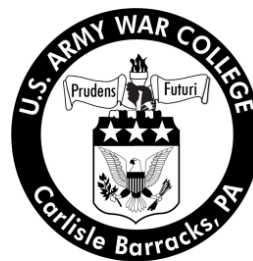


Preventing Suicide: A Mission Too Big to Fail

by

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United States Army War College
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USAWC STRATEGY RESEARCH PROJECT

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Abstract

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Suicides in the U.S. military are at record highs. Senior leaders have taken a number of important steps to stem the rise in suicides, but they acknowledge it is a complex problem that requires a comprehensive approach. This Strategy Research Project provides a brief overview and history of the various studies that have been aimed at suicide prevention, details the U.S. Army War College's (USAWC) suicide prevention exercise and findings related to policy and prevention efforts, reviews additional research aimed at prevention, and explores recommendations on moving forward to create a comprehensive prevention strategy. USAWC students identified gaps in policies and programs, as well as an overall lack of national understanding of the root causes of suicide. The authors of this paper recommend that DoD adopt a strategic approach which focuses suicide prevention across four major Lines of Effort (LOEs): leadership, resiliency, belongingness, and policy.

Preventing Suicide: A Mission Too Big to Fail

Suicide is preventable and its prevention is a shared responsibility among all members of the Army family.¹

—GEN David M. Rodriguez
U.S. Army Forces Command Commander

Since the beginning of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), the Army has experienced a dramatic increase in the number of suicides and suicidal ideations among service members.² Since 2001, suicide in the military has been on the rise.³⁴ According to a June 2012 Medical Surveillance Monthly Report (MSMR), "suicide has been the second leading cause of death among U.S. service members" since 2010.⁵ Prior to 2004, civilian suicide rates outpaced Army suicide rates. From 2004 through the present, Army suicide rates have exceeded those of their civilian counterparts of the same age group.⁶ Additionally, the number of Army suicides through the first six months of 2012 outpaced the number of service members killed in combat by nearly 50 percent or more.⁷ In July 2012, "Soldiers killed themselves at a rate faster than one per day."⁸ And the most recent veteran data from 2010 indicated that between 21-22 veterans were dying by suicide each day.⁹

The authors of this paper believe that the Army is approaching the issue of suicide as they would any typical "enemy": with overwhelming force using a shock and awe campaign. The Army has taken several steps to reduce suicides, but when confronted with growing numbers in 2009, it felt pressured to create visible programs aimed at what were perceived as the correct target areas. As a result of that pressure, the Army created the *Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention (ACPHP)* that same year in an effort to quickly identify and gain

visibility on the processes, policies, and procedures that assessed the underlying issues that lead to suicide.¹⁰ In order to better understand the root causes, the Army also launched the largest research program of its kind in 2009 to focus on suicide risk—the Study to Assess Risk and Resilience in Servicemembers (STARRS). The study was a collaborative effort in conjunction with the National Institute of Mental Health to “address the Army’s concern about the rising suicide rate among soldiers.”¹¹ During that same time, the Congress, through the National Defense Authorization Act of 2009, directed the Department of Defense (DoD) to establish a Task Force to focus on Department-wide suicide prevention efforts.¹² The group published a report in August 2010 and addressed suicide prevention efforts across DoD.¹³ Several other groups have also published reports on suicide.¹⁴

The increasing loss of Soldiers to suicide has rightfully been the focus of Army senior leaders. The Vice Chief of Staff of the Army (VCSA) chairs regular Suicide Senior Review Group (SSRG) meetings to discuss recent suicides by command. Commanders discuss the actions they took in response to suicides under their respective command and assess how their actions will further reduce suicides. While these actions may lead to new programs designed to reduce the risk of future suicides, the impetus for the actions is based on the suicide(s) that have already occurred. In other words, we may need to consider whether and how these programs will allow the Army to be *proactive* rather than reactive. Although suicides do share some common risk factors, each suicide is unique. There could be a sense that the programs reviewed at the SSRG are reactions to what has happened, but do not change nor address the fundamental nature of why Soldiers are killing themselves at record rates. In addition, due to the lack of a

standardized, comprehensive program and sharing amongst the Services, home-grown, service (and at times, installation-specific) programs have sprouted up as leaders struggle to find solutions.

Another way the Army focused importance on reducing the number of suicides is through an Army-wide Stand Down on 27 September 2012. The intent was “to preserve the strength of our Army, prevent further loss of life, enhance awareness of resources available to Soldiers, [Department of] Army Civilians (DACs), and Family Members (FMs), improve the health and discipline of the Force, reduce stigma, and increase resilience.”¹⁵ To help achieve the intent of the Army-wide Stand Down, the U.S. Army War College (USAWC) created a Suicide Prevention Experiential Education Exercise (SPE³). During the SPE³, students examined current Army policies and other research as it related to suicide. As a result of this College-wide effort and the subsequent research reviewed in this paper, three themes are clear. First, academic research into the causes, triggers, and protective factors related to suicide needs to continue.¹⁶ Second, programs designed to help stop suicide need to focus on *prevention*, not treatment. Third, although the Army has expended tremendous effort, the host of suicide prevention programs currently in existence may not necessarily complement one another, contain relevant performance metrics, nor work in conjunction with the other Services. There is still much to be done to help stem the tide.

This paper provides a brief overview and history of the various studies that focused on suicide prevention, details the USAWC’s SPE³ exercise and findings related to policy and prevention efforts, discusses additional research aimed at prevention, and

explores recommendations on moving forward to create a comprehensive suicide prevention strategy.

Literature and Program Review

DoD Task Force on the Prevention of Suicide by Members of the Armed Forces

Due to the global nature of suicide, several organizations have conducted studies to determine causal factors and prevention methods. The National Defense Authorization Act of 2009 directed the DoD to create a Task Force to focus on suicide prevention efforts. The DoD established the *Task Force on the Prevention of Suicide by Members of the Armed Forces* (hereafter referred to as the DoD TF), which published a 2010 report that kicked off additional internal DoD research designed to further investigate suicide prevention.¹⁷ The DoD TF made recommendations in five focus areas: foundational principles, organization and leadership, wellness enhancement and training, access to and delivery of quality care, and surveillance investigations and research. The core recommendations were derived from the full list of specific recommendations. They reflect critical components of suicide prevention such as creating an oversight office, holding leaders accountable, reducing stress on the force, focusing on total fitness, reducing the stigma of seeking help, strengthening strategic messaging, developing skills-based training, incorporating program evaluations, continuing quality healthcare, expanding tracking mechanisms, standardizing investigation protocols, and funding additional research programs.

The Army Red Book

Also in 2010, the Army published its *Health Promotion, Risk Reduction, and Suicide Prevention Report*, also known as the *Army Red Book*.¹⁸ This report was a compilation of the findings of the *Army Suicide Prevention Task Force* and included the

Army's campaign plan, all of which was aimed at reducing suicide. This publication claimed that some of the most important individuals in preventing adverse outcomes were vigilant and engaged commanders and supervisors. The *Army Red Book* suggested that leaders are the most capable at providing accurate observations of high-risk service members.¹⁹ The publication also included topics that focus on the reality of suicide, the lost art of leadership in the garrison, the composite life-cycle, the Army suicide prevention campaign, program governance, investigations and reporting, information-sharing and retrieval, and research. The report also identified several risk factors, including high-risk behaviors such as illicit drug use and criminal activity, medical information such as a mental health diagnosis or physical injury, and stressful life events such as relationship or financial issues or work stress.²⁰ The *Army Red Book* served as the foundational basis for subsequent Army reports on suicide, such as the *Army Gold Book* which is discussed in later paragraphs.

The War Within: Preventing Suicide in the U.S. Military

In 2011, the Office of the Secretary of Defense (OSD) sponsored the research corporation RAND to study suicide and provide a comprehensive report on suicide in the U.S. military.²¹ DoD charged RAND to review current epidemiological evidence, identify best practices, evaluate suicide prevention programs across DoD and make recommendations to ensure that DoD coordinated and resourced activities appropriately. The RAND study identified that individuals in the following categories are most at risk of dying by suicide: those with prior suicide attempts, presence of a mental health or substance abuse disorder, evidence of head trauma or a traumatic brain injury (TBI), history of hopelessness, aggression and impulsivity or problem-solving deficits, triggering life events, access to a firearm, and media coverage/community exposure to

suicide. RAND also evaluated existing suicide prevention programs in the military, but had difficulty identifying best practices because only a handful of programs were based on empirical evidence targeting causation for suicide, and overall there was not much data supporting effectiveness.²²

Based on their research, RAND recommended that all suicide prevention programs should incorporate the following best practices:

1. Raise awareness and promote self-care. This category includes focusing on prevention efforts targeted at risk factors such as substance or mental health disorders.
2. Identify those at high risk. This recommendation includes targeted outreach efforts, including screening for mental health problems.
3. Facilitate access to quality care. This area covers reducing barriers to health care and integrating programs for a comprehensive approach.
4. Provide quality care, which means keeping the standard of care at a high level.
5. Restrict access to lethal means, which should include programs targeted toward high-risk individuals.
6. Respond appropriately. This includes creating a comprehensive strategy and communications plan.²³

RAND also made fourteen specific recommendations²⁴ to all branches of the military on how to improve their current programs and create a comprehensive approach moving forward.²⁵ RAND's recommendations are important, but mostly address effective programs for treatment rather than prevention.

The Army Gold Book

In January 2012, the Army released its *Army 2020: Generating Health and Discipline in the Force Ahead of the Strategic Reset* report, referred to as the *Army Gold Book*, which included a section on suicide as a subset of the section Challenges Facing Army Leaders and Healthcare Providers.²⁶ The Army considers the *Army Gold Book* as

an update and expansion of the *Army Red Book*.²⁷ The *Army Gold Book* is intended for use as a resource for military and civilian leaders within DoD, health care providers, and researchers to focus their efforts in the coming years. Overall, the *Army Gold Book* addressed current challenges, discussed lessons learned, and identified remaining gaps in Army policies and programs. The report also addressed seven specific areas, including a discussion of suicide as a national issue, suicide among military veterans, the impact of suicide on the Army, suicide as compared between branches of Service, risk factors, current policies and programs, and protected health information. The *Army Gold Book* expanded on the *Army Red Book* by identifying additional risk factors and addressing a larger spectrum of the Army's high-risk population.

Similar to the *Army Red Book*, the *Army Gold Book* identified several risk factors²⁸ pertaining to suicide including: military work stress, relationship problems, legal history, substance abuse, physical health problems, victim of abuse, financial abuse, perpetrator of abuse, spouse/family/friend death, family advocacy program use, spouse/family/friend suicide, and family health problems.²⁹ The report also listed several triggers, which are described as the “last straw” events that may cause someone already feeling a significant amount of stress to feel overwhelmed to the point that they attempt suicide. Finally, the research team noted that a high number of individuals were under the influence of a substance (e.g., alcohol and/or drugs, legal or otherwise) at the time of their death.³⁰

USAWC Suicide Stand Down

SPE³

As a result of the studies mentioned above and the Suicide Prevention Stand Down, the USAWC created the SPE³ as an opportunity for students to engage in a

meaningful and relevant effort to both raise their awareness concerning suicide and challenge them to leverage their critical thinking skills learned in the first core course of the academic year to solve a wicked problem.³¹ The USAWC designed the SPE³ to “challenge students to carefully assess current Army suicide prevention policies, approaches, and strategies” in order to make recommendations for a comprehensive solution.³² The exercise consisted of three parts: individual research and learning, small group discussion, and a back-brief of the results and recommendations to the VCSA, General Lloyd Austin, via video teleconference.

SPE³ Findings

During the individual research and learning phase, students read several core documents, such as the *Army Gold Book*, Congressional testimony, the *Army Red Book*, and RAND’s 2011 report on suicide prevention. Next, students focused on researching six core areas: leadership, policy, resiliency and team-building, stigma, research, and societal trends. Following individual research, over 386 USAWC students discussed the six core areas in the context of 24 different “seminar groups.” Each seminar group was composed of 14-16 students representing Active Component (AC) and Reserve Component (RC) service members, interagency and intergovernmental partners, and international fellows.³³ The seminar groups compiled a list of recommendations based on their small group discussions. The students then briefed some of the more prevalent recommendations to the VCSA. Students identified gaps in policies and programs, as well as an overall lack of national understanding of the root causes of suicide.³⁴ Appendix A of this paper provides a full listing of the problems identified by the USAWC students and their recommendations. Overall, the recommendations naturally fell into several major categories. The authors of this paper

focused the recommendations into the following four major Lines of Effort (LOEs) and decisive points in Figure 1 below: leadership, resiliency, belongingness, and policy.

These LOEs are discussed in further detail in later sections of this paper.

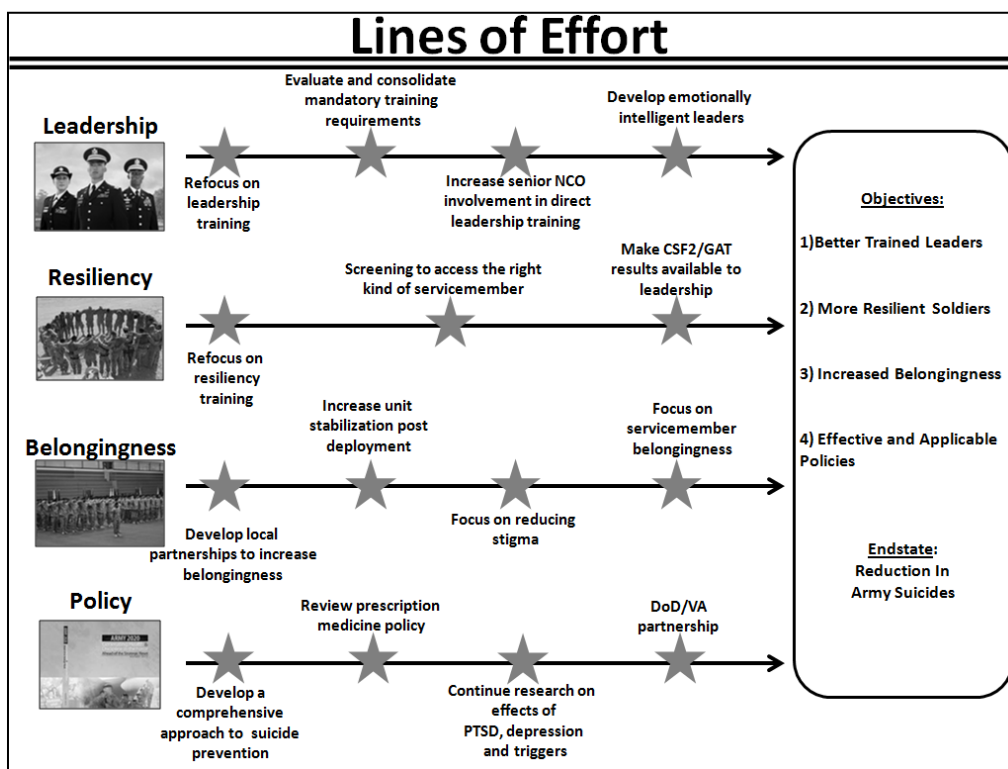


Figure 1. Lines of Effort and Decisive Points for the SPE³
Suicide Rates in the Army

Active and Reserve Component Soldiers

Although the Army has developed countless programs aimed at reducing suicide, the number of Soldiers and DACs who commit suicide has steadily increased since the beginning of OEF and OIF. According to Army data, 2,284 Soldiers, DACs, and FMs committed suicide between 2001 and 30 January 2013.³⁵ The recent and consistent rise in suicide has appropriately and understandably captured the attention of national military and civilian leaders around the world.³⁶

Despite aggressive policy reviews, dramatic increases in resources to address the problem, and increased awareness of everyone to make a difference, service members and civilians are engaging in suicide and suicidal ideation in unprecedented numbers. No single organization knows this better than the Army. In a November 2012 *USA Today* article, "Army, Navy Suicides Continue At Record High, more than one/day," the author stated that "suicides among active-duty forces across the military reached 323."³⁷ The official Army record as captured in figures 2 and 3 below break down the numbers of active duty suicides and the number of suicides among Soldiers not on active duty (NAD) from calendar year (CY) 2003 to CY 2013. Both policymakers and military leaders agree: these numbers are unacceptable. And to compound the problem, these numbers only address a portion of the problem.

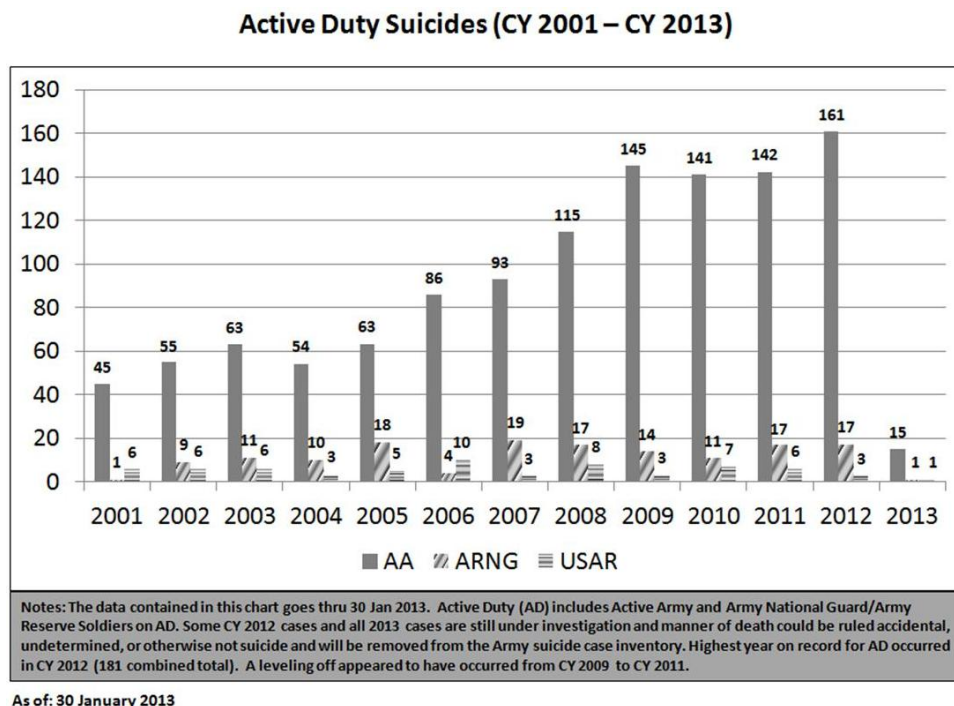


Figure 2. Active Duty Suicides from CY 2001 to CY 2013

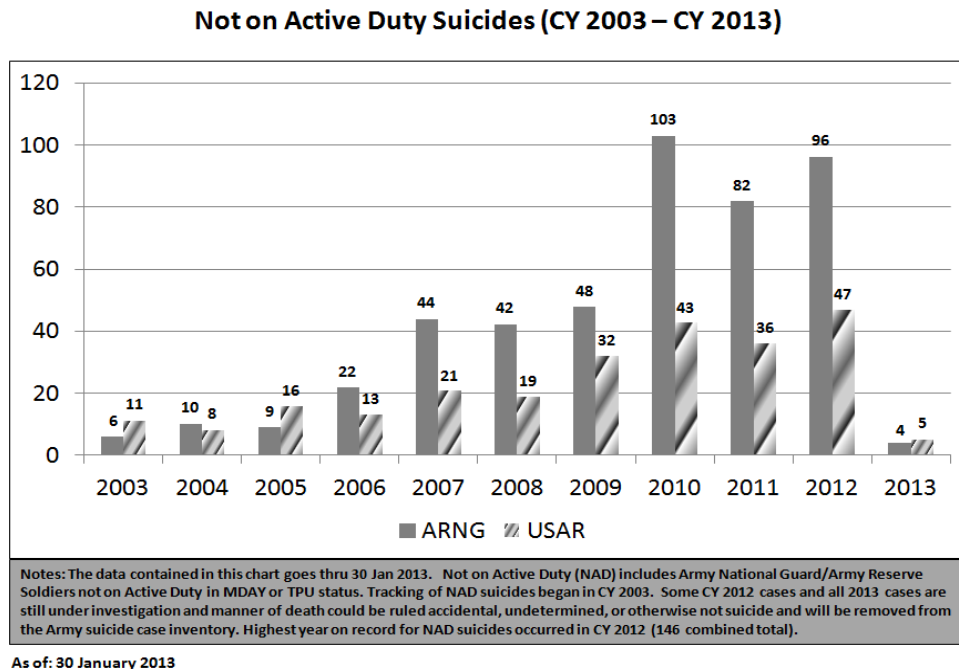
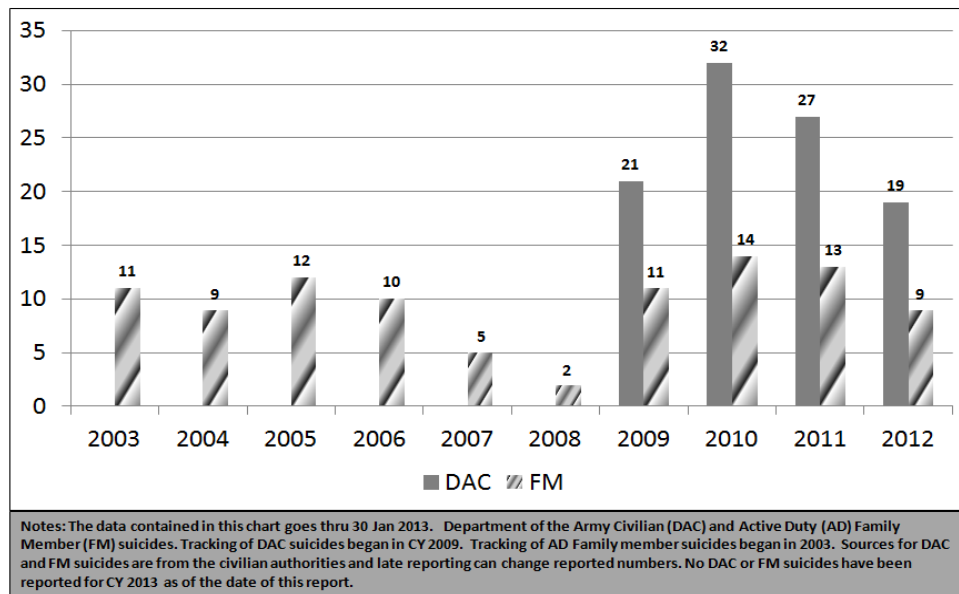


Figure 3. Soldiers Not on Active Duty Suicides from CY 2003 to CY 2013

Department of the Army Civilian and Family Member Suicides

The *USA Today* article mentioned above did not articulate the suicide rates among DACs and FMs.³⁸ While most media outlets that track Army events correctly highlight Soldiers' suicides, they often may forget about the growing trend of suicide in the broader military community - one that affects civilians and FMs. Figure 4 below captures the most current suicide data on DACs and FMs from CY 2003 to CY 2013.³⁹ If the Army wants to be "One Team" in "One Fight," then it cannot neglect DACs and FMs in their suicide prevention programs.

DA Civilians and AD Family Member Suicides (CY 2003 – CY 2013)



As of: 30 January 2013

Figure 4. DAC and FM Suicides from CY 2003 to CY 2013

The drastic increase in the total number of suicides has caused the Army to commit enormous amounts of time and resources into suicide prevention. The increase in suicide coincides with the growing trend in society but also reinforces the fact that the Army must ensure it addresses suicide *holistically*, for the entire Army profession (military and civilians) and their FMs.

Risk Factors Associated With Suicide

Age and Gender

There are differences in gender and age regarding suicide statistics. Table 1 below depicts demographic characteristics for AC and RC service members from 1998 to 2011.⁴⁰ The June 2012 issue of MSMR indicated that “most service members who die by suicide are males (95%), active component members (89%), of white, non-Hispanic race/ethnicity (70%), and [individuals 20 to 29].”⁴¹ Additionally, the Centers for Disease Control and Prevention (CDC) reported the ratio of females to males committing suicide

is 1 for every 3.75 males.⁴² The preferred methods of suicide for males are firearms, hanging, and poisoning,⁴³ whereas the use of firearms among female service members is higher than for civilian females.⁴⁴ Compounding the problem, service member demographics are heavily weighted toward younger males (military and civilian), who have the highest rate of suicide overall.

Table 1. Demographic Characteristics of Active Duty Military Members Who Died by Suicide, Active and Reserve Components, U.S. Armed Forces, 1998-2011⁴⁵

	Active and Reserve Components	Active Component		
	No.	No.	Rate ^a	Rate ratio
Total	2,990	2,652	13.7	-
Sex				
Male	2,848	2,536	15.3	ref
Female	142	116	4.1	0.27
Race/ethnicity				
White, non-Hispanic	2,098	1,861	15.3	ref
Black, non-Hispanic	364	328	9.5	0.62
Other	528	463	12.5	0.82
Age				
<20	234	222	12	0.77
20-24	1,070	1,012	15.7	ref
25-29	660	610	15.1	0.96
30-34	355	313	11.1	0.7
35-39	369	294	12.1	0.77
40+	302	201	11.5	0.73
Marital status				
Single, never married	1,347	1,219	15.2	ref
Married	1,472	1,288	12.2	0.8
Divorced/separated/widowed	171	145	18.9	1.24

^aRate per 100,000 p-yrs; rate for active component only

Potential Suicide Triggers

Although not an underlying cause, “triggers” are external factors that may cause service members to feel overwhelmed, which may lead to suicide. As noted earlier, triggers are considered “last straw” events because they are often associated with, or believed to have “caused,” someone already feeling a significant amount of stress to feel even more overwhelmed to the point that they attempt suicide. The *Army Gold Book* identified the following three triggers strongly associated with military suicide: failed relationships, legal/disciplinary issues, and financial problems.⁴⁶ The Army’s SSRG meetings also identified these same triggers. According to the *Army Gold Book*,

“failed relationships were associated with 49% of suicides and 60% of suicide attempts...[legal issues] with 44% of suicides and 43% of the suicide attempts...[and financial problems] with 12% of suicide and suicide attempts.”⁴⁷

Combat Deployment

It may appear that the steady rise of suicide in the military since 2001 has increased as deployments in support of Overseas Contingency Operations (OCO) has increased. Are the increased incidences of suicide in the military directly related to an increase in combat deployments? Are the stressors associated with deployment and combat experience the reason for the increased incidences? There is not sufficient evidence to support this theory. According to the *DoD Suicide Event Report (DoDSER) 2011*, 53% of reported suicides in 2011 were by service members who had not deployed.⁴⁸ Additionally, more than 84% of those service members who had deployed did not experience direct combat.⁴⁹ The data suggests that while combat-related stressors may contribute to suicide, the causes of suicide are more complicated and not as directly related to combat as first anticipated. In his June 2012 address to the DoD/Department of Veterans Affairs (VA) Suicide Prevention Conference, Secretary of Defense (SECDEF) Leon Panetta stated:

More than half of those who have committed suicide in the military have no history of deployment...we’re dealing with broader societal issues. Substance abuse, financial distress and relationship problems — the risk factors for suicide — also reflect problems ... that will endure beyond war.⁵⁰

This quote highlights that while combat experience may be a contributing factor in suicide, DoD needs a wider approach to solve the problem. Any comprehensive approach should consider the entire spectrum of causation, prevention, and treatment.

Post-traumatic Stress Disorder (PTSD)

The RAND study on invisible wounds stated that “although not as strongly associated with suicide as depression, PTSD *is* more strongly associated with suicide ideation and attempts than any other anxiety disorder.”⁵¹ The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR),⁵² which is the guide used by mental health professionals to determine diagnoses in order to provide the correct treatment, stipulated that individuals must meet the following criteria for a proper diagnosis of PTSD: 1) “[An individual] is exposed to a traumatic event; 2) the traumatic event is persistently re-experienced; 3) [an individual persistently avoids stimuli] associated with the trauma and [experiences] numbing of general responsiveness and 4) the individual experiences hyperarousal.”⁵³ Additionally, “these symptoms must persist for at least 30 days” and impair the functioning of the individual to some degree in order to reach the threshold for a clinical disorder.”⁵⁴

Approximately 20 percent of the service members returning from OEF and OIF reportedly experience symptoms of PTSD.⁵⁵ These symptoms can be long-lasting and cause significant impairment in social, occupational and other areas. There is increasing concern about the effects of PTSD since as noted above, PTSD is associated with suicidal ideation and therefore may increase the risk for suicide. Although PTSD symptoms are attributed to five percent of service members’ suicides, there is still a lot to learn about the connection between PTSD and suicide.⁵⁶ Therefore, applicable strategies used to reduce suicide should also examine factors contributing to service members’ susceptibility to PTSD.

Post Traumatic Stress Disorder Predictors

Historically, some people have called this change by many names: shell shock, battle fatigue, Vietnam Syndrome and most recently, PTSD. Although not identical, they share many similar symptoms and characteristics such as the inability to concentrate, nightmares, flashbacks, sleeplessness, and hopelessness. Often, these symptoms can be referred to as the “invisible wounds” of combat.⁵⁷ While medical professionals are successful at identifying and treating *visible* wounds, they may not be as successful in treating service members if they do not recognize or know that “the wound” exists.⁵⁸

PTSD does not affect every service member deployed to a combat zone or exposed to trauma. In fact, “most of the 1.64 million military service members who have [been] deployed in support of OEF and OIF will return home from war without problems and readjust to civilian life successfully.”⁵⁹ This section of the paper explores studies related to two possible factors that may contribute to an eventual diagnosis of PTSD: 1) Pre-deployment mental health conditions and 2) Exposure to combat.

Pre-deployment Mental Health Conditions

Pre-deployment mental health conditions have been studied by the medical community, including the Millennium Cohort Study.⁶⁰ The Millennium Cohort Study evaluated more than 22,000 service members, and is one of the largest studies performed to examine the potential relationship between pre- and post-deployment mental health conditions in service members.⁶¹ This study revealed “that pre-deployment characteristics indicating baseline psychotic problems, such as psychiatric history, use of psychotropic drugs, and stressful life events, were all significantly associated with post deployment symptoms.”⁶² This study and similar studies suggested that service members deploying with preexisting mental health conditions who are

exposed to intense combat are more susceptible to developing PTSD.^{63,64} Even though the Millennium Cohort Study did not directly assess suicide among these service members, it did correlate PTSD and depression to the reported “increase of dysfunction, health care utilization, and the risk for suicide.”⁶⁵ The Millennium Cohort Study suggested that assessing pre-deployment mental health:

...might be useful to identify a combination of characteristics of deployed military personnel that could predict those most vulnerable or, conversely, those most resilient to post-deployment PTSD, thereby providing an opportunity for the development of pre-deployment interventions that may mitigate post-deployment mental health morbidity.⁶⁶

DoD should consistently use valid screening measures to indentify risk factors prior to deployment. Evidence suggests this has not always been the case. For example, Remington Nevin conducted a study on 15,195 service members and assessed the validity of the Pre-Deployment Health Assessment (PreDHA) questionnaire.⁶⁷ Only 11,179 of those service members surveyed had a record of taking the PreDHA in the Defense Medical Surveillance System (DMSS).⁶⁸ Nevin, using the DMSS data, compared the service members’ comments on the questionnaire with documented mental health issues in their medical records.⁶⁹ Results indicated that “out [of] the 615 subjects with diagnosed mental health disorders, 465 had a [record of taking the] PreDHA. Among these, only 224” sought mental health counselling within the past year.⁷⁰ Service members who did not seek help were more likely to be referred to a health care provider for further evaluation.⁷¹ In addition, Nevin found that 210 service members deployed whose health care provider annotated on their PreDHA that they were “not deployable”.⁷² Based on his results, Nevin concluded that the validity for the PreDHA is low. DoD should pair additional behavioral health screening with the PreDHA to add credibility.⁷³ These findings, along with concerns raised during the SPE³,

identified several problems with the PreDHA process. First, not all service members took the PreDHA. Second, service members deployed despite issues identified in the PreDHA. Additionally, because the PreDHA is based on self-reported data, it is only as accurate as the data entered. The authors of this paper (i.e., USAWC students) suggest that such screening might help to better protect service members during deployment. DoD needs to establish an effective screening process to reliably and validly identify and prevent service members from deploying with mental health conditions that create increased vulnerability for PTSD or risk of suicide.

Exposure to Combat

A second factor which may contribute to PTSD is combat exposure. Combat exposure includes events such as taking another person's life, seeing a person die or losing a body part, and fearing bodily harm or death.⁷⁴ Consequently, researchers are exploring the link between combat exposure and service members with PTSD. Thomas et al. performed a study to examine post-deployment depression and PTSD in 13,226 combat arms Soldiers in the AC and National Guard (NG).⁷⁵ Results indicated that NG Soldiers experienced more symptoms of PTSD than the AC Soldiers following deployment. The study also referenced two Millennium Cohort Studies, which had similar results as the Thomas et al. study.⁷⁶ The Millennium Cohort Studies found that “incidence[s] of posttraumatic stress disorder is two to three times higher among those [service members] exposed to combat.”⁷⁷ Finally, service members exposed to combat are diagnosed with PTSD at a “relatively high” rate in comparison to their civilian counterparts.⁷⁸ In addition, a RAND study estimated 303,000 OEF and OIF service members who were exposed to combat will suffer from PTSD and depression, and if left untreated, those service members are at risk for suicidal ideation.⁷⁹

Depression

In “The Invisible Wounds of War,” RAND suggested that “depression, PTSD, and TBI all increase the risk for suicide.”⁸⁰ Research indicated that in the general population, individuals who have a history of depression are “10 times more likely to report having thought about killing themselves and 11 times more likely to have made a nonfatal suicide attempt.”⁸¹ In the *American Journal of Psychiatry*, researchers suggested that “lifetime risk of suicide in major mood disorders has been estimated at 19%, and the mortality risk from them is comparable to that of many severe medical illnesses.”⁸² Both PTSD and depression are potential risk factors for suicide, and need to be considered in future research.

Life Stress

In addition to PTSD, life stress is believed to be another cause or contributor to service members' suicide and suicidal ideation. Every person experiences transitions in life, whether it is deployment while on active duty, moving away from home for the first time, starting a new job, or experiencing the birth of a child. There is a growing body of research that indicates that transitions can be a trigger event for an act of suicide. Times of transition trigger stress, which in turn can increase vulnerabilities and decrease coping mechanisms.⁸³ The very nature of military service is fraught with transitions. Young service members early in their career, like other young adults in society, generally have fewer life skills to draw on, and therefore may be more susceptible to the stress of transitions. Feelings of hopelessness can turn into a lack of will to live, and in turn, cause suicidal ideation.⁸⁴ Combined with the means to do so, individuals who report feeling hopeless are more at risk for a completed suicidal act.

Unit Level Program Concerns

Troubled by the continued rise in suicide rates and the lack of effective higher-level programs, several units have developed and implemented unit programs to address suicide within their ranks. RAND researchers suggested that there is no way to accurately determine if local programs are effective because many of the organizations that established them do not capture, analyze, or test data.⁸⁵ As a result, there are few ways to tell if units effectively and consistently apply interventions in order to determine with some scientific rigor which programs effectively reduce suicide.

The DoD should identify key metrics for all suicide prevention programs based on the USAWC students' recommended LOEs, develop instruments to collect data on current suicide programs, then develop the means to analyze the data collected to determine program effectiveness.⁸⁶ The metrics for prevention programs may not directly correlate with reductions in the number of suicides, but provide important reductions in the underlying high-risk behaviors and triggers. Once the DoD develops the means to evaluate existing and future programs, it should distribute the evaluation criteria to units to serve as the benchmark for all programs.⁸⁷ DoD should terminate or modify programs that do not meet the standardized criteria, then package select successful programs for widespread implementation.

USAWC Recommended LOEs

As discussed above, USAWC students developed four LOEs aimed at programs focused on proactive prevention of suicide. The LOE "leadership" encompassed several trends, including recommendations that leaders should become more engaged and that DoD should evaluate and consolidate mandatory training requirements. The "resiliency" LOE addressed accessions, Comprehensive Soldier and Family Fitness (CSF2)

standardized implementation and allowing leaders access to some of the CSF2 results. The LOE “belongingness” brings together principles such as unit stabilization, stigma and partnering with local organizations. The “policy” LOE focused on continued research, DoD and VA partnerships and the potential for “medicalizing” the suicide prevention programs and processes.

Leadership

The roles of leaders and their ability to affect the people they lead are critical factors in determining service members' behavior and morale. Army Doctrine Reference Publication (ADRP) 6-22 defined leadership as “...the process of influencing people by providing purpose, direction, and motivation to accomplish the mission and improve the organization.”⁸⁸ Engaged and emotionally intelligent leaders connect with their Soldiers, anticipate their needs, and model attitudes and behavior that enable service members to overcome their mental and emotional issues.⁸⁹ The U.S. Army's Training and Doctrine Command (TRADOC) Pamphlet 600-22, "Leader's Guide for Risk Reduction and Suicide Prevention," directs leaders to "know their Soldiers" and to sustain a climate that encourages them, without prejudice, to seek necessary professional help for issues involving their "psychological, ethical, and spiritual readiness" needs and to "demonstrate care for [their Soldiers]."⁹⁰ Additionally, the Department of the Army Pamphlet (DA Pam) 600-24 directed commanders to reduce stigma through a command climate that encouraged those in the command to seek help.⁹¹

In a September 2012 *USA Today* interview, SECDEF Leon Panetta said that "Leaders ought to be judged by how they lead on this issue."⁹² The DoD must consider poor leadership and unsupportive unit climates as possible enablers to suicide and suicidal ideation. Leaders should devote time to know their service members; otherwise

they might miss signs of distress. In a time when suicide and suicidal ideation in the military are on the rise, it is imperative that the DoD recruit, train, and retain engaged and emotionally intelligent leaders.

Engaged Emotionally Intelligent Leaders

The DoD must address the leaders who are ineffective and fail to know and understand their service members. Two ways to get to know service members and demonstrate care for them are listening actively and building trust. Leaders who listen actively encourage two-way communication and gain a better understanding of their service members and their issues.⁹³ These thoughts are consistent with the SPE³ results to increase direct leader engagement.

In "Primal Leadership: Learning to Lead with Emotional Intelligence," authors Goleman et al. defined emotional intelligence as "how leaders handle themselves and their relationships."⁹⁴ Goleman et al. also described the two emotional intelligence domains and four associated competencies used by socially aware leaders to display empathy that enables them to perceive their service members' emotions and be aware of their perspectives and concerns.⁹⁵ Lindy Ryan expounded on the Goleman et al. definition of emotional intelligence by combining several of the domains and competencies of emotional intelligence (EI) leaders. Ryan stated that "EI is the learned capacity to fully understand oneself and relate well with others while having the ability to motivate, empathize, master verbal and nonverbal communications skills and promote harmony."⁹⁶ Therefore, officers as well as non-commissioned officers (NCOs) should possess EI traits.

Leaders build trust with subordinates by focusing on service members' well-being, by mentoring and coaching, and by promoting a positive unit climate.⁹⁷ Leaders

also demonstrate care by enduring the same "hardship and dangers" as the service members they lead.⁹⁸ Below is a personal account by one of the authors (TWH) during his tenure as a battalion commander.

As a commander, I often executed missions with my Soldiers during our Afghanistan deployment. After we returned from our deployment to Afghanistan, I required my Soldiers to spend at least 15 minutes with the Military Family Life Consultant (MFLC). I was the first to visit the MFLC and one of the first in my command to schedule an appointment with a mental health physician. I was a normal person who displayed normal reactions to the extraordinary circumstances I experienced in combat. I wanted to show my Soldiers that it was ok to seek help. I wanted them to know that it took more courage to seek help than it did to suffer in silence. I wanted the Soldiers to know that I too was susceptible to the emotional scars of combat.⁹⁹

EI leaders, who genuinely care about the personal lives of their service members, are more likely to detect changes in behavior and attitude. When leaders can detect risk factors, they might be able to intervene early and possibly save lives by preventing suicides.¹⁰⁰ The HelpGuide.org document, "Suicide Prevention: How To Help Someone Who Is Suicidal," said that "most people who commit suicide don't want to die — they just want to stop hurting. Most suicidal individuals give warning signs or signals of their intentions."¹⁰¹ Engaged, EI leaders connect with service members and can detect signs of serious problems. These leaders—both officers and senior NCOs —can encourage distressed service members to seek help to reduce the risk for suicide.

Leaders who fail to handle themselves properly and fail to develop personal relationships with their service members put themselves, their units, and their service members at risk. However, EI leaders create climates that build cohesion, a sense of belongingness, and the trust necessary to encourage service members to seek needed support. Such climates help individuals who need behavioral health care to seek help without fear of being stigmatized by their peers. EI leaders who provide a supportive

climate also allow service members to "work through" their combat experiences with other unit members.

Good leaders also have the ability to influence or sway their subordinates' emotions, to increase their enthusiasm, and to build their confidence while curtailing anxiety and preventing their subordinates from feeling isolated.¹⁰² It is a fairly common belief that recent combat operations have enabled the military to develop great combat leaders, but that these same experiences have also eroded the ability to sufficiently care for returning service members in garrison environments.¹⁰³ In combat, the DoD needs service members who are mentally prepared to execute combat missions and, if necessary, to close with and destroy the enemy. Some people may argue that the Army is far better at such missions today than at any time in its history. However, while noted earlier, many service members may find the transitions between combat and garrison difficult. Many service members who built mental toughness in combat may find it difficult to later seek help for emotional scars created during those combat experiences. They may equate toughness with strength, and their need for help to address the mental scars of war to weakness.¹⁰⁴ This is when engaged, EI leaders who understand their service members, and who understand the mental demands of the warrior mindset, can intervene and help service members seek help.

Unit Level Leadership

Engaged leadership championed by senior enlisted advisors to commanders, such as Command Sergeants Major (CSM) and First Sergeants (1SG), can help the DoD significantly reduce suicides in the ranks. A decade of war has caused us to necessarily focus our training time and effort towards developing technical skill proficiency. The DoD has a large number of Sergeants and Lieutenants who could

benefit from a deliberate training program focused on the human elements of leadership.

As an organization that values every member of the team, the DoD needs to shift more accountability and responsibility to lower in the supervisory chain and involve first line leaders in its efforts to establish the bonds of leadership to help reduce service members' suicide. The SPE³ also recommended that first line leaders become more engaged in garrison activities. For example, several research studies have helped the Army identify several teachable skills to decrease many of the stresses associated with and thought to contribute to increased risk for suicide.¹⁰⁵ While the top-down data driven concept may identify a few of the most at-risk service members, DoD should ensure that leaders at the supervisory level have the skills they need to lead. In a 2006 *MilitaryGear.com* blog titled "Every Soldier Has a Sergeant," CJ Grisham said that every Soldier deserves to have a leader who knows them and looks out for their interests.¹⁰⁶ A leader can only learn about their service members by communicating, and not just while on duty.

The *Army Red Book* identified that part of the problem with leadership training is that technical skills training to support operations replaced leadership training in much of PME.¹⁰⁷ Is it possible that by removing leadership training from PME, it caused first line leaders to miss signs of suicide? If so, DoD should address the lack of leadership training immediately. DoD needs to recruit and train individuals capable of being both great combat leaders in war and effective leaders in garrison; otherwise it risks a continuation of the current trends in suicide and suicidal ideation.¹⁰⁸ DoD should require

the same intensive leadership training for individuals who lead in garrison as they require for individuals who lead combat missions.¹⁰⁹

Leadership Effects of Mandatory Training Requirements and Operational Tempo

The DoD cannot train its leaders to become engaged and EI without addressing its current training regimen. According to the *Army Red Book*, the current Operational Tempo (OPTEMPO) has had dramatic effects on our current force. Though the current OPTEMPO cannot directly be connected to suicide, DoD should scrutinize mandatory requirements with regard to its particular effects on developing and sustaining leadership skills.

Army units must conduct training as mandated by Department of the Army Regulation (AR) 350-1¹¹⁰ and Army Force Generation (ARFORGEN) to prepare for deployment and to certify for combat.¹¹¹ However, in a 2002 monograph "Stifling Innovation: Developing Tomorrow's Leaders Today," Dr. Leonard Wong calculated that Army policies required company commanders to execute 297 days of required training per year. However, of the 365 days in a year, 109 of those days were unavailable for training due to mandatory days off — weekends, holidays, etc. In other words, company commanders only have 256 days to complete the 297 days of required training.¹¹² Ten years later in 2012, the Department of the Army Inspector General's (DAIG) Office finalized the "Report of the Disciplined Leadership and Company Administrative Requirements." This report identified training issues similar to those in Wong's monograph. The DAIG found that there are "over 400 days of pre-deployment training requirements" outlined in the ARFORGEN process.¹¹³

As a result of these requirements, company commanders could not complete "all mandatory training" and were "forced to assume risk" in several areas "because there

simply was no time to train on them."¹¹⁴ If leaders focus on training service members for combat but are not given enough time to conduct training, they are accepting risk for completing training requirements. It then follows that leaders also are accepting risks in areas such as barracks inspection, risk assessment, getting to know their service members and their families, and understanding their service members' mental health issues? If so, and reports suggest that they are, the garrison skills of our first-line leaders may atrophy.¹¹⁵ Soldiers could pay with their lives if leaders do not have the time to lead, or worse, the time to detect warning signs of Soldiers at risk.

The current OPTEMPO has also stressed leaders and their FMs with repeated deployments. When they return from these deployments, they too often quickly prepare for the next deployment. The result has been that they are not properly attending to their service members' garrison skills and needs.¹¹⁶ No one should assume that their lack of supervision in garrison is intentional. However, part of the first phase of the ARFORGEN process is to reset Soldiers and FMs.¹¹⁷ While leaders are responsible for ensuring service members and FMs reset, leaders also have to reset themselves and FMs.

As noted earlier, these issues compound yearly as the Army has added several mandatory requirements—CSF2, suicide prevention, computer training etc.— without deleting much, if any, of the existing mandatory requirements.¹¹⁸ Wong's 2002 findings and the 2012 DAIG's findings make all too objective the subjective frustrations that our leaders now experience. In fact, students from the USAWC's SPE³ recommended that "the only new program the Army needs is a program to assess all the Army programs.

[The Army needs] to stop the additive trend...and use the gained time to spend on building the team."

Another policy which challenges leaders and warrants review is the 90-day stabilization policy for AC units returning from deployment.¹¹⁹ Many leaders depart the unit within the first 90 days after the unit returns from combat. This results in leaders transitioning before the 90 - 180 day timeframe, which experts believe is the post-combat equivalent of the "golden hour for treatment" after an injury. This period of time is when Soldiers would most benefit from intervention if they exhibit complications as a result of their combat experiences.¹²⁰ As a result of the quick transition in leadership, the newly arrived leaders may overlook Soldiers' warning signs as they enter the ARFORGEN cycle to prepare for the next deployment.

This policy may also inadvertently contribute to an increased sense of isolation with Soldiers who are diagnosed with behavioral health issues since the peers with whom they shared the stress of combat have now moved on to other units. Those peers may be replaced by new "peers" who do not know or understand what the unit went through while deployed. The SPE³ recommended that the Army extend Post-Deployment Stabilization from 90 days to 180 days or more in order to address this problem. This additional time enables leaders to identify Soldiers who display problematic symptoms and to provide details of their combat experience to their primary care provider, all of which is done to ensure Soldiers receive the appropriate level of care.

Resiliency

The second LOE is resiliency. The Army defines resilience as "a reaction to stress, transitions, or life events...an increase in one's resiliency may be the result of

preparedness or becoming adjusted to changes and events.”¹²¹ CSF2 is the current approach to build capacity or resilience across the Army “to not only survive, but also thrive at a cognitive and behavioral level in the face of protracted warfare and everyday challenges.”¹²²

CSF2 consists of three phases. The first phase is online and includes the Global Assessment Tool (GAT), which is “an annual requirement for Soldiers and deploying DACs.”¹²³ The GAT is a web-based survey instrument that measures Emotional Fitness, Social Fitness, Family Fitness, and Spiritual Fitness. There are 42 Comprehensive Resilience Modules (CRMs) available online, and based on the GAT score, specific modules are recommended depending on individual survey results.¹²⁴ The CRM “provide practical exercises and activities that improve one’s resilience when coping with the stress of Army life.”¹²⁵ Although not required, service members can take additional modules in addition to those recommended based on their GAT score.

The second phase of CSF2 is formal classroom instruction integrated into the courses for most of the professional military education (PME) courses for officers, Warrant Officers (WOs) and NCOs. Appendix B includes a matrix depicting training goals instructed in myriad pre-commissioning and other PME courses across a Soldier’s career.

The third phase of CSF2 is the Master Resiliency Training (MRT) program. This program is a ten-day “train the trainer” course designed around the research conducted in the Penn Resilience Program at the University of Pennsylvania.^{126,127} The MRT program assists instructors with understanding how to help others build resilience, mental toughness, positive relationships, and to learn techniques to conduct

sustainment training. Research shows that the MRT program is effective for Soldiers between 18-24 years-old and that these positive effects are sustained over time.¹²⁸ At the same time, this study showed that training is less effective for Soldiers older than 24,¹²⁹ which demonstrates that effective resilience training should be conducted early in a service member's career.

The SPE³ highlighted concerns that society is not creating resilient citizens. This lack of resilience across the population, combined with the need for increased numbers of service members to support recent conflicts, has perhaps caused the DoD to bring more people into military service who are not as resilient as past generations. The Army attempted to address this issue through CSF2, by integrating resilience training into its formal courses. However, CSF2 does not appear to be implemented consistently across the Army. A final SPE³ comment on resiliency is that DoD should change resiliency messaging from an expectation of weakness and vulnerability, towards toughness and capacity; an expectation of strength.

CSF2 is often referred to as one of the suicide prevention programs despite not being designed for that purpose. Researchers Knox and Bossarte suggest that “treating groups at high risk for suicide is a necessary, but insufficient response to suicide.”¹³⁰ CSF2 should be part of the foundation to prepare Soldiers to cope with the stresses of military life and avoid suicide. Additionally, CSF2 results should be available to leaders so that they can identify high-risk Soldiers, get them the help they need, maintain awareness in the unit, and be better positioned to help service members build capacity in Emotional Fitness, Social Fitness, Family Fitness, and Spiritual Fitness, the subcomponents of resilience.

Belongingness

Belongingness as a Protective Factor

The third LOE is belongingness. Baumeister and Leary developed a hypothesis of belongingness in 1995, which suggested that “human beings have an almost universal need to form and maintain at least some degree of interpersonal relationships with other humans.”¹³¹ Baumeister and Leary further stated that “belongingness is an innate quality [with an] evolutionary basis...and... would have both survival and reproductive benefits.”¹³² Additionally, psychological experts suggest that there are three “protective” factors that inhibit someone from committing suicide: “belongingness, usefulness, and an aversion to pain or death.”¹³³ The Center for a New American Security (CNAS) study on suicide prevention postulated that military service promotes the first two protective factors, belongingness and usefulness, while actually training someone to feel comfortable with death and killing.¹³⁴ CNAS referenced Thomas Joiner’s research on suicide, and suggested that individuals who quickly lose the first two protective factors, either when they return from deployment or leave active duty, while still retaining an ability to override aversion to pain or death can be a potential explanation for high suicide rates in the veteran and RC population.¹³⁵

Studies have shown that cohesive units contribute to service members' sense of "belongingness," which then serves to "protect against suicide."¹³⁶ So, if units remove service members for medical reasons, service members could feel isolated, lose their sense of inclusion and become susceptible to suicide. Therefore, the military should involve the commander and unit, where applicable and not in violation of the Health Insurance Portability and Accountability Act (HIPAA), in the treatment and care of service members who desire to continue to be a part of their cohesive units. By

continuing to include service members in unit training and activities, units should be able to help service members retain the feeling of being connected to others who understand their situation. Since studies suggest that belongingness and connectedness may help prevent suicide, units that retain a connection to service members receiving behavioral health care and treatment could also prevent service members from losing their sense of belongingness and possibly choosing suicide as an alternative.¹³⁷

In "The Interpersonal-Psychological Theory of Suicidal Behavior," Thomas Joiner suggested that individuals with minimized belongingness often feel alienated and not a part of the group. Additionally, he claimed that evidence confirms that a "low sense of belongingness" is associated with behavior linked to suicide. It is hard to prove this theory without an evidence-based scientific study addressing identity as a protective factor. Finally, Joiner cited evidence from research published in 1999 that makes the case that among the risks associated with suicidal behavior, social isolation was the "strongest and [had the] most uniform support."¹³⁸ Since the authors of this paper assert that this evidence is indeed valid, service members should remain in training to maintain a sense of normalcy after a deployment in order to prevent suicide. This evidence also means that RC service members could be at greater risk because the majority of them spend most of their time serving in their civilian capacity. While serving in their civilian capacity, they are away from service members with similar experiences, risk becoming isolated and often have insufficient support if they contemplate suicide. The propensity for suicidal ideation in RC service members may be due to the quickness with which

units disband and return back to their civilian positions, but research has yet to confirm this hypothesis.

Implications of Belongingness for RC Service members

RC service members operate in two separate cultures — civilian and military. This unique environment means that suicide prevention programs must also cross both cultures. Several factors challenge RC leaders. Limited contact between units and service members make assessment, referral, and implementation of solutions difficult. This situation makes it difficult for leaders to stay engaged with the service members. Additionally, service members can feel separated from the cohesiveness of their unit, decreasing belongingness. Resolution of the suicide problem in RC forces requires solutions and implementation methods that are applicable across these two cultures (i.e., the military and the civilian), while seeking to leverage the strengths of both and minimizing their weaknesses.

From 2007-2012, over 80% of the suicides among NG Soldiers occurred while not on active duty.¹³⁹ This fact is significant because it illustrates that the vast majority of deaths occur when NG service members are not serving with their unit. This presents significant challenges in regards to instituting military or unit level mitigation techniques. Without direct contact with their unit, RC service members may not be as ready or willing to reach out to their unit peers or chains of command to receive help. RC leaders should use alternate social integration techniques like social media and local resources to help service members connect.

The variables affecting suicide increase because RC service members find themselves in two distinct cultures. At its roots, suicide is simultaneously an individual and a social act.¹⁴⁰ Indeed, across the military, the causes of suicide vary widely and are

difficult to classify.¹⁴¹ Therefore, finding culturally independent methods of identifying and mitigating the problem at its roots is paramount to solving it. Coping and prevention methods must be broad enough to cover the spectrum of causes and be applicable to all situations (e.g., for the Total Force).

DoD must also look to the social aspect of suicide prevention to develop effective strategies. Key protective factors within the social realm help prevent and identify suicidal behavior. As noted above, Psychologist Thomas Joiner attributed suicide to failed belongingness.¹⁴² Additionally, Joiner summarized Durkheim's specific theory, suggesting that collective or social forces contribute more to the problem than individual factors.¹⁴³ According to Joiner, Durkheim's theory stated that the common denominator in all suicides was "disturbed regulation of the individual by society."¹⁴⁴ As a result, Durkheim studied two kinds of regulation: social integration and moral integration.¹⁴⁵ Social and moral integration are the foundation on which to address this complex problem. Social and moral integration, seen through both civilian and military cultural lenses, serve as the core of any systematic approach to suicide. While addressing both the civilian and military cultures may present problems when implementing solutions focused on either one specifically, it also provides two viable and equally effective routes for implementing solutions.

The options to communicate electronically today are numerous, with social media as one way to increase connectedness. Leveraging alternate sources of social interaction via social media may also offer service members and their unit an effective (and protective) means to stay in touch and reinforce the sense of belonging without being physically co-located. Facebook groups, message boards, internet chatrooms,

and telephone calls can provide avenues to increase connectedness and lead to a greater sense of belongingness. This may seem like an inadequate alternative for many service members and leaders who prefer face-to-face interaction. However, there is a growing body of evidence that social media and other forms of electronic communication can be as effective as face-to-face communication, especially in 18 to 24 year old service members.¹⁴⁶ It is also important to note that part of the empirical foundation for the PENN Resiliency Program that currently serves as the basis for the CSF2 training leveraged such an approach.¹⁴⁷ A simple text from a peer or leader asking how the service member is doing can make a difference. This is just one method to bridge the gap when service members separate from their units.

Another way to bridge the gap is through local resources. There are 3300 NG armories across the 54 states and territories and a similar number of Army Reserve facilities. This translates into the potential for a vast network of available places from which to get resources for service members and their families. Units can integrate service members and FMs into an informal support network by offering them support at facilities close to home. This would integrate both service members and FM into a military support network that benefits them regardless of their assigned unit. It would also ensure that there are healthy support networks available in times of need.

While increased belongingness and interaction are key components in prevention, it also facilitates identification of high-risk and at risk service members. Increased interaction with peers and unit leaders should enhance the service member's sense of belongingness.¹⁴⁸ If service members' sense of belongingness increases, they will be more likely to seek assistance from their military peers and leaders. Reinforcing

this relationship can also serve to counteract or mitigate relationship difficulties. Proper unit belongingness can serve as an additional protective factor by providing service members a positive support group in the absence of healthy relationships while not on duty.

Cohesive units that live the Warrior Ethos should create a sense of belongingness. The Army's Warrior Ethos states: 1) *I will always place the mission first*, 2) *I will never accept defeat*, 3) *I will never quit*, and 4) *I will never leave a fallen comrade*.¹⁴⁹ The SPE³ recommended modifying the current Warrior Ethos from "I will never quit" to "I will never quit on my comrades or myself" as further social reinforcement. Leveraging this ethos, the Army can strengthen the social values that help protect against self-destructive behavior. Durkheim addressed this as a concept called *social integration*. Social integration is "the extent to which individuals are linked to and feel allegiance for social groups to which they are attached."¹⁵⁰ By ensuring that service members are held accountable for their behavior while not on duty, as well as on duty, we strengthen moral integration¹⁵¹ into service members' unit and society. Social and moral integration should also help stem some of the inter-family relationship problems that may arise from poor or unguided choices.

As mentioned previously, over 80% of RC service members commit suicide while not on active duty. This is an expected statistic because RC service members spend an average of only two days a month of actual duty time at the unit performing drill. However, this disparity also highlights the necessity of maintaining a healthy social and moral integration since for the majority of each month; these Soldiers are not with their units. During the last two quarters of 2011, 19 of the 22 reviewed cases of suicide

reported by the Army NG and United States Army Reserve (USAR) indicated the presence of family relationship problems.¹⁵² This indicated that relationship problems were one of the most frequent triggers for suicide in Soldiers.¹⁵³

These statistics point out the importance of addressing relationship issues as one way to help reduce the risk of suicide for both groups. This also highlights the importance of equipping FMs with the knowledge and resources to build and maintain healthy relationships with service members as an essential component of suicide prevention. FMs should also have an outlet to share problems and concerns so they do not feel isolated. The SPE³ noted that FMs did not understand the stress and tempo service members endure and suggested educating them so they become part of a comprehensive suicide prevention strategy. While all military families experience difficulties, this seems especially true for RC families since they often live in areas without large military family populations. AC military installations have informal and formal networks established to help FMs with issues, as opposed to resources available to RC service members. Formal networks are those associated with the service members' unit. Informal networks result from the large proximity of military families that live near a military installation. Unless a RC service member lives near one of these installations, they do not benefit from these networks. Kansas and Arizona offer online "resiliency centers" to supplement support networks for RC service members, but these centers do not necessarily provide face-to-face interaction.¹⁵⁴ Limited availability of other military families makes it hard to establish social or behavioral norms. When FMs can talk to someone with shared experiences in a peer to peer fashion, it can be invaluable when coping with challenges.¹⁵⁵

Since RC Soldiers spend most of their time serving in their civilian capacity, their community must be considered in forming a solution. Some of the best solutions could involve facilitating the establishment of partnerships with locally-based organizations such as the Veterans of Foreign Wars (VFW) and American Legion. These organizations exist nationwide and focus on helping the community, specifically former service members and their families. Members of these organizations have shared experiences. These locally-based organizations could receive training in peer counseling and benefits currently offered by the DoD and VA in order to adequately assist service members and their families. Since the community-based peer programs are not associated with the military medical system, service members can access them without fear of perceived stigma within the unit. The SPE³ recommended developing national awareness about suicide outside of the DoD by partnering with one or some of these locally-based organizations, similar to the partnership the Army has with the National Football League (NFL) on mild Traumatic Brain Injury (mTBI).¹⁵⁶

Individual Augmentee (IA) Deployment

Individual Augmentees (IAs)¹⁵⁷ are service members from units tasked to deploy with units other than their own. RC units have frequently needed IAs from other states and Major Area Commands (MACOMs) to fill critical shortages within the deploying unit. While IAs enjoy the benefit of remaining in contact with their deploying unit during pre-deployment training and the actual deployment or mobilization, that is not always the case. Upon redeployment, IAs return to their original unit, breaking the connectedness with the other unit members developed during their shared deployment. This feeling of isolation can increase especially if the IAs have any deployment-related issues that need addressed such as medical or administrative issues. Service members who

deployed as IAs may feel that even though they are back with their parent unit, those within their unit who did not share their experiences cannot understand their challenges. In some cases, no one at the IA's parent unit may even have awareness that the service member had a deployment-related problem if there was an inadequate unit-to-unit transition. Both units share a responsibility to successfully reintegrate IAs and conduct a proper handoff of IAs but the parent unit must maintain accountability and help IAs maintain a sense of belongingness.

DoD's premier program to help reintegrate service members and FMs post-deployment is the Yellow Ribbon Reintegration Program (YRRP), which provides training and resources for service members and FMs throughout the deployment cycle.¹⁵⁸ The YRRP directs a 30, 60, and 90 day reintegration event which service members and FMs attend. The program consists of three events during the first 90 days following redeployment. However, unit commanders can request extensions of up to 180 days through their Service, so that all service members can attend the YRRP with their deploying unit.¹⁵⁹ Once the service members finishes the event, they return to their parent unit or state. During the YRRP, service members are under the direct control or influence of their deployment unit, which can help mitigate post deployment issues. DoD should instead make 180 days the standard timeline for YRRP transition time in order to increase the effectiveness of IA transition following deployment. This increase allows service members to attend the YRRP and serve with their deploying unit during a critical reintegration time, preventing isolation, identifying and addressing potential issues which could devolve into triggers, and increasing service members' sense of belongingness.

Policy

The fourth LOE is policy. Several of the recommendations made by USAWC students fell into the category of policy, which is defined as “a high-level overall plan embracing the general goals and acceptable procedures especially of a governmental body.”¹⁶⁰ USAWC students identified several areas in which policies should be modified to aid in preventing suicide, the first of which is health care.

Health Care Implications

One of the first issues DoD leaders need to address is the perceived tendency to "medicalize" suicide and suicidal ideation. Some experts have suggested that the DoD addresses suicide or attempted suicide mainly as medical issues. Operational commanders with limited medical expertise should be cautious about questioning medical providers' expertise and violating HIPAA. However, commanders should work with medical providers to understand how best to help service members and restore them to operational readiness.

The first responsibility of commanders and medical professionals is to ensure service members receive proper and adequate medical treatment if and when they require it. However, service members who experience issues should not be immediately removed from the operational environment, especially if their removal could trigger elevated levels of stress or reduce their sense of belongingness. Removing service members from their units and placing them in the medical system could also exacerbate the stigma associated with military mental health issues and further isolate the service member. The June 2012 MSMR posits that such stressors could cause events that trigger "an impulsive act" and potentially cause a service member's suicide.¹⁶¹ One recommendation from the SPE³ is that DoD should create a mechanism to ensure that

service members and veterans remain with their military family. The SPE³ also recommended Commanders and medical authorities find innovative ways to provide the best intervention to help service members, to include medical care if needed, while keeping them involved in their units.

The stigma associated with receiving treatment for behavioral health concerns is another issue associated with removing service members from their unit by "medicalizing" suicide. Each medical appointment takes service members away from their unit and reduces their time to train for missions. Additionally, when service members are away from their unit for behavioral health reasons, it may cause other members of the unit to further stigmatize them and judge them as unfit for military service. Despite intense emphasis to reduce the stigma by senior leaders such as the VCSA and the Sergeant Major of the Army (SMA), the USAWC's SPE³ showed that there is still a stigma associated with receiving behavioral health treatment. Since 2011, 280,403 Soldiers¹⁶² have sought behavioral health treatment regardless of the stigma, but one must wonder what those numbers might be in the absence of a stigma with seeking care. Regardless, we must ask why this stigma persists.

There is much speculation about the stigma associated with behavioral health issues in the military. In a 26 September 2012 *Army News Service* article, SMA Raymond Chandler announced that "Our ultimate goal is to change [the] mindset across the force, build resilience, strengthen life-coping skills and address the stigma associated with asking for help."¹⁶³ In an August 2012 *CNN* segment "Army sees highest suicide rate in July," VCSA General Lloyd Austin likewise said, "Ultimately, we want the mindset across our Force and society at large to be that behavioral health is a

routine part of what we do and who we are as we strive to maintain our own physical and mental wellness."¹⁶⁴ The USAWC students echoed his sentiments with a recommendation that DoD should normalize behavioral health across the force.

The DoD has directed much of its attention and resources toward eliminating the stigma of seeking care.¹⁶⁵ However, some research suggests that anti-stigma campaigns tend to increase, not reduce, stigma.¹⁶⁶ If this is true, does the stigma associated with behavioral health concerns and receiving mental health treatment persist because current policies and procedures have made it more deeply rooted? Has the DoD, by "medicalizing" suicide and behavioral health issues, given more credence to the stigma? The Army medically out-processed approximately 21,408 Soldiers on either a Chapter 5-13 (Separation for Personality Disorder) or a Chapter 5-17 (Other Designated Physical or Mental Conditions) from 2001 to December 2012.¹⁶⁷ It is possible that Soldiers who separated from the Army because of behavioral health issues believe they were stigmatized.

However, the very reason that many service members avoid treatment may also leave them vulnerable to committing suicide or to entertaining suicidal ideation.¹⁶⁸ Even though the DoD is already making a concerted effort to curtail the stigma associated with behavioral health concerns, it must continue to search for ways to eliminate circumstances that prevent service members from seeking assistance. One way is to ensure that the unit continues to include service members receiving behavioral health treatment into unit activities. A powerful recommendation from the SPE³ is for leaders to lead by example and attend behavioral health counseling sessions routinely. This recommendation could help reduce the prejudice surrounding behavioral health care

and encourage service members with suicidal thoughts to open up to others and discuss their problems.¹⁶⁹

The SPE³ further recommends that routine health care should include behavioral health counseling. The Army's Warrior Ethos' final phrase declares, "I will never leave a fallen comrade."¹⁷⁰ The Army sends Soldiers "into battle and [later treats their] resulting emotions as though their origins were irrelevant, as though they were [caused by pre-existing problems]."¹⁷¹ Although experts label service members' adverse reaction to extraordinary circumstances, such as combat, as normal, many times medical professionals diagnose those same individuals with behavioral health issues.¹⁷² As noted previously, too often service members are even medically boarded out of the military, and then become that "fallen comrade" who is left behind. There is something fundamentally wrong with this process. Out of an abundance of concern for some of the more typical symptoms (e.g., feeling on edge, inability to sleep, etc.), medical professionals have reportedly been quick to provide medical treatment for combat stress symptoms to service members returning from deployment.¹⁷³ The increase in treatment for behavioral health issues has prompted concern¹⁷⁴ by commanders and was also an issue identified through the USAWC SPE³. Herein lies the dilemma for the medical professionals: to ethically treat, they must have a reason for doing so and the diagnosis provides that medical basis. However, if they are treating an expected combat stress reaction, they may inadvertently send a message of vulnerability to both the service member and to that service member's unit. What was initiated to help does so in one aspect, but potentially harms in another. This is less likely if the diagnosis is correct but possible if the diagnosis is rendered as a means for the medical provider to help the

service member. It is easy to see how this issue may increase the possibility to initially misdiagnose an underlying mental disorder when perhaps a service member is only experiencing “temporary” reactions to the stress of combat. This further compounds the initial problem for service members, disrupts the unit's teamwork and cohesion, and may undermine the DoD's overall efforts to reduce suicide.

Effects of Prescription Medication

As described above, part of the reason the Army has "medicalized" behavioral health can be attributed to medical professionals' growing tendency to use what appears to be a "medication first" approach in treatment. In "When Johnny and Jane Come Marching Home," Paula Caplan cautioned that mental illness is not like a physical problems. She claimed that there are no proven methods to reliably diagnose mental health issues,¹⁷⁵ and other researchers have supported her theory that diagnosis is subjective.¹⁷⁶ The DoD continues to rely heavily on prescription medication for treatment despite lacking the proper means to diagnose mental issues. The DoD should consider whether using prescription medication as a first alternative may be causing irreversible conditions in service members. Research indicates that drugs intended to treat depression and anxiety target service members' nervous system. Medications that initially alleviated the symptoms later become ineffective or caused adverse effects.¹⁷⁷ Furthermore, researchers have argued that prior to the introduction of current drugs on the market to treat behavioral health conditions, patients recovered from mental health conditions quicker.¹⁷⁸

Increased prescription of medication is readily seen in the military. In 2011, as many as 358,203 Soldiers had prescriptions "for psychotropic and controlled substances."¹⁷⁹ And of those 358,203 Soldiers, at least 160,175 of them were victims of

polypharmacy.¹⁸⁰ While many Soldiers included in this 160K "[suffered] from multiple health issues" some Soldiers simply may have been victims of different "medication options...and a lack of alternative treatment options."¹⁸¹ These statistics are very alarming. As noted earlier, service members may often be misdiagnosed with behavioral health concerns despite reactions judged as a normal response to extraordinary circumstances (i.e., combat experiences). If medical professionals are prescribing medication in these circumstances, they may be creating additional problems not associated with the service member's true condition. The DoD must continue to scrupulously review its prescription medication policies and practices.¹⁸²

The RAND monograph "The War Within: Preventing Suicide in the U.S. Military," provided evidence affirming that individuals who develop substance-use disorders could be at "an increased risk of suicide" if they become addicted to certain drugs.¹⁸³ The Army's current prescription drug policy directs providers to prescribe the fewest amount of drugs possible "to treat an acute illness or injury."¹⁸⁴ It also directs the prescribed quantity to not exceed a 30-day supply.¹⁸⁵ Finally, it states that providers "may prescribe a 30-day supply of medication with up to 5-refills."¹⁸⁶ This policy is certainly a step in the right direction; however, a 30-day supply of medication is still a large quantity of drugs for a person who could be contemplating suicide. While the Army's DoDSER shows that prescription drugs only account for 4% of actual suicides, drugs are associated with 58% of suicide attempts.¹⁸⁷ This should cause us to question whether or not a 30-day supply is still too much. Would it be better to reduce the quantity of drugs and increase the frequency with which prescriptions are filled?

In another personal account, one of the authors (TWH) of this project shares two experiences with Soldiers and prescription medication.

As a battalion commander, I had the unfortunate opportunity of witnessing Soldiers abuse prescription drugs. Two of the worst days of my two-and-a-half years in command involved Soldiers in my command who attempted to overdose on drugs prescribed for their behavioral health issues. Fortunately, other Soldiers intervened and saved their fellow Soldiers' lives. In both cases, the Soldiers were diagnosed with PTSD and prescribed 30-day supplies of more than one type of antidepressants. This enabled the Soldiers to attempt suicide by ingesting massive amounts of several prescription drugs. After investigating the incidents and determining that excessive prescriptions were common themes, I met with the clinic commander and the psychiatrist who administered the prescriptions. I explained the situation and asked the officers to re-evaluate the Soldiers' current prescriptions and prescribe the Soldiers smaller quantities of drugs on a more frequent schedule. Additionally, I asked them to use this prescription technique in the future for any of my Soldiers diagnosed with behavioral health issues. While I cannot say that my actions had a direct impact, I can say the unit never had another overdosing crisis.¹⁸⁸

Incidents such as the ones described above may be common among Army units despite the latest prescription drug policies. Therefore, as recommended in the SPE³, the Army should continue to study its prescription procedures and policies to determine if drugs are the best means of treatment, and if so, the optimal quantity of drugs high-risk Soldiers should be prescribed at one time.

Another troubling factor with prescription medications is that research has found evidence which suggests "second-generation antidepressants [mostly serotonin-specific reuptake inhibitors (SSRI)] increase suicidal behavior in adults [from] 18 to 29 years [old]."¹⁸⁹ This is the same age group with some of the highest suicide rates in the nation and in the Army.¹⁹⁰ Additionally, Caplan claimed that psychiatric drugs and psychotherapists have often provided only minimal assistance to individuals with mental health concerns. In particular, Caplan asserted that the failure to achieve results caused

individuals to blame themselves for their condition, in some cases.¹⁹¹ The Army should review the potential impact of prescribing medications that may lead Soldiers to develop "self-stigmas" if they believe they cannot be "cured."¹⁹²

Screening and Military Career Field

Another policy that should be addressed is screening and military career fields. There are moments in the military life cycle that are key to the development of the health and well-being of a service member, most important of which is accession and initial training. Screening during accessions is important because the military should be seeking the best and brightest to handle one of the toughest and most challenging jobs in the world. Service members who experience high levels of stress also have lower functioning on the job.¹⁹³

Traditionally, the Army has used cognitive testing as the basis for screening recruits. Cognitive testing, in the form of intelligence-type tests via the Armed Services Vocational Aptitude Battery (ASVAB)/Armed Forces Qualification Test (AFQT), has historically been a reasonably valid and reliable predictor of job performance in the military.¹⁹⁴ But cognitive testing only tells part of the story. The Army is developing and testing a new screening measure that will address some other important screening measures, such as motivation, with further predictive capabilities than previous measures.

The Tailored Adaptive Personality Assessment System (TAPAS) was developed as a supplement to the ASVAB/AFQT for the Army to measure non-cognitive characteristics, particularly personality, in a way that is not transparent to the test taker.¹⁹⁵ In other words, the results are harder to fake through forced-choice responses, which lead to more truthful results than previously used measures.¹⁹⁶ The purpose of

developing this type of measure was initially to assess motivation and in turn, better match recruits with particular Military Occupation Specialties (MOS) and predict the likelihood of initial training completion. However, test results produced additional areas of interest. The Physical Conditioning scale of the test predicted Army Physical Fitness Test (APFT) scores, level of adjustment to Army life, and three-month attrition rates.¹⁹⁷ Further testing of the measure showed significant relationships between scores and six-month attrition, as well as disciplinary incidents. Notably, scores on the test showed that “40-50% of individuals were predicted to perform substantially different in a different MOS” than the one to which they were currently assigned.¹⁹⁸

But job performance, attrition, and job-match were not the only interesting results of the test. TAPAS measures several temperament scales, including dominance, cooperation, adjustment, self-control and tolerance.¹⁹⁹ Some potential psychological red flags for future suicidal tendencies are a history of mental or substance-abuse disorders, and characteristics such as hopelessness, aggression and impulsivity, and problem-solving deficits.²⁰⁰ If TAPAS can screen out a large portion of the population susceptible to suicidal tendencies, this measure would help reduce suicide rates overall over time. The DoD should continue to explore the viability of using TAPAS in addition to the ASVAB/AFQT to screen out individuals who may not be most suitable for military service. The SPE³ also recommended that DoD revise accession procedures to be more selective of individuals brought into military service.

Basic Training

Basic training is probably one of the most stressful events of service members' military career. New recruits are placed into a highly regimented, directive environment where they are asked to perform extremely difficult tasks. Most recruits adjust to the

stress by the end of the typical nine weeks of training, but there have been few studies that link psychological adjustment with attrition during basic training.²⁰¹ One study of the Strategies to Assist Navy Recruits' Success (STARS) program suggested that particular mental health interventions enabled Navy recruits to have “significantly higher group cohesion, higher scores on problem-solving copying strategies, and higher perceived social support”.²⁰² The group also scored lower on anger expression as compared to the group that did not experience the interventions. Results of the study indicated that mental health intervention strategies can help improve performance and coping mechanisms, as well as decrease attrition. Early interventions can reap a lifetime of benefits.

At least one study has identified how the stress of constant military training may in fact cause maladaptive coping mechanisms. A study of Israeli special forces demonstrated that “traumatized individuals, particularly when they develop stress-related symptoms, shift their attention away from the threat.”²⁰³ When individuals are under acute stress, they experience threat avoidance. Other studies have shown that acute stress leads to cognitive impairment,²⁰⁴ and even perceived stress can cause performance deficits.²⁰⁵ Therefore, the military must carefully consider the impact of prolonged stress and how it may alter the innate resiliency of individuals who experience it over a period of time.

Basic training is the core foundation of preparation for military service, but few substantial changes have been made since its inception. Service members need to be prepared for a career of combat, but also need to be prepared for a lifetime of successful problem-solving. The introduction of CSF2 into basic training was designed,

in part, to help strengthen our Soldiers in this area. However, more research is needed to evaluate the basic training model, and how service members can better achieve a balance enduring the demands of combat while maintaining their psychological health and well-being.

Department of Veterans Affairs Responsibilities

Finding a way to reduce suicide must extend beyond military service given recent reports that between 21 - 22 veterans commit suicide per day.²⁰⁶ While DoD has the responsibility to care for service members while they are in the military, the VA has the obligation to maintain a high level of care once an individual separates from military service.

The VA can trace its roots and contributions back to the Revolutionary War. Following the war, Congress created the Bureau of Pensions to provide oversight over payment of pensions to veterans, and later consolidated all programs for veterans under the new Bureau.²⁰⁷ After several name changes and movement to various Departments in the federal government over the years, Congress created a separate Veterans Administration in 1930 and eventually authorized the creation of a Cabinet-level agency in 1988. Today, the VA is comprised of three main areas: the Veterans Health Administration, the Veterans Benefits Administration, and the National Cemetery Administration, as well as several staff and special interest offices. The VA employs over 316,000 people, one-third of whom are veterans themselves, and provide benefits and services to veterans and their dependents.²⁰⁸

One of the most popular benefits that VA provides is health care, which is administered at 152 medical centers and over 1,100 other direct access points across the nation. Over 8.6 million veterans are enrolled in VA healthcare, which is the largest

integrated network in the United States.²⁰⁹ The VA has a tremendous amount of touch points across the nation, many with enhanced technologies like telehealth programs that can even reach veterans via multimedia devices. However, not all veterans eligible to use VA services do, and VA lacks visibility into problems and conditions affecting the greater veteran population because not all veterans are enrolled in the VA's healthcare system.

The VA, like the DoD, realized that behavioral health issues, including suicide, were becoming more prevalent after several continuous years at war. Both the Congress and the media began highlighting the effects of war, which created pressure on federal agencies to produce measureable reductions in suicides. In 2007, VA began taking steps to address suicide among veterans by increasing the number of mental health professionals and reviewing existing programs and services. That same year, the President signed into law the Joshua Omvig Act, which required VA to "...develop and implement a comprehensive program for reducing the incidence of suicide among veterans."²¹⁰ As a result of internal efforts and the new law, VA increased the number of mental health professionals, expanded crisis programs and outreach, and increased research and data collection.²¹¹

In 2007, VA and DoD also partnered with the National Suicide Prevention Lifeline to create specialized suicide *prevention* services for veterans and service members.²¹² VA established a standardized "suicide surveillance and clinical support system" in 2008 based on feedback from individual VA facilities.²¹³ Since 2009, VA tripled funding for mental health programs and doubled investments in suicide prevention.²¹⁴ Beginning in 2010, the VA developed data sharing agreements with all 50 U.S. states in order to

gather more information on suicidal events.²¹⁵ VA also increased hiring to almost 22,000 total mental health professionals and will pace their hiring actions based on DoD growth estimates to ensure a seamless transition from the DoD to VA systems in order to reduce the reliance on crisis intervention for veterans in need of services.²¹⁶

The Veterans Crisis Line is one of the most successful programs from the past several years of VA's increased emphasis on suicide prevention. "The Veterans Crisis Line connects Veterans in crisis and their families and friends with qualified, caring [VA] responders through a confidential toll-free hotline, online chat, or text."²¹⁷ The service is available all day, every day of the year, and is also a resource available for active duty service members and their families. As of June 2012, nearly 600,000 people used the Veterans Crisis Line, including over 8,000 active-duty service members. From these calls, VA has made over 93,000 referrals for care and rescued nearly 22,000 from potential suicide.²¹⁸ VA also added an online chat service in 2009 and a texting service in 2011. Since the inception of those services, VA has engaged almost 54,000 people in chats and another 3,000 via text as of June 2012.²¹⁹

The great successes of some of these VA initiatives reinforce the need for the VA and DoD to work together, sharing information and resources for a seamless continuum of care in suicide prevention. The fact that some estimates place veteran suicides at 18-22 a day is both tragic and incomprehensible. There once was a time when service members came into the military service to strengthen their foundation and straighten out their life. We need to re-take that initiative, help service members start their careers in DoD and provide them a strong foundation in resiliency that the VA then can continue to build upon after separation from service. In short, serving in the military should not

increase a veteran's risk of suicide later in their life; we need programs to *strengthen* the individual and their families.

This makes evident the importance of the VA and DoD to continue to work together on joint programs outside of direct suicide prevention initiatives, like the Integrated Electronic Health Record (iEHR) and the Transition Assistance Program (TAP), to ensure that they bridge the gap and provide a seamless transition from DoD to VA care. One's sense of identity as a Soldier is captured well by the recent acknowledgement that individuals who serve in the Army are *Soldier[s] for Life*.²²⁰ It is both in that mindset and with our practice that we will continue to create the seamless transition from the DoD to the VA in order to increase belongingness and provide resources for a strong post-military foundation.

Recommendations

Military service to our great nation should strengthen citizens who serve and create in them a sense of belongingness and instill in them a set of *Soldier for Life* skills that provide them physical and mental strength to confront the challenges of life and service. The authors' review and analysis of the various research studies and their appraisal of the USAWC's SPE³ results reviewed within this paper result in the following recommendations that are focused mainly on comprehensive suicide *prevention*, not treatment. The intent here is to be proactive rather than reactive. It is acknowledged that DoD may already be in the process of implementing some of these recommendations, while other recommendations may require policy changes and resourcing. The following un-prioritized list delineates 11 recommendations.

1. *DoD should develop a comprehensive approach to suicide prevention.*

Prevention should focus not only on service members and consider VA

suicide prevention program findings to ensure a *Soldier for Life* approach is maintained. The program must also focus on FMs and DACs and take into account the entire spectrum of causation, prevention, and treatment. Suicide prevention needs to start with entry into service and emphasize strengthening through resiliency in PME instead of creating a stigma through treatment programs. The authors recommend that the DoD identify key metrics for all suicide prevention programs based on the four recommended LOEs (leadership, resiliency, belongingness, and policy) and develop instruments to collect data on current suicide programs. DoD should then develop the means to analyze the data collected to determine program effectiveness with metrics that extend into the VA system to reflect the true continuum of *Soldier for Life*.

2. *DoD should develop a valid means to assess pre-deployment health conditions.* Pre-existing health conditions need to be correctly identified through a set of valid pre-deployment health assessments, and service members with any identified conditions should not deploy without more rigorous assessment.
3. *DoD should continue to conduct research on underlying conditions that can lead to suicide.* The STARRS research program is a good start but the timeline and scope need to be carefully reviewed to determine if more practical and timely results are possible. Some of these early research results should include information on issues such as triggers, risk factors, mTBI and mental health conditions.

4. *DoD should refocus leadership training.* DoD should reassess its current leadership training, policies, and PME programs to enable its leaders to retain the war-fighting skills developed over the last eleven years, while developing and/or reemphasizing garrison leadership skills which might have atrophied over time. DoD should ensure leader development and education programs develop emotionally intelligent leaders who are capable of reinforcing healthy relationships and helping service members developing coping skills and readiness to respond effectively to stressful situations as *Soldier[s] for Life*.
5. *DoD should evaluate and consolidate mandatory training requirements.* The continued trend of adding mandatory requirements without assessing and deleting outdated requirements is resulting in leaders accepting risks in areas such as leader-to-service member engagement and counseling. Leaders are so preoccupied that they may not be focused on detecting signs of suicides in their subordinates.
6. *The Army should refocus on resiliency training.* MRT training should be expanded within PME rather than conducted as a standalone program. CSF2 results should be made available to leaders so that they can identify high-risk individuals, get them the help they need and maintain awareness in the unit. If CSF2 is not a medical program then treating the data generated from it should not be treated as if it falls under HIPAA.
7. *DoD should consider the effects of belongingness as a protective factor. 1)* DoD should leverage partnerships with local organizations such as veterans service organizations and RC facilities to establish belongingness outside the

- unit. 2) DoD should increase post-deployment unit stabilization to increase belongingness and continue service member integration through the highest risk period of the deployment cycle. This is especially true for individual augmentees.
8. *DoD should continue to reduce the stigma associated with seeking help.* DoD should find ways normalize seeking help. DoD should also find ways to allow service members to remain connected with their unit while receiving treatment.
9. *The Army should continue to monitor its policy on prescription medication.*
The Army should consider mandating non-medical approaches as the first line of defense with combat stress reactions. Similarly, the Army should consider reducing the prescription quantity from a 30-day supply for at-risk Soldiers to lower quantities. This technique will increase the frequency of visits for refills, but should reduce on-hand quantities or prescription medications, and possibly reduce the likelihood of a service member overdosing.
10. *DoD should implement more rigorous screening measures for recruits.*
TAPAS can provide additional screening and ensure that recruits are more resilient prior to entering service.
11. *VA and DoD should continue to partner.* VA and DoD should continue to work together to share information and resources to ensure suicide prevention programs are successful with a vision toward developing individuals who serve as *Soldier[s] for Life*.

Conclusion

War changes you. There once was a time when individuals came into the military to strengthen their foundation and straighten out their life. We need to re-take that initiative, help service members start their careers in DoD and provide them a strong foundation in resiliency that the VA then continues to build upon after separation from service. Serving in the military should not increase a veteran's risk of suicide later in their life; we need military programs to *strengthen* the individual and their families.

RAND's 2011 study recommended that all suicide prevention programs should incorporate several best practices, including targeting high-risk individuals and underlying risk factors, facilitating access to and providing quality care, and creating a comprehensive strategy and communications plan. RAND's study focused more on treatment programs and high-risk behaviors as opposed to early intervention and resiliency. The authors of this paper believe that treatment is important, but a comprehensive program should focus on prevention as well; DoD needs to be proactive rather than reactive.

DoD has done much to create new programs and initiatives designed to reduce the risk of future suicides but needs to be proactive by focusing on the four LOEs identified in this paper: leadership, resiliency, belongingness, and policy. However, focusing on the LOEs is not enough. RAND researchers suggested that there is no way to accurately determine if the many local DoD suicide prevention programs are effective because many of the organizations that established these programs do not capture, analyze, or test data. Many recommendations of the 386 USAWC students during the SPE³ seem to reinforce RAND's findings on treatment programs. As a result, given the uncertainty of program implementations and the absence of true metrics for program

effectiveness, there are few ways to tell with certainty which programs are offering true merit or to tell if interventions which are being adapted as each suicide occurs, are effectively reducing other suicides or merely adding to the fog of this war of suicide.

Principles of the scientific method lay the foundation for determining if an intervention is effective. The metrics for prevention programs may not directly correlate with reductions in suicide, but actually get at underlying high-risk behaviors and triggers. The authors recommend that for DoD to implement the recommendations presented above, a strategic approach will involve clearly identifying the key metrics for all suicide prevention programs based on the recommended LOEs, develop instruments to collect data on current suicide programs, then develop the means to analyze the data collected to determine program effectiveness.²²¹ Once the DoD develops the means to evaluate existing and future programs, it should distribute the evaluation criteria to units to serve as the benchmark for all programs. Programs that do not meet the criteria should be terminated, or modified to comply with DoD standards. Programs that demonstrate success should be validated by DoD and packaged for widespread implementation.

The authors of this paper believe that the Army is approaching the issue of suicide as they would any typical “enemy”: with overwhelming force using a shock and awe campaign. While shock and awe may work when facing a conventional “enemy,” it is not the appropriate technique to stem the tide of suicide. Although DoD and each of the services have expended tremendous effort, the host of suicide prevention programs currently in existence may not necessarily complement one another, do not make evident that they contain relevant performance metrics, nor do they demonstrate they effectively extend to the other Services. If the DoD works together to test and share

programs, it can reverse the current suicide trends and strengthen the military foundation. In the final analysis, the collective voice and judgment of over 386 senior leaders during the USAWC's SPE³ helped to guide the critical analyses and insights contained herein. They provided a rare opportunity to offer their judgments and insights from around the world; offering over 386 different perspectives that were formed and shaped by personal experiences and by their review and discussion of existing suicide prevention program policies and implementation across organizations and countries worldwide (e.g., USAWC International Fellows). The true answer for how to reduce suicide within the military and in our veteran population will remain elusive until we have leaders who know and understand how to instill and sustain a sense of belongingness that is greater than any one individual's perception of other problems, have policies that support both the leader and the service member in achieving this objective, and a military culture that promotes a mindset that strengthens the *Soldier for Life*.

Endnotes

¹ Army News, "Army Releases October Suicide Statistics," November 16, 2012, linked from *The United States Army Home Page* at "Army News Service," http://www.army.mil/article/91396/Army_releases_October_suicide_statistics/ (accessed December 15, 2012).

² For the purposes of this paper, the term, "service member" means a member of the uniformed services, as that term is defined in section 101(a)(5) of title 10, United States Code (USC), and title 32 § USC, section 502(a). In this paper, "service member" refers to all AC and RC DoD uniform military personnel. When the term "Soldier" is used it is within the specific context of the U.S. Army, not DoD-wide.

³ George R. Mastroianni and Wilbur J. Scott, "Reframing Suicide in the Military" *Parameters* 41, no. 2 (Summer 2011): 6.

⁴ DoD lists accidents as the number one cause of death in 2001 (422 total); illness as the second leading cause (175 total); self-inflicted (118 total). The authors of this paper interpreted "self-inflicted" to mean acts of suicide. U.S. Department of Defense, Defense Manpower Data Center, "American War and Military Operations Casualties: Lists and Statistics," updated July 3,

2005. <http://www.history.navy.mil/library/online/american%20war%20casualty.htm> (accessed March 7, 2013).

⁵ Army Forces Health Surveillance Center, "Death by suicide while on active duty, active and reserve components, U.S. Armed Forces 2000-2011," *Medical Surveillance Monthly Report Online*, (June 2012): 7. http://www.afhsc.mil/viewMSMR?file=2012/v19_n06.pdf (accessed December 15, 2012).

⁶ U.S. Department of the Army, *Army Health Promotion, Risk Reduction, Suicide Prevention: Report 2010, Army Red Book* (Washington, DC: U.S. Department of the Army, 2012), 11. <http://csf.army.mil/downloads/HP-RR-SPReport2010.pdf>. (accessed December 15, 2012).

⁷ Associated Press. 2012. Military suicides rising, even as combat eases. *Politico*. June 7. <http://www.politico.com/news/stories/0612/77188.html> (accessed December 15, 2012).

⁸ Gregg Zoroya, "Army Suicide rate in July hits highest one-month tally," *USA Today Online*, August 16, 2012. <http://usatoday30.usatoday.com/news/military/story/2012-0809/army-suicides/57096238/1> (accessed December 15, 2012).

⁹ Janet Kemp and Robert Bossarte, "Suicide Data Report 2012," *Department of Veterans Affairs, Mental Health Services Suicide Prevention Program Online*, 18, <http://www.va.gov/opa/docs/Suicide-Data-Report-2012-final.pdf> (accessed February 1, 2013).

¹⁰ U.S. Department of the Army, Office of the Vice Chief of Staff, "Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention (ACPHP)," April 16, 2009.

¹¹ U.S. National Institute of Mental Health, "The Making of Army STARRS: An Overview," (<http://www.nimh.nih.gov/health/topics/suicide-prevention/suicide-prevention-studies/the-making-of-army-starrs-an-overview.shtml>) accessed: February 19, 2013).

¹² Department of Defense, *The Challenge and the Promise: Strengthening the Force, Preventing Suicide, and Saving Lives August 2010*, Final Report of the Department of Defense on the Prevention of Suicide by Members of the Armed Forces (Washington, DC: Department of Defense, 2010), http://www.health.mil/dhb/downloads/Suicide%20Prevention%20Task%20Force%20report%2008-21-10_V4_RLN.pdf (accessed November 19, 2012).

¹³ Ibid.

¹⁴ Two major studies on suicide were conducted by the Center for New American Security (CNAS), "Losing the Battle: The Challenge of Military Suicide," and RAND, *The War Within: Preventing Suicide in the U.S. Military*. Those studies are referenced later in this paper.

¹⁵ HQDA, ALARACT 221/2012: HQDA Execution Order (EXORD) 282-12, Army Stand Down for Suicide Prevention, DTG: 141638Z AUG 12.

¹⁶ In 2009, the Army launched the largest research program of its kind to focus on suicide risk, the Study to Assess Risk and Resilience in Servicemembers (STARRS) in conjunction with the National Institute of Mental Health to "address the Army's concern about the rising suicide

rate among soldiers.” While STARRS is intended to partially address this issue, we should remain open to other research that addresses suicide given its complexity.

¹⁷ Department of Defense, *The Challenge and the Promise: Strengthening the Force, Preventing Suicide, and Saving Lives* August 2010.

¹⁸ U.S. Department of the Army, *Army Red Book*, 106.

¹⁹ *Ibid.*, 46.

²⁰ *Ibid.*, 24.

²¹ Rajeev Ramchand, Joie Acosta, Rachel M. Burns, Lisa H. Jaycox, and Christopher G. Pernin, *The War Within: Preventing Suicide in the U.S. Military* (San Monica, CA: RAND Center for Military Health Policy Research, 2011), xviii-xxiv.

²² Authors of this paper attended two Senior Review Group (SRG) meetings. It appears that despite all of the reports and studies, and all of the home-grown programs, little has changed in stemming the tide of suicide.

²³ Ramchand, Acosta, Burns, Jaycox, and Pernin, *The War Within: Preventing Suicide in the U.S. Military*, xviii-iv.

²⁴ The following is the list of 14 recommendations from RAND’s report: *The War Within: Preventing Suicide in the U.S. Military*: (1) Track suicides and suicide attempts systematically and consistently, (2) Evaluate existing programs and ensure that new programs contain and evaluation component when they are implemented, (3) Include training in skill building particularly help-seeking behavior, in programs and initiatives that raise awareness and promote self-care, (4) Define the scope of what is relevant to preventing suicide, and form partnerships with the Agencies and organizations responsible for initiatives in other areas, (5) Evaluate gatekeeper training, (6) Develop prevention programs based on research and surveillance; selected and indicated programs should be based on clearly identified risk factors specific to military populations and each Service, (7) Ensure that continuity of service and care is maintained when service members or their caregivers transition between installations in a process that respects service members’ privacy and autonomy, (8) Make service members aware of the benefits of accessing behavioral health care, specific policies and repercussions for accessing such care, and conduct research to inform this communication, (9) Make service members aware of the different types of behavioral caregivers available to them, including information on caregivers’ credentials, capabilities, and the confidentiality afforded by each, (10) Improve coordination and communication between caregivers and service providers, (11) Assess whether there is an adequate supply of behavioral health-care professionals and chaplains available to service members, (12) Mandate training on evidence based or state-of-the-art practices for behavioral health generally and in suicide risk assessment and management specifically for chaplains, health-care providers, and behavioral-care professionals, (13) Develop creative strategies to restrict access to lethal means among military service members or those indicated to be at risk of harming themselves, and (14). Ramchand, Acosta, Burns, Jaycox, and Pernin, *The War Within: Preventing Suicide in the U.S. Military*, 109-120. <http://www.rand.org/pubs/monographs/MG953.html> (accessed March 6, 2013).

²⁵ Ramchand, Acosta, Burns, Jaycox, and Pernin, *The War Within: Preventing Suicide in the U.S. Military*, xxiv-v.

²⁶ U.S. Department of the Army, *Army 2020 Generating Health and Discipline: Ahead of the Strategic Reset, Report 2012, Army Gold Book* (Washington, DC: U.S. Department of the Army, 2012), 51-66.

²⁷ Per the *VCSA Sends* memo in the Army Gold Book: “[The Army Gold Book] continues—and in many ways expands—that dialogue, providing a thorough assessment of what we have learned with respect to physical and behavioral health conditions, disciplinary problems, and gaps in Army policy and policy implementation. It provides important information on the challenges confronting our Soldiers and Families, challenges that we must collectively address to reduce the stress on the Force, promote Soldier health and discipline and improve unit readiness. To this end, this report is designed to educate leaders, illuminate critical issues that still must be addressed and provides guidance to leaders who are grappling with these issues on a day-to-day basis.”

²⁸ *Army Red Book* risk factors: individual relationship stressors, life conditions, high risk behavior and medical conditions have been found to increase the likelihood of suicide. The *Army Gold Book* further explored risk factors in more detail and identified additional areas of interest: military work stress, relationship problems, legal history, substance abuse service use, physical health problems, victim of abuse, financial abuse, perpetrator of abuse, spouse/family/friend death, family advocacy program use, spouse/family/friend suicide, and family health problems.

²⁹ U.S. Department of the Army, *Army Gold Book*, 56.

³⁰ U.S. Department of the Army, *Army Gold Book*, 58.

³¹ A wicked problem is defined as a problem for which each attempt to create a solution changes the understanding of the problem and has no given alternative solution. CogNexus Institute, Wicked Problems. <http://www.cognexus.org/id42.htm> (accessed February 28, 2013).

³² U.S. Army War College, *Directive Academic Year 2013, Suicide Prevention: Experiential Education Exercise Applying Strategic Thinking to this National Problem* (Carlisle Barracks, Pennsylvania: U.S. Army War College, 2012), 1.

³³ The USAWC student population for the exercise was comprised of 290 individuals representing Army, Navy, Air Force, Marines, and Coast Guard, 25 individuals from civilian agencies, and 71 international fellows representing 70 different international militaries. All had the opportunity to bring different perspectives to the discussion of suicide.

³⁴ DoD has also recognized the need to better understand mental health risk factors and resilience, and is working with the National Institute of Mental Health to conduct a more in-depth study. Army STARRS Home Page (<http://www.armystarrs.org/node/2> accessed February 19, 2013).

³⁵ The data are through 30 January 2013 and includes statistics for active duty suicides from CY01 - CY12, not on active duty (NAD) suicides from CY03 - CY13, and Department of the Army Civilians (DAC) and family Members (FM) from CY03-CY14. Not on active duty includes

Army National Guard/Army Reserve Soldiers not on active duty in Mobilization Day (MDAY) or Troop Program Unit (TPU) status. Some CY 2012 cases are still under investigation and manner of death could be ruled accidental, undetermined, or otherwise not suicide and will be removed from the Army suicide case inventory. Ms. Sherry Simmons-Coleman from the Department of the Army's Suicide Prevention Program Offices emailed the slides to the author on January 31, 2013. The author converted the slides to black and white to meet Army War College requirements for this SRP.

³⁶ Ed Pilkington, "US Military Struggling to Stop Suicide Epidemic Among War Veterans," *The Guardian Online*, February 2013, (<http://www.guardian.co.uk/world/2013/feb/01/us-military-suicide-epidemic-veteran>) (accessed February 19, 2013).

³⁷ Gregg Zoroya, "Army, Navy suicides at record high," *USA Today Online*, November 18, 2012, <http://www.usatoday.com/story/news/nation/2012/11/18/navy-suicides-army/1702403/> (accessed February 17, 2013).

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³⁹ The data are through 30 January 2013 and includes statistics for active duty suicides from CY01 - CY12, not on active duty (NAD) suicides from CY03 - CY13, and Department of the Army Civilians (DAC) and family Members (FM) from CY03-CY14. Not on active duty includes Army National Guard/Army Reserve Soldiers not on active duty in Mobilization Day (MDAY) or Troop Program Unit (TPU) status. Some CY 2012 cases are still under investigation and manner of death could be ruled accidental, undetermined, or otherwise not suicide and will be removed from the Army suicide case inventory. Ms. Sherry Simmons-Coleman from the Department of the Army's Suicide Prevention Program Offices emailed the slides to the author on January 31, 2013. The author converted the slides to black and white to meet Army War College requirements for this SRP.

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⁴⁶ U.S. Department of the Army, *Army Gold Book*, 57-58.

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⁴⁹ *Ibid.*

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¹⁰⁵ Paul B. Lester, Harms, Mitchel, Herian, Dina Krasikova, and Sarah Beal, "The Comprehensive Soldier Fitness Program Evaluation, Report #3," *Online Report*, (December 2011): 44. www.ppc.sas.upenn.edu/csftechreport3mrt.pdf (accessed February 24, 2013).

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¹⁰⁸ When comparing leadership competencies in *Primal Leadership: Learning to Lead with Emotional Intelligence* — Emotional self-awareness, accurate self-assessment, self-confidence, emotional self-control, transparency, adaptability, achievement, initiative, optimism, empathy, organizational awareness, service, inspirational leadership, influence, developing others, change catalyst conflict management, building bonds, and teamwork and collaboration with the attributes and competencies of leaders from ARDP 6-22 — Army Values, empathy, Warrior Ethos, Discipline, Leaders others, builds trust, extends influence beyond the chain of command, leads by example, communicates, military bearing, fitness, confidence, resilience, creates a positive environment, prepares self, develops others, stewards the profession, mental agility, sound judgment, innovation, interpersonal tact, expertise, gets results — it is clear that the two publication share similar definitions thought ARDP 6-22 does not define them as such.

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¹¹⁴ Ibid.

¹¹⁵ U.S. Department of the Army, *Army Red Book*, 4.

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APPENDIX A

USAWC Suicide Prevention Experiential Education Exercise (SPE³)

Category	Problem Identified	Recommendation
Belongingness	Religion needs to be a component of spirituality.	Commanders should ensure unit-based religious support.
Belongingness	A large percentage of the population at risk desires more control and connection to their environment.	Create anonymous virtual help environments to assist in coping and direct to further help if needed.
Belongingness	Leaders help reinforce the stigma of seeking help when they do not attend counseling sessions themselves.	- Mandatory counseling for all legal commanders and their senior enlisted counterpart. - Include regular counseling as a part of all routine health care (PHA).
Belongingness	Reduce stigma by normalizing behavioral health.	Update DA PAM 600-24.
Belongingness	No standardized method to identify and track high-risk service members.	Establish protocol policy for transfer of high-risk service members' information between units.
Belongingness	The military places too much emphasis on detection and surveillance processes which are mechanistic, formal, ineffective, and easily manipulative.	- When service members disclose personal information/issues, it causes overreaction and unnecessary follow-up by the institution. - Stabilize units for 180 days post-deployment and encourage leaders (both officers and NCOs) to engage with service members. - Create more opportunities for peer-to-peer counseling. - Deemphasize institutional methods.
Belongingness	Army has created a culture that proliferates a focus on the individual (individual barracks rooms, lack of common areas, etc.).	- Consider making barracks more community-focused. - Promote positive military traditions.

Category	Problem Identified	Recommendation
Belongingness	Military policies and practices decrease service member connectedness.	• Revise assignment and force generation policies. • Revise room assignments to ensure unit integrity. • Incorporate spirituality (to include religion) as a source of connectedness and future hope. • Reinforce culture and social military traditions to reinforce spirit de corps, connectedness, and uniqueness of the profession.
Belongingness	Unit cohesion is degrading and reducing the connectedness/sense of belonging in service members.	• Incorporate team-building events as part of quarterly training brief. • Reflect mentorship participation in the NCOER/OER. • Sustain Warrior Adventure Quest. • Provide resourcing for unit day rooms.
Belongingness	Current programs address the symptom and not the root causes of individuals becoming more isolated from peers and their respective organizations.	• Refocus efforts on direct lower-level leadership and cohesive unit team-building. • Avoid over-reliance on electronic means of communication.
Leadership	Know your Soldier and know when to recommend resources.	• Provide junior leader training and education to include prevention and intervention skills. • Increase human engagement programs (leader checks, social events, monthly counseling, etc.) • Examine best practices for encouraging reporting. • Work with lawyers to get HIPAA exemptions.
Leadership	Lack of engaged leaders due to time and resource constraints	• Review all required training and eliminate redundancy. • Incorporate NCO leadership development focused on suicide prevention training.

Category	Problem Identified	Recommendation
Leadership	Difficult to identify high-risk service members.	• Increase leader interaction with service members and their families (command emphasis on sponsorship programs, presence in barracks, team events, etc.). • Greater emphasis on leadership/mentorship effective counseling in basic/career courses and warrior/senior/advanced leader courses.
Leadership	Imbalance between commander accountability and access to service members' medical and criminal records.	• Increase integration between commanders and medical professionals. • Update/change HIPAA laws.
Leadership	Study best practices from other countries.	• Work with the South Koreans to learn from their approach to leadership training for suicide prevention.
Leadership	Need more engaged leaders.	• Re-evaluate current housing policies, PME, HIPAA, WTU, AR 350-1, and overall leadership responsibilities.
Leadership	Discipline needs to be consistent across the force.	• Institute more stringent controls for accountability of DA Form 4833s, such as an automated tracking system updated by the Provost Marshals with view access for commanders. • Adopt better education for commanders on legal actions, ASAP program, and installation urinalysis coordination. • UCMJ authority for drug-involved offenses to O6-level.
Leadership	Reinstitute garrison leadership principles.	• Improve the mechanism for service member performance counseling beyond the current counseling form. • Implement a system that is tied to desired attributes within the framework of the Human Dimension Study.

Category	Problem Identified	Recommendation
Leadership	OPTEMPO is too high and increases stress without need.	• Establish priorities, 350-1 requirements. • Review a day in the life of a company commander. • Review personnel management priorities to avoid high turnover during critical periods.
Policy	There is no organizational structure to allow self-reporting outside the chain of command when service members fear stigma.	• Establish a suicide prevention representative or incorporate into Master Resiliency Trainer (MRT) program and duties. • Provide training for leaders and suicide prevention representatives. • Establish restricted and unrestricted reporting criteria similar to sexual harassment and assault programs (SHARP). • Provide a commander's policy letter on suicide prevention.
Policy	Imbalance between vague and prescriptive rules and regulations.	• Promote the use of DA PAM 600-24 for a healthy command climate.
Policy	Over-prescription of narcotics.	• Doctors should schedule and follow-through with follow-up visits after prescribing narcotics.
Policy	Screening for behavioral health issues is not rigorous enough.	• Review policy regarding privacy regulations. • Review policy to determine what behavioral health conditions are compatible with effective service. • Review procedures by which critical service member information moves between units. • Re-examine the behavioral health system for effectiveness.
Policy	Policy for entry//exit screening does not address overall indicators for likelihood of suicide.	• Provide targeted education for at-risk members and commanders. • Provide commanders with access to health/behavioral data.

Category	Problem Identified	Recommendation
Policy	No true method to identify high-risk service members.	- Establish means to maintain counseling file which is accessible by gaining commanders. - Mandate input into DTMS-like system that provides continuity of information unit-to-unit. - Mandate a system (OIP-like inspection) to ensure compliance.
Policy	Service members are not given a chance to decompress in a non-threatening environment after a stressful event.	Use one of Australia's best practices: units are allowed to drink a limited amount of alcohol in a controlled environment after a stressful event to promote discussion and reduce tension.
Policy	Medical records are not transferred unit-to-unit efficiently.	Create an electronic tracking system that moves with the service member.
Policy	Service members lose their sense of identity and belongingness once they separate from service.	Create a mechanism that keeps veterans integrated with their military family.
Policy	Delegitimize suicide as an option.	Do not memorialize service members who commit suicide in the same manner as someone who is killed in action, etc.
Policy	Current policy encourages perceptions that suicide is an honorable/acceptable death.	- Increase service member perception that suicide is a selfish act outside of military values. - Increase value placed on team, unit and family needs. - Conduct remembrance v memorial ceremonies in order to deglamorize. - Line of duty "NO" emphasizes suicide is outside military values.
Policy	The Army/military does not fully understand the problem.	- Use the Army War College to create: elective, strategic research project, red team on suicide. - Conduct research individuals who attempt suicide and other long-term studies.

Category	Problem Identified	Recommendation
Policy	We have not identified risk factors early enough to prevent suicidal tendencies.	• Increase risk assessment tools such as FORSCOM Risk Assessment Tool (FRAT), in conjunction with 360 degree input. • Use at all levels of training. • Increase awareness, enforcement and accountability. • Involve leaders by creating a dashboard for each service member.
Policy	Unclear root causes of suicide.	• Conduct a long-term study with a diverse team of military and civilian experts to identify root causes.
Policy	Suicide is perceived by many as a viable course of action.	• Provide messaging that seeking help is okay and suicide is not an acceptable means of coping. • Provide service members and leaders life coping skills. • Remove the stigma for treatment and self-reporting. • Dis-incentivize suicide (honors, SGLI, retirement benefits). • Encourage national-level suicide awareness and prevention program.
Policy	Strategic messaging is unclear: suicide is not the fault of the individual service member, but the fault of the community. This effectively relieves the service member of responsibility for him/herself.	• Message should be changed to say: seeking help is okay. Suicide is wrong.

Category	Problem Identified	Recommendation
Policy	Increased emphasis on suicide awareness has unintentionally caused presented suicide as an option and encouraged self-perpetuating behavior.	• Reorient strategic message to be clear that suicide is wrong. • Place increased emphasis on spiritual fitness as a practice as opposed to a prevention measure. • Consider changes to military/veteran benefits for individuals who choose suicide as an option. • Sustain programs designed to address high-risk behaviors.
Policy	Strategic messaging can be read as glamorizing suicide.	• Increase messaging to discuss the value of an individual to family and promote self-identity and worth. • Target strategic messaging in the aftermath of a suicide to reinforce that it is not an appropriate life choice.
Policy	Messaging for suicide using the words “problem” and “enemy” alienate at-risk service members.	• Use mental health experts to help create appropriate strategic messages.
Policy	Focus on suicide education, not training.	• Future-focused prevention not after-the-fact training and incorporated into all levels of education.
Policy; Belongingness	Multiple (and possibly duplicative) suicide prevention programs in an austere environment. Lack of social connectedness.	• Reassess all suicide prevention programs and stop the additive trend to reduce time burdens and increase effectiveness through team-building.
Resiliency	Society is not producing a resilient culture with positive coping skills.	• Revise accession procedures to be more selective of individuals brought into military service. • Initiate mental health screening as a part of the enlistment process. • Include resiliency training during basic training.
Resiliency	Need to better recruit, train, and sustain a more resilient force.	• Increase resiliency and coping skills training.

Category	Problem Identified	Recommendation
Resiliency	The five pillars of CSF do not encompass individual decision-making skills component—cognitive or psychological.	Examine CSF and consider three pillars: physical, mental, spiritual.
Resiliency	Resiliency training is focusing on allowing service members to be vulnerable when that is contradictory to their warrior ethos.	Resiliency training should focus on toughness, not vulnerabilities.
Resiliency	Add resiliency training to current training modules.	Add resiliency training to AR 350-1.
Resiliency	Families do not fully understand the stress and tempo service members undergo.	Mandate that family members attend education classes so that they can become part of a suicide prevention strategy.
Resiliency	Suicide is a permanent solution to a temporary problem. Society has become more insular and individual-rights focused, removing opportunities for interaction which provides informal opportunities for surveillance and outlet.	- Educate leaders on how to create a culture of interaction through both formal/informal methods - Empower leaders to provide opportunities for interaction, even though these may seemingly be at odds with individual rights. - Educate leaders on what it means to be a leader at every level. - Capitalize on social media to interact with a generation that increasingly relies on this medium of communication.
Resiliency	Suicide has become more socially acceptable.	- Awareness campaign needs to begin in the generating force. - Change bullet three of the Warrior Ethos to “I will never quit on my comrades or myself.”
Resiliency	Society unintentionally reinforces problems of helplessness through emphasis of blame diffusion (“it’s the system”) and lack of personal accountability.	- Create a consistent understanding and enforcement of the commander’s authority under HIPAA. - Capture message from healthcare providers as it is sent to service members.

Category	Problem Identified	Recommendation
Resiliency; Belongingness	Manpower requirements over the past decade required an overall lowering of standards for service member accessions, and mental health is not adequately addressed. Need to recruit resilient people.	• Train and incentivize recruiters to conduct high risk counseling. • Provide intensive mental health screening as part of MEPS. • Increase mental health providers and resources. • Create separation standards and push authority down to the lowest level. • Include suicide prevention strategies into Professional military Education System at every level. • Prompt cultural change through using suicide prevention as a leader skill. • Train coping/team-building skills for life as early as JROTC. • Train service members in basic skills and high risk behavior identification.
Resiliency; Belongingness	Lack of life, coping and conflict resolution skills are a problem for many service members.	• Incorporate resiliency training earlier in career to include follow-on training. • Provide greater emphasis on team and cohesion-building within organizations, starting with initial entry and continuing throughout service member development. • Institute more family and community bonding activities.

APPENDIX B

Assessment of Suicide Prevention Programs across the Soldier Life Cycle

Years in Service*		-4 to 0				0-3			3-6				6-10			10-20			
	Course	W/OCS	OCS	ROTC	BCT	W/LC	W/OBC	BO/LC	ALC	SLC	W/OAC	CCC	W/OBC	ILE/CGSC	CO1SG PCC	BN/BDE PCC	SMC	W/OSSC	SSC
Time in Hours		1			2	3	10	10	2	2	2	2	1.5	1.5	1		2	1	1
Testing							2:25 Spent in Written Practical Exercise	2:25 Spent in Written Practical Exercise											
Instructor-to-Student ratio					1:60	1:30	1:45	1:45	1:16	1:16	1:16						1:30		
TLOs																			
	Introduction to CSF	x																	
	Concepts dispersed in class topics as health, fitness, stress management, communication, leadership, and evaluation.		x																
	Discussion of resilience, teamwork, buddy aid, and our initial reactions to situations and events				x														
	Identification of techniques to "check and adjust" initial reactions and energy management to ensure optimal performance				x														
	Describing the effects of leadership and Assertive Communication in assuring Soldier resilience					x													
	Describing the IDEAL model and the resilience skill of Putting It In Perspective (PIIP)					x													
	Describing the resilience skill of Active Constructive Responding (ACR) and Praise					x													
	Hunt the Good Stuff and ATC (Module One)						x	x											
	Thinking Traps, Icebergs, Energy Management (Module Two)						x	x											
	Problem Solving, Put It In Perspective, Real-Time Resilience (Module Three)						x	x											
	Character Strengths, ACR and Praise (Module Four)						x	x											
	Effective Communication, Comprehensive Review (Module Five)						x	x											
	Discussing key principles and identifying leader skills that enhance resilience and mitigate the impact of combat and operational stress reactions								x										
	Reviewing behavioral health symptom indicators, referral resources and actions leaders can take to reduce behavioral health related stigma								x										
	Describing the realities of combat and operational deployments and the role leaders have in ensuring Soldier resilience within this environment									x	x	x							
	Discussing the critical role leaders have in managing traumatic events and their support of Soldiers when these events occur within an organization									x	x	x							
	Describe a leader's role in building resilience in Soldiers and organizations.												x	x					

APPENDIX C

Glossary

AC - Active Component

ACPHP - Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention

ADRP - Army Doctrine Reference Publication

AFQT - Armed Forces Qualification Test

APFT - Army Physical Fitness Test

AR - Army Regulation

ARFORGEN - Army Force Generation

ASVAB - Armed Services Vocational Aptitude Battery

BOLC - Basic Officer Leaders Course

CDC - Centers for Disease Control and Prevention

CNAS - Center for a New American Security

CRM - Comprehensive Resilience Modules

CSF2 - Comprehensive Soldier and Family Fitness

CSM Command Sergeant Major

CY - Calendar Year

DA - Department of the Army

DAC - Department of the Army Civilians

DAIG - Department of the Army Inspector General

DA Pam - Department of the Army Pamphlet

DMSS - Defense Medical Surveillance System

DSM-IV-TR - Diagnostic and Statistical Manual of Mental Disorders

DoD - Department of Defense

DoDSER - DoD Suicide Event Report

DoD TF - Department of the Defense Task Force

EI - Emotional Intelligence

FM - Family Members

GAT - Global Assessment Tool

HIPAA - Health Insurance Portability and Accountability Act

IA - Individual Augmentee

iEHR - Integrated Electronic Health Record

IG - Inspector General

LOE - Lines of Effort

MACOM - Major Army Command

MFLC - Military family Life Consultant

MOS - Military Occupational Specialty

MRT - Master Resiliency Training

MSMR - Medical Surveillance Monthly Report

mTBI - mild Traumatic Brain Injury

NAD - Not on Active Duty

NCO - Non-commissioned Officer

NG - National Guard

NFL - National Football League

NVVRs - National Vietnam Veteran's Readjustment Study

OCO - Overseas Contingency Operations

OCOnUS - Outside the Continental United States

OEF - Operation Enduring Freedom

OIF - Operation Iraqi Freedom

OPTEMPO - Operational Tempo

OSD - Office of the Secretary of Defense

PME - Professional Military Education

POW - Prisoner of War

PreDHA - Pre-Deployment Health Assessment

PSMAG - Pacific Standard Magazine

PSP - Peer Support Person

PTSD - Post-Traumatic Stress Disorder

RC - Reserve Component

SECDEF - Secretary of Defense

SMA - Sergeant Major of the Army

SPE³ - Suicide Prevention Experiential Education Exercise

SSRG - Suicide Senior Review Group

SRP - Strategy Research Project

SSRI - Serotonin-Specific Reuptake Inhibitors

STARRS - Study to Assess Risk and Resilience in Service members

STARS - Strategies to Assist Navy Recruits' Success

TAP - Transition Assistance Program

TAPAS - Tailored Adaptive Personality Assessment Screening

TBI - Traumatic Brain Injury

TRADOC - United States Army Training and Doctrine Command

U.S. - United States

USAR - United States Army Reserves

USAWC - United States Army War College

VA - Veterans Affairs

VCSA - Vice Chief of Staff of the Army

VFW - Veterans of Foreign Wars

WO - Warrant Officer

WOCS - Warrant Officer Candidate School

YRRP - Yellow Ribbon Reintegration Program

1SG - First Sergeant