or renovated workspaces when applicable, and provide options for existing workspaces, to allow access to natural light and sunlight, including secure buildings. INSCOM HQ may be able to assist in identifying potential options by working with other military and nonmilitary intelligence organizations.

APHC recommendations are in order of importance/urgency, based on the CHA results.

Participants may also have felt that they were pressured or "voluntold" to participate in the survey and focus group data collection. The assessment team described the importance and intended use of the data to all participants. Participants had the option to opt out of the survey, and to decline participation in focus groups after reporting to the focus group location and hearing the overview. Finally, INSCOM personnel may have needs that are unique to their mission set; therefore, the results from this CHA will not be generalizable across all Army or military. While the final sample seemed representative, sampling bias remains a possibility.

Acknowledging these limitations and understanding that the improvement process is ongoing, INSCOM's culture is shifting from a reactive mentality toward building positive, preventive, proactive, long-term resilience, with an emphasis on the pursuit of mental fitness. The Command is adopting a generational mind-set within the intelligence enterprise that seeks to maximize adaptation and readiness in order to dominate adversaries while thriving in a volatile, complex, uncertain and ambiguous multi-domain battlespace. Upon obtaining results from the APHC CHA, a Force Health Improvement Plan was developed (CDC. (2015a, 2015b). Additionally, operational and clinical outcomes will be measured over the next three years. We are also developing plans for a Center for Military Intelligence Research (CMIR) and to identify technology driven tools to improve mental well-being and decrease the incidence of suicide.

Data availability statement

Due to legal restrictions and the sensitive nature which could result in adverse impact to United States Army and Civilian personnel and possible insurability and employability impacts, data cannot be made publicly available. Our organization requires establishment of data sharing agreements with institutions or investigators requesting the data collected from human volunteers. For questions about data, contact the Intelligence and Security Command Office of the Command Surgeon at thomas.a.vandillen2.civ@mail.mil.

Disclosure statement

Dr. Jobes discloses the following potential conflicts: Grant support for clinical trial research from the American Foundation for Suicide Prevention and the National Institute of Mental Health: book royalties from American Psychological Association Press and Guilford Press; Founder and Partner of CAMS-care, LLC (a clinical training/consulting company). There is no other known conflict of interest to disclose.

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