

INCREASED SUICIDES IN THE UNITED STATES ARMY:
IMPROVING THE EFFECTIVENESS OF THE US
ARMY'S SUICIDE PREVENTION PROGRAM

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General Studies

by

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The opinions and conclusions expressed herein are those of the student author and do not necessarily represent the views of the U.S. Army Command and General Staff College or any other governmental agency. (References to this study should include the foregoing statement.)

ABSTRACT

INCREASED SUICIDES IN THE UNITED STATES ARMY: IMPROVING THE EFFECTIVENESS OF THE US ARMY'S SUICIDE PREVENTION PROGRAM, by MAJ Sheila Coker, 99 pages.

The purpose of the US Army Suicide Prevention Program is to improve readiness and minimize suicidal behavior. Despite their best efforts, the US Army's leadership has not identified a means to reduce suicide throughout its ranks. The objective of this study was to explore the program in order to determine whether or not it is effectively preventing suicide, or if the program needs to be revised or replaced by another program that is more effective at achieving its goals. This thesis is solely based on gathered data and personal analysis of research that has already been completed and cited. Through collection and analysis of data, the intent is to provide information to assist in determining an understanding of where the disconnect lies (if there is one) between the Army's Suicide Prevention Program and the rising rate of Soldier suicide. There is no absolute way to determine if the suicide rates would have been as high or even higher had the Army not implemented the Suicide Prevention Program. The rates have, however, continued to increase and have not decreased; therefore, one cannot declare the program as successful.

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Finally, I dedicate this thesis to my brother, Ronald (Ronnie) Alan Franks. Not one day goes by that we do not miss you and wish you were still here with us. I pray that this work honors your memory, and that the research I have provided may help prevent others from experiencing the pain of suicide.

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ACRONYMS

ACE	Ask, Care, Escort
AR	Army Regulation
ARNG	Army National Guard
ASIST	Applied Suicide Intervention Skills Training
DA	Department of the Army
DoD	Department of Defense
DoDSER	Department of Defense Suicide Event Report
DSPO	Defense Suicide Prevention Office
HASC	House Armed Services Committee
LTG	Lieutenant General
PTSD	Post Traumatic Stress Disorder
STARRS	Study To Assess Risk and Resilience in Service members
TBI	Traumatic Brain Injury
US	United States
USAR	United States Army Reserve
VA	Department of Veterans Affairs

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CHAPTER 1

INTRODUCTION

Since late 2001, U.S. military forces have been engaged in conflicts around the globe, most notably in Iraq and Afghanistan. These conflicts have exacted a substantial toll on Soldiers, marines, sailors, and airmen, and this toll goes beyond the well-publicized casualty figures. It extends to the stress that repetitive deployments can have on the individual service member and his or her family. This stress can manifest itself in different ways—increased divorce rates, spouse and child abuse, mental distress, substance abuse—but one of the most troubling manifestations is suicides, which are increasing across the Department of Defense (DoD).

— Ramchand et al., *The War Within: Preventing Suicide in the US Military*

While various definitions describe [the act of] suicide, the Merriam-Webster Online Dictionary defines suicide as the act or an instance of taking one's own life voluntarily and intentionally especially by a person of years of discretion and of sound mind (Merriam-Webster 2013). In essence, suicide is a self-inflicted act that results in death to the person who completes it. Although some individuals view suicide as honorable or ceremonial because of cultural backgrounds, religious beliefs, or other reasons, in this thesis the term suicide refers to individuals that kill themselves to escape their feelings or as a solution to their problem (Khoshaba 2012). Suicide is not simply a tragedy; it is an exceptionally heart-wrenching event that affects the lives of those left behind forever. Once a person commits suicide, family, friends, and associates, often referred to as "survivors," are left perpetually asking unanswerable questions such as, "Why?" "Why did they choose to leave us this way?" "Why didn't we see the signs?" or "What could we have done to prevent this from happening?" Those questions may be too difficult or many times impossible to answer. One person's reason(s) for suicide may not

be true for another. Some individuals who attempt or even consider suicide may seek help knowing that suicide is not a viable solution. Perhaps they have experienced thoughts of suicide, or suicidal ideation, but understand the outcome and may choose to seek counsel either through clergy or through mental health channels. “Suicide is perhaps the most complex and severest outcome of co morbidity and life stressors” (DA 2012b, 51). But just as each suicide is unique, the methods used to prevent it cannot be conventional. Treatment of one person may not work for another; there is no “one size fits all” approach to preventing suicide. As former Army Deputy Chief of Staff of Personnel, (then) Major General Thomas Bostick, stated, “It’s very, very difficult to assess the effectiveness of the programs. I think some are very early, some are still in the progress of piloting and, because it’s not one solution fits all, we really need to come at this at multiple levels from multiple directions. It is very, very complex” (Wong 2011, 1).

Suicidal ideation is a term that is defined in Army Regulation (AR) 600-63, *Army Health Promotion*, as, “any self-reported thoughts of engaging in suicide-related behaviors (without an attempt)” (DA 2007, 38). Those experiencing suicidal ideation may write a suicide note, overdose on potentially fatal drugs, or make a physical attempt on their life that is unsuccessful either because the individual was inaudibly crying out for help or because their attempt was ineffective or prevented in time (Ramchand et al. 2011, 8). Throughout 2008-2009, almost four percent of adults in the United States (US) admitted to experiencing genuine suicidal thoughts, one percent made a suicide plan and 0.5 percent attempted suicide, as compared to the 0.01 percent national rate of those that completed suicide (Substance Abuse and Mental Health Services Administration 2010). According to the Department of Defense (DoD) 2011 Health Related Behaviors Survey

of Active Duty Military Personnel, within the ranks of the military 7.9 percent reported suicidal ideation since joining the service, while 1.3 percent reported actually having attempted suicide since they joined (Barlas et al. 2013). These statistics demonstrate that a great number of individuals have thoughts about taking their own life or wishing they were dead, but a smaller number actually attempt to end their own lives. Accordingly, it is important that researchers address and explore suicidal ideation as it offers understanding of suicide in view of the fact that attempts that are not fatal are the strongest predictors of future attempts (Ramchand et al. 2011, 28). “For every person who dies by suicide, about 25 others attempt suicide, and even more have ideations about taking their own lives” (DA 2012a, 6). Sadly, most individuals who attempt suicide complete it on their first time, but fortunately the majority of those who do not die as a result of their first attempt often do not actually commit suicide (Ramchand et al. 2011, 28).

Purpose of Study

According to the Department of Veterans Affairs and the Centers for Disease Control and Prevention, at least 30,137 members of the Armed Forces and veterans have committed suicide since the Department of Defense began closely tracking these incidents in 2009. (United States Senate 2013a, 2)

The purpose of this study is to explore the US Army’s Suicide Prevention Program in order to highlight the importance of a shared understanding of the program, its advantages, and to narrow the knowledge gaps within the Army formation. This data concentrates on all active duty Soldiers, as well as Soldiers serving in the US Army National Guard (ARNG) and US Army Reserve (USAR), both while on active duty and while not on active duty. Sections of the thesis discuss Army veterans and Department of

the Army (DA) civilians; however, researching information pertaining to those groups does not assist in answering the primary research question. While some of the statistics encompass all branches of the military, this thesis specifically focuses on Soldiers serving in the US Army, including active duty, ARNG, and USAR.

Issues

There are a number of significant issues that are addressed in this research. Three principal issues concentrated on in this research paper include:

1. Suicides in the US Army in 2012 exceeded the number of combat deaths in Afghanistan. Considering the US Army has been actively engaged in war over the last decade, and is still in a state of war, the fact that the number of suicides outnumbers combat deaths is alarming.

2. The current Army suicide prevention program has been active since 2009, yet the suicide rates have continued to rise.

3. Many Soldiers are not adequately prepared for or equipped with the tools needed to identify risks or obtain coping skills in life.

The Problem

“Taking care of soldiers is one of our top priorities. It is not just a necessity but a moral imperative,” Secretary of the Army John McHugh stated at a news conference held at Joint Base Lewis-McChord in February 2013 (Reuters 2013). It goes without saying that Soldiers are the Army’s most valuable asset. Without Soldiers, there is no Army; without an Army, the national defense may be compromised. If a Soldier’s experience causes them to feel so hopeless that they decide to end their lives, not only does the Army

lose a Soldier, but families are stripped of daughters, sons, wives, husbands, mothers, fathers, sisters, and brothers. Regardless if the issue that caused the Soldier to commit suicide was a result of an Army experience or if it had nothing to do with their military assignment, Army leaders must continue to be zealous with measures of preventing suicides within its ranks (McLaughlin 2012).

One possible response to this issue is conceivably that the Army's current Suicide Prevention Program should be modified or completely made over into a new program that builds on the Army Profession and Leader Development. Doing nothing to prevent suicide is obviously not a practical option for the Army, but if proof of effectiveness is in the statistics (that indicate the suicide rate is rising), then the current suicide prevention program could be considered as failing.

Identifying clearly what the problem is provides a critical stepping stone to solving that problem, but frequently we stop when we define components—pieces and parts—of problems before we get to the underlying problem itself. This process is similar to a doctor's only defining a patient's symptoms without making a complete diagnosis of the disease. (Kem 2012, 9)

Primary Research Question

During the course of this study, the primary research question for this thesis is, “Does the US Army's Suicide Prevention Program effectively prevent or reduce the rate of suicide?”

Secondary Research Questions

To facilitate the research of the primary question, the following secondary questions must be answered:

1. What statistics can be used to measure the true effectiveness of the US Army's Suicide Prevention Program?

2. What training techniques does the US Army Suicide Prevention Program incorporate and are these methods effective across demographics?
3. How does the Army's Suicide Prevention Program prevent or reduce the rate of suicide?

Tertiary Research Questions

There are also a number of tertiary questions that support the research. The three questions that further augment this study are:

1. What gaps can be identified in the US Army's Suicide Prevention Program?
Are the gaps manageable?
2. Why has the amount of reporting increased since the implementation of the current Army Suicide Prevention Program?
3. How would incorporating life skills training into annual training requirements help reduce suicides in the US Army?

Thesis Statement

The Army has taken an aggressive approach with its suicide prevention program. The Army G-1 is the proponent charged with the lead on designing, implementing, and analyzing the suicide prevention initiative. The mission of the US Army G-1 Suicide Prevention Program is to:

Improve readiness through the development and enhancement of the Army Suicide Prevention Program policies designed to minimize suicidal behavior, thereby preserving mission effectiveness through individual readiness for Soldiers, their families, and DA Civilians. (Army G-1 2013)

Instead of suicide rates declining since the induction of the program in 2009, rates have continued to rise, frustrating individuals who have attempted to save lives by applying

suicide prevention measures. “The true impact of Army suicide prevention efforts is unknown; like any prevention program, it can be hard if not impossible to measure its effectiveness” (DA 2012b, 55). Identifying the effectiveness of a program cannot always be established strictly through analyzing statistics, but the ever-increasing rates should cause Army leaders to question if there is a disconnect, or gaps, between the Army’s Suicide Prevention Program and the goal of decreasing the rates of suicide, and address the gaps if they exist.

Assumptions

A number of assumptions are made while formulating this thesis. There are a range of reasons or contributing causes that might provoke an individual to commit suicide (Soreff 2013). This fact leads to the first assumption in this study: unless the Soldier left a note or somehow indicated a specific explanation for their act, one can only assume the reason(s) why they chose to end their lives. Often, no reason is ever determined.

Research suggests, and one may assume that many, or perhaps even most, reported cases of suicide ended their lives to: (1) escape a problem or anticipated consequence, (2) because they believed there was no [other] solution to their problem, or (3) that suicide was the best choice for them in dealing with their circumstance.

Another assumption is that most leaders in the Army are capable of administering effective suicide prevention measures if and when a need arises. The Army’s training prerequisites for leaders, such as the Warrior Leader Course or the Officer Basic Course, promote an environment of caring for Soldiers. Even if a leader cannot personally help a Soldier through their crisis, one can assume that most Army leaders know that resources

are available, and they know who to contact or where to go to get their Soldiers the help they require.

The final assumption is that suicides will not be eliminated regardless of the amount of training or intervention by first line leaders, family members, or friends. There is no perfect, or ideal, suicide prevention program that reaches every individual who considers suicide or experiences suicidal ideation. One can therefore assume that no class or program will completely eradicate suicide, but instead leaders should attempt to reach as many as possible with prevention measures.

Limitations

There are three significant limitations to this study. The first and perhaps most difficult limitation is determining an actual reason for a suicide. So often the reason a Soldier chose to end their life is simply unknown, and at times unknowable. According to Suicide.org, the number one cause for suicide is untreated depression (Caruso 2013b). The Soldier could be experiencing depression, but for whatever reason chooses not to seek treatment. An event or experience may occur that basically induces the Soldier into a depressive state, which could ultimately lead them to commit suicide if not effectively treated for the depression (Caruso 2013b).

The second limitation is cultural beliefs producing presumptions. In the American culture, suicide is considered to be linked to hopelessness, mental illness, and deep depression (Caruso 2013a). While Soldiers understand going into combat may result in death, many consider dying in combat as the most honorable way to die, and reasonably believe they would be honored as a hero if that occurred. Other cultures view suicide as honorable, perhaps resulting in martyrdom for them (Bunting 2005).

The third and final limitation is accurately determining how effective the Army's Suicide Prevention Program truly is at preventing suicide. Surveys are only as useful as the information provided by the respondents. Every individual is not willing to admit to suicidal ideation or attempts even in an anonymous study. Therefore it is improbable to accurately assess the number of Soldiers who, as a result of the Army's Suicide Prevention Program, gained knowledge or opened lines of communication, and were either directly or indirectly prevented from committing suicide. However, analyzing the program and determining if it is effective is not without merit.

Delimitations

Both the DoD and the Department of Veterans Affairs (VA) have made suicide prevention a major focus as a result of the increasing number of suicides by Soldiers and veterans. Because of the attention the topic has received in the media over the past several years, there is no shortage of information readily available to conduct a thorough research of this topic.

Significance of the Study

Although losing a loved one by any circumstance is painful, a loss by suicide is unlike others. It is not the same experience as losing a loved one to natural causes. The person who committed suicide chose to leave their family, their friends, this world, and the people who love and need them. It leaves its survivors asking endless questions, only to receive no answers, regardless of whether or not a note was left explaining the reason for the suicide. It is quite natural for people to try to make sense of a situation, or come up with a solution when faced with a problem. Generally speaking, people want answers

in order to accept an outcome, or at least know how to manage or process it in their minds. When a family member, friend, or acquaintance commits suicide, there is usually no sense or understanding to be made of it.

Being a nation at war over the past decade has undoubtedly led to the Army's increase not only in stress, but also in recruiting and retention of Soldiers, which may have contributed indirectly to the rise in suicide rates. The Army invests in recruiting and retaining its Soldiers, but is "missing something" when it comes to retaining them through suicide prevention measures. On 6 March 2013 in his sworn statement before the House Armed Services Committee Subcommittee on Military Personnel, United States Army Deputy Chief of Staff, G-1, Lieutenant General (LTG) Howard Bromberg testified:

We have invested a tremendous amount of resources and deliberate planning to preserve the All-Volunteer force. Simply put, People are the Army. We have a continued responsibility to the courageous men and women who defend our country to take care of them and their Families. We must not break faith with those who dedicate their lives to serving our nation. (US Senate 2013b, 9)

While the Army invests a great deal in its retention programs, it would seem reasonable that the Army's Suicide Prevention Program should be designed and implemented in a way that truly retains Soldiers by reducing the number lost to suicide. While the DoD has been assertive in tracking suicides, evaluating the effectiveness of the suicide prevention programs, and trying to determine what and where the gaps exist, the answers to why the suicide rates continue to rise instead of decline need to materialize sooner than later.

Summary and Conclusion

The focus of the first chapter was on defining suicide and suicidal ideation, and identifying the problem of suicide which is plaguing the nation and the US Army. Research questions, key assumptions, limitations, and delimitations were presented. Additionally stated was the significance of researching the effectiveness of the Army Suicide Prevention Program and validating the urgent need for a program. The following chapter will be comprised of the literature review of published articles about suicide. Chapter 2 is presented in the following order: recent rates of suicide, demographics of individuals that have committed suicide with comparisons to the national population, named causes of suicide, US Army suicide prevention initiatives, and finally treatment/counseling options. The upcoming chapter will lay the foundation for analyzing the effectiveness of the US Army's Suicide Prevention Program in preventing or reducing the rate of suicide.

CHAPTER 2

LITERATURE REVIEW

As part of the Army's team-based and holistic approach to suicide prevention and stigma reduction, Army chaplains remain committed to fostering a resilient and ready force by enhancing strength, reducing stigma and encouraging help-seeking behaviors.

— Chaplain (Major General) Donald L. Rutherford,
Soldiers Facing Lethal Internal Enemy Off the Battlefield

This thesis involves researching the importance and understanding of the effectiveness of the Army's Suicide Prevention Program. There are a number of sources that discuss the rates of suicide. These sources discuss demographics, causes, and other information critical to understanding the nature of suicide. In this thesis, what has previously been written about this subject was examined.

Recent Rates of Suicide

The latest data available at the time of this writing reveals that suicide accounted for 38,364 deaths in the United States, making it the tenth leading cause of death in 2010. Preliminary data suggests that it will maintain its ranking in 2011 (Centers for Disease Control and Prevention 2013). Not only is suicide a national problem, with rates steadily increasing ever since 2000, over the last decade it has developed into an emergent crisis throughout the military. According to Pentagon officials, while the military suicide rate has risen since 2004, it is still lower than the national average (Burns 2013a). This declaration does little to pacify concerns of the alarming increase in the number of Soldiers committing suicide within its ranks.

The Defense Suicide Prevention Office (DSPO) was established in 2011 as part of the Under Secretary of Defense for Personnel and Readiness. According to the DSPO website, the office is charged with managing all aspects of the DoD suicide and risk reduction programs (Defense Suicide Prevention Office 2013). Jacqueline Garrick, Acting Director of the DSPO, testified to the House Armed Services Committee (HASC) on 21 March 2013 by the Subcommittee on Military Personnel entitled, “Update on Military Suicide Prevention.” At the hearing, Ms. Garrick stated that the national rate in 2010 for males ages 17 to 60, an age demographic most representative of the US Army, increased from 21.8 in 2001 to 25.1 per 100,000, while the service member suicide rate had increased from 10.3 to 18.3 per 100,000.

According to the DoD, the aggregate number of US active duty military members across all branches of the DoD who committed suicide in 2012 reached a record high of 349 (which equates to over 32 per 100,000) compared to 295 combat losses (Burns 2013b). The Army suffered 182 suicides, the Marines 48 suicides, the Air Force 59 suicides, and the Navy had 60 suicides among active duty troops. The DoD also declares that most severely impacted has been the US Army, challenging its leadership to take a more aggressive approach to suicide prevention. The following figure (see figure 1) portrays the suicide rates among active-duty personnel across all branches of the military and the aggregate through 2008, and illustrates the Army’s growing suicide rate since 2004.

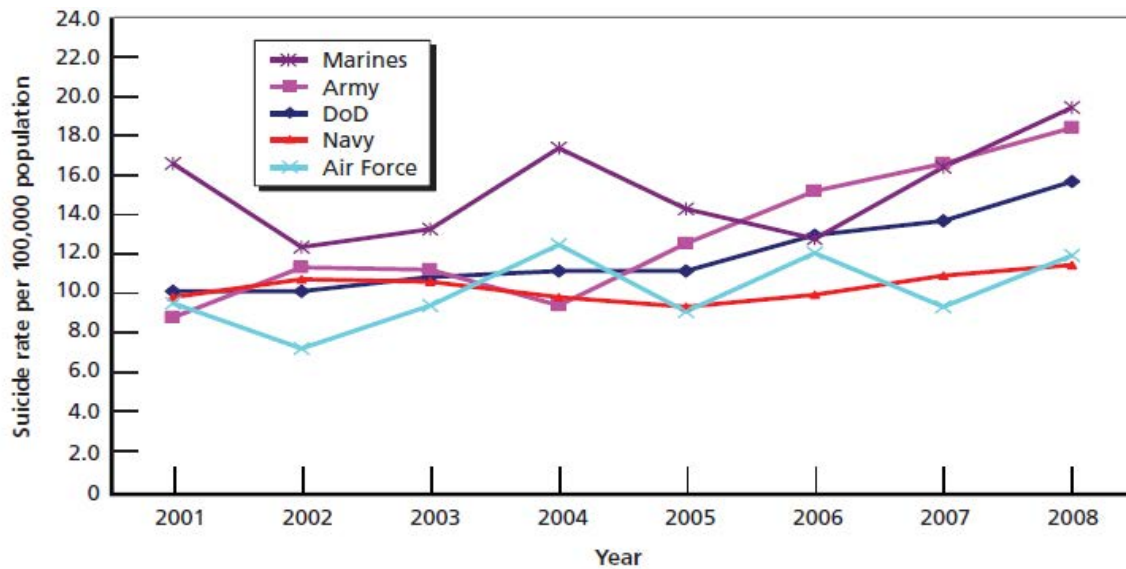


Figure 1. US Department of Defense and Service Suicide Rates, 2001-2008

Source: Rajeev Ramchand, Joie Acosta, Rachel M. Burns, Lisa H. Jaycox, and Christopher G. Pernin, *The War Within: Preventing Suicide in the US Military* (Santa Monica, CA: RAND Corporation, 2011), xiv.

Although the Army has battled to prevent suicide, for almost a decade the numbers continue to rise. According to the 1 February 2013 news release by the Office of the Assistant Secretary of Defense, 325 US Army Soldiers, both active duty and ARNG or USAR, potentially committed suicide in 2012, averaging almost one per day (Ramirez 2013). As of the date of the news release, the confirmed suicides for the US Army in 2012 total 247 Soldiers, of which 130 were active duty, and 117 were ARNG or USAR not on active duty at the time of death. The remaining 78 suspected cases (52 active duty, 26 ARNG/USAR) are still under investigation, of which 90 percent will likely be confirmed.

The news release states that the confirmed suicides for the US Army in 2011 total 283 Soldiers, of which 165 were active duty, and 118 were ARNG or USAR. Table 1 illustrates these statistics.

Table 1. Calendar Year 2012 and Calendar Year 2011 Army Suicides			
2012	Potential	Confirmed	Under investigation
Active Duty	182	130	52
Not on AD -USAR: 47 -ARNG: 96	143	117	26
Total	325	247	78
2011	Potential	Confirmed	Under investigation
Active Duty		165	0
Not on AD -USAR: 36 -ARNG: 82		118	0
Total		283	0

Source: Created by author, data from Military.com, “2012 Military Suicides Hit Record High of 349,” <http://www.military.com/daily-news/2013/01/14/2012-military-suicides-hit-record-high-of-349.html> (accessed 11 February 2013).

It is important to understand the impact not only on the active duty Army, but across the ARNG and USAR, in that, although all groups are Soldiers, causes may not necessarily correlate. According to USAR Chief LTG Jack Stultz, causes identified as being factors for Soldier suicide reflect those of the civilian population, such as financial

trouble, failed relationships, or lack or loss of employment (Miles 2011). At a breakfast in February 2011, LTG Stultz told the Defense Writers Group:

One challenge is that most of the suicides within both the Army Reserve and Army National Guard occur when the soldier is in civilian, rather than military, status. And contrary to what one might expect, most of the reserve-component soldiers who took their own lives had never deployed and were not about to deploy. In fact, some had not yet even attended basic training or started drilling with their reserve units. (Miles 2011)

Suicide can be preventable if signs are displayed and recognized, or if the Soldier is willing and open to receive help. However, these statistics exemplify that although the Army has taken aggressive measures to combat suicide, there is still a deficit or gap, perhaps either in understanding the problem or in accomplishing preventive measures. How has this preventable health problem developed into such a conundrum for the Army's top leadership? Has the Army allowed the problem to get worse by simply executing campaigns to raise suicide awareness while failing to identify and address the root cause of suicide? With the resources allocated to the US Army Suicide Prevention Program, why has the Army not been able to reduce the rate of suicide? Is the US Army treating a complex problem as a complicated problem, which requires a different methodology or course of action? Or perhaps the fundamental question may be, is there any proven method to prevent suicide from occurring?

Demographics

Who commits suicide? Research shows that no one type of individual is immune, but there are categories that are more susceptible than others (Resnick 2012). According to the American Foundation for Suicide Prevention, many share common risk and environmental factors such as untreated depression, alcohol or substance abuse, financial

or legal troubles, or prolonged stress (American Foundation for Suicide Prevention 2013). A remarkable finding by the DoD military suicide review revealed that 53 percent of the Soldiers who committed suicide had not ever deployed to combat, and 85 percent had “no direct combat histories (Kime 2012). In his sworn testimony LTG Bromberg stated:

While physical injuries may be easier to see, there are many invisible wounds such as depression, anxiety [and] post-traumatic stress that also take a significant toll on our service members. Suicidal behavior is an urgent national problem that affects all Americans across all dimensions of society, including those who have chosen to serve the nation. (US Senate 2013b, 1)

Suicide by Soldiers Who Have Deployed

Deployments are considered to be one of the contributing factors for the increase in suicides. “More US Soldiers have died this year (2012) by taking their own lives than on the battlefield. The Pentagon says there have been at least 154 suicides among active-duty troops in 2012, a rate of nearly one each day” (Democracy Now! 2012). The following figure (figure 2) illustrates the suicides that occurred during a Soldier’s deployment. The higher Army rates are due largely to the majority of service members in theater being Soldiers and Marines.

While “approximately 30 percent of Army suicides since 2003 occurred in theater” (Ramchand et al. 2011, 26), most Soldier suicides occurred in the US in personal residences or in residences of friends or family members as depicted in table 2 (Luxton 2012, 130).

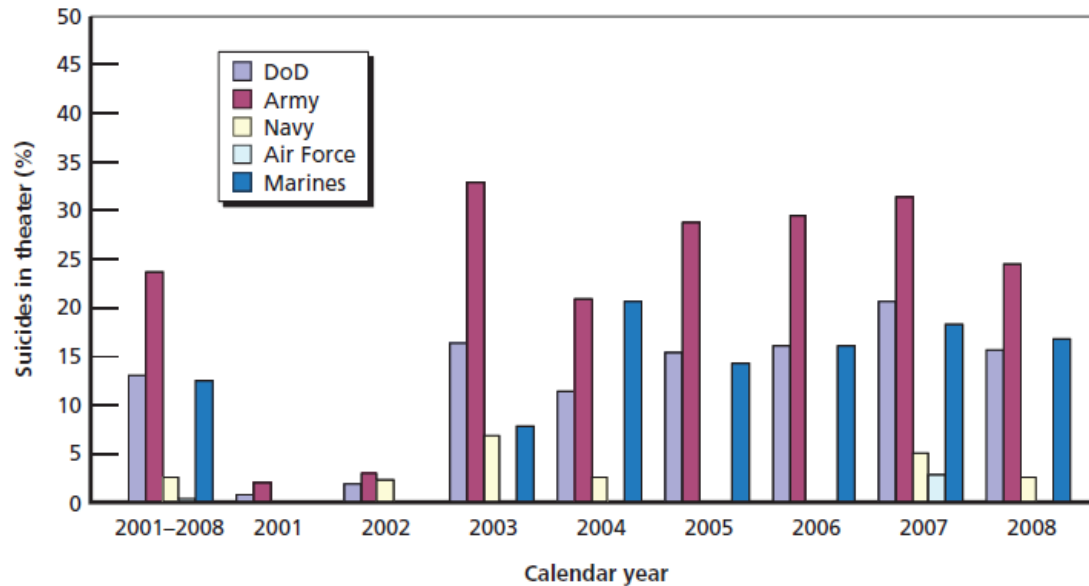


Figure 2. Proportion of Suicides Occurring in Theater, Operation Enduring Freedom and Operation Iraqi Freedom

Source: Rajeev Ramchand, Joie Acosta, Rachel M. Burns, Lisa H. Jaycox, and Christopher G. Pernin, *The War Within: Preventing Suicide in the US Military* (Santa Monica, CA: RAND Corporation, 2011), 26.

Table 2. 2011, 2010, and 2009 Army DoDSER Event Geographic Location

		2011		2010	2009
		Count	Percent	Percent	Percent
GEOGRAPHIC LOCATION	United States	126	79.25%	78.91%	73.20%
	Iraq	9	5.66%	8.16%	14.38%
	Afghanistan	14	8.81%	8.16%	1.96%
	Kuwait	0	0.00%	0.00%	0.00%
	Asia	1	0.63%	3.40%	3.27%
	Europe	7	4.40%	0.68%	4.58%
	Canada or Mexico	0	0.00%	0.00%	0.65%
	Other	0	0.00%	0.68%	1.31%
	Don't Know	2	1.26%	0.00%	0.65%

Source: David D. Luxton, Janyce E. Osenbach, Marc A. Reger, Derek J. Smolenski, Nancy A. Skopp, Nigel E. Bush, and Gregory A. Gahm, *DoDSER Calendar Year 2011 Annual Report* (Washington, DC: Government Printing Office, 15 November 2012), 130.

According to the DoDSER, in 2011, “nine suicides occurred during deployment in Iraq (5.66 percent) and 14 occurred in Afghanistan (8.81 percent)” (Luxton 2012, 130).

Table 3 illustrates the location of Soldier suicides for the years 2009-2011.

Table 3. 2011, 2010, and 2009 Army DoDSER Event Setting

		2011		2010	2009
		Count	Percent	Percent	Percent
EVENT SETTING	Residence (own) or barracks	88	55.35%	53.06%	58.17%
	Residence of friend or family	14	8.81%	12.93%	9.15%
	Work/jobsite	10	6.29%	7.48%	5.23%
	Automobile (away from residence)	11	6.92%	4.76%	6.54%
	Inpatient medical facility	0	0.00%	0.68%	0.00%
	Other	36	22.64%	21.09%	20.92%
	Don't Know	0	0.00%	0.00%	0.00%

Source: David D. Luxton, Janyce E. Osenbach, Marc A. Reger, Derek J. Smolenski, Nancy A. Skopp, Nigel E. Bush, and Gregory A. Gahm, *DoDSER Calendar Year 2011 Annual Report* (Washington, DC: Government Printing Office, 15 November 2012), 130.

Suicide by Veterans

Although this topic is outside of the scope of this thesis, it is an area for future research; the next several pages will support this conclusion. “Almost once an hour—every 65 minutes to be precise—a military veteran commits suicide, says a new investigation by the Department of Veterans Affairs. By far the most extensive study of veteran suicides ever conducted, the report, issued Friday [1 February 2013], examined suicide data from 1999 to 2010” (Haiken 2013). Suicide among veterans is another crisis that deserves, and is receiving, serious attention by the VA. The VA has taken its outreach to those who have relationships with veterans by launching a public awareness

campaign entitled “Stand by Them” designed to educate family members and friends about suicide prevention methods (Donahue 2013). The VA has also given serious attention to the literature it has published concerning suicide by veterans. According to the VA, an estimated 18 veterans die by suicide every day, which is one out of five suicides in the US. “Veterans who die after leaving the military are not included in the death count of America’s wars. And no one, including the Department of Veterans Affairs, seems to know how many Iraq and Afghanistan veterans are killing themselves after they are out of the service” (Janner 2012). The following figures (see figure 3 and 4) demonstrate the estimated number of veteran suicides per day by year from 1999-2010, and the percentage of suicides identified as veteran by year from 1999-2010, respectively.

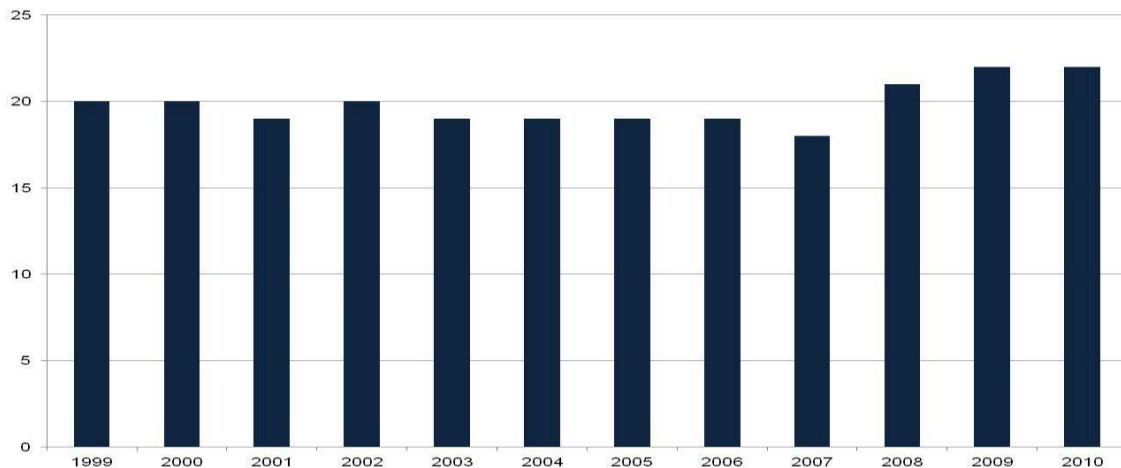


Figure 3. Estimated Number of Veteran Suicides per day by Year

Source: Janet Kemp and Robert Bossarte, *Suicide Data Report 2012* (Department of Veterans Affairs, Mental Health Services Suicide Prevention Program, 2012), 18.

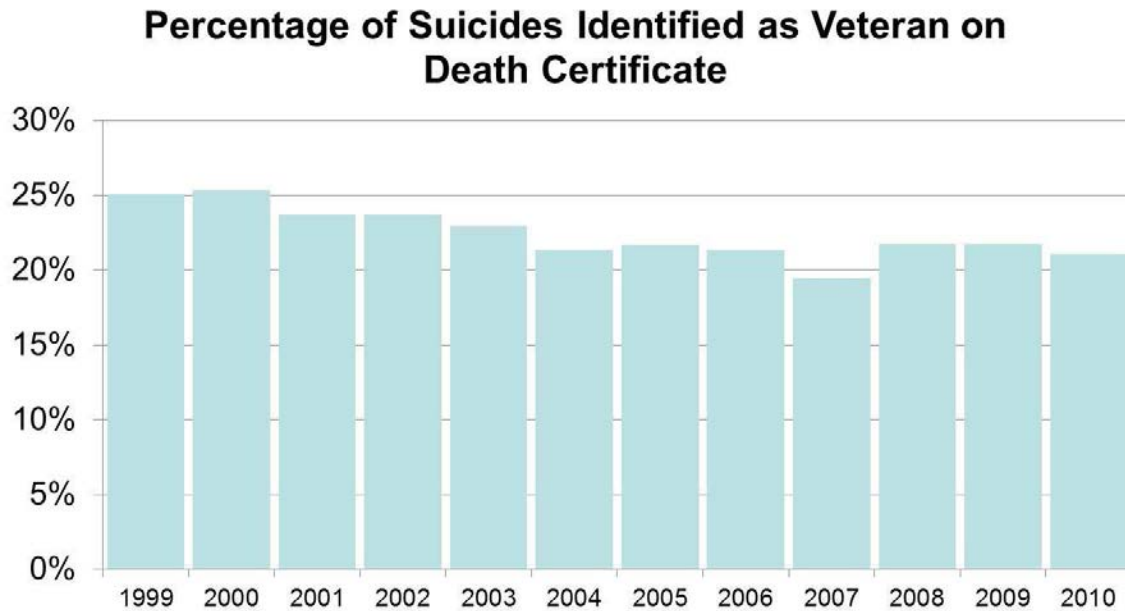


Figure 4. Percentage of Suicides Identified as Veteran by Year (1999-2010)

Source: Janet Kemp and Robert Bossarte, *Suicide Data Report 2012* (Department of Veterans Affairs, Mental Health Services Suicide Prevention Program, 2012), 17.

A constant theme of the US Department of Veterans Affairs is that veterans need to be honored for their sacrifice, which includes proper medical and mental health care after they leave active service. Responding to the VA's report released on 1 February 2013, Secretary Eric Shinseki stated, "We have more work to do and we will use this data to continue to strengthen our suicide prevention efforts and ensure all veterans receive the care they have earned and deserve" (VA 2013, 1). Seemingly, the VA takes this job very seriously, and these words are not simply rhetoric. Although many veterans have had negative experiences at the VA, Secretary Shinseki, a retired US Army four-star General and former Chief of Staff of the Army, is dedicated to improving the quality and care of the nation's veterans.

Medical Linkage

Individuals are screened during the accessions process for behavioral health concerns to determine if they are mentally competent to serve in the US Army. During the upsurge in the war, an increased number of medical waivers were given to individuals with behavioral health issues identified during the accessions process (Boyle 2013). The former Vice Chief of Staff of the Army, General Peter Chiarelli, explained to the Pentagon on 29 July 2010 that waivers were given to recruits that allowed individuals “with certain medical conditions and minor criminal offenses to enlist, helping the Army to meet recruiting goals” (Carden 2010). Furthermore, General Chiarelli stated that some Soldiers “are considered a higher risk for suicide than others” (Carden 2010).

The *Army Health Promotion, Risk Reduction, Suicide Prevention Report 2010*, commonly referred to as the Army Red Book, indicated the increased suicide rates could possibly be linked to the lowering of recruiting and retention standards, which were a residual effect of the rapid pace of continuous deployments (Bumiller 2010). The report states, “Simultaneous with the decreased rate of administrative separation of at-risk Soldiers, the Army brought in more Soldiers with waivers who are potentially at-risk” (DA 2010b, 69). Many new recruits were granted waivers [it said] for behavior that would have kept them out of the service in earlier years” (Bumiller 2010). Furthermore, the report indicated that of the over 80,000 waivers that had been granted since 2004, over 47,000 were granted to individuals with either a past of substance abuse, or had a criminal record. Although some Soldiers were granted more than one waiver, the next figure (figure 5) illustrates a substantial number of waivers were granted from fiscal year 2006 to fiscal year 2008 to meet the increased demand of Army recruits.

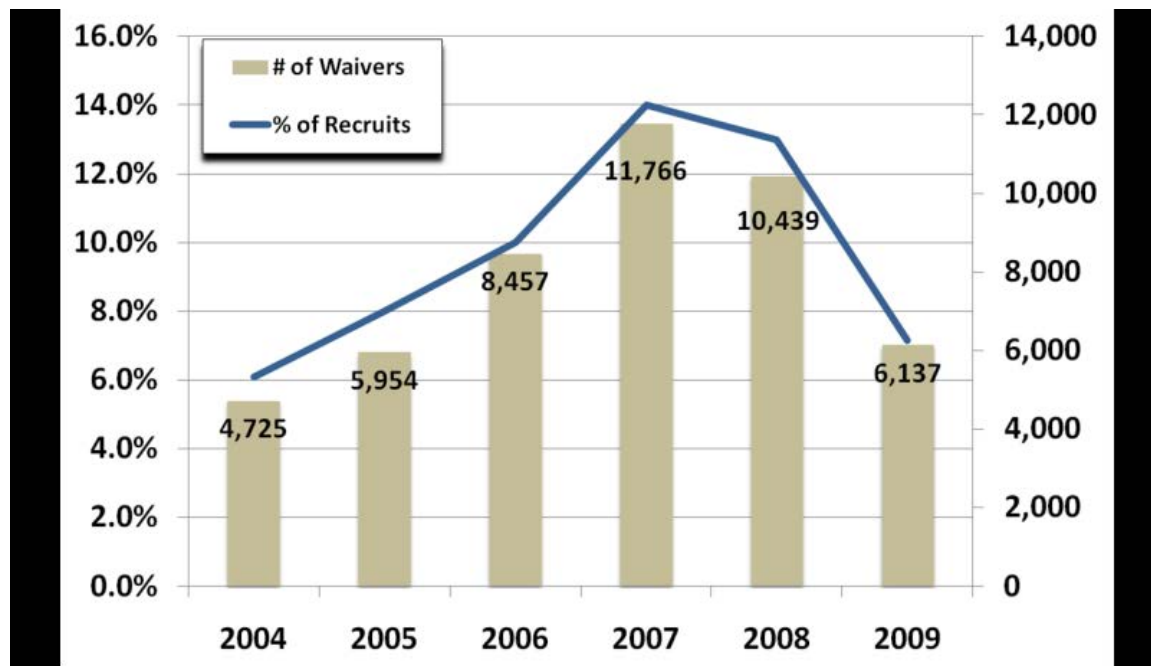


Figure 5. Fiscal Years 2004 to 2009 Drug and Conduct Waivers

Source: Department of the Army, *Army Health Promotion/Risk Reduction/Suicide Prevention Report 2010*, <http://csf2.army.mil/downloads/hp-rr-spreport2010.pdf> (accessed 27 May 2013), 70.

According to Kathleen Welker, US Army Recruiting Command spokesperson, “the Army approved 377 fewer medical waivers for recruits in 2012 than 2011, down 5.7 percent. About 8 percent of new Soldiers have medical waivers” (Boyle 2013). An evaluation, however, of Soldiers who had received accession waivers from fiscal years 2006 to 2010 for health and conduct exposed no considerable correlation between waivers and Soldier suicides (DA 2012b, 142).

Approximately 16% of suicide victims from FY [fiscal year] 2006-10 had received an accessions waiver. However, this percentage is true of all accessions from FY [fiscal year] 2006-10, which means that it is unlikely that waivers provide a meaningful indicator of potential suicide. (DA 2012b, 142)

A follow-up to the Red Book, the *Army 2020: Generating Health and Discipline in the Force Ahead of the Strategic Reset, Report 2012* (Gold Book) augments the Red Book, and provides a current assessment of the US Army Suicide Prevention Program. According to the US Army Gold Book, “Behavioral health issues (comprised of mood and anxiety disorders) were associated with 46 percent of the [Army] suicides.” Table 4 summarizes Soldiers with any behavioral health disorder identified at the time of death (DA 2012b, 57).

Table 4. 2011, 2010, and 2009 Army DoDSER Co morbidity Rates

		2011		2010	2009
		Count	Percent	Percent	Percent
NUMBER OF BEHAVIORAL HEALTH DIAGNOSES	No DX	84	52.83%	54.42%	54.25%
	1 DX	32	20.13%	17.01%	22.22%
	2 DX	17	10.69%	18.37%	13.73%
	3 DX	16	10.06%	4.08%	5.23%
	4 or more DX	10	6.29%	6.12%	4.58%

Source: David D. Luxton, Janyce E. Osenbach, Marc A. Reger, Derek J. Smolenski, Nancy A. Skopp, Nigel E. Bush, and Gregory A. Gahm, *DoDSER Calendar Year 2011 Annual Report* (Washington, DC: Government Printing Office, 15 November 2012), 36.

It is difficult to determine whether a Soldier committed suicide simply or primarily because of their experience(s) in the Army, or if they would have been suicidal even if they had never served. That question is similar to attempting to prove if a person who smoked cigarettes for years and is diagnosed with cancer would have gotten cancer even if they never had smoked. Answering this question with absolute certainty is unfeasible, although analyzing the effectiveness and acceptability of the programs the Army currently employs for suicide prevention is worth pursuing. The methodology

applied analytically combines findings from previous studies and summarizes those using meta-analytic methods. The next table (table 5) illustrates the number of Soldiers who had identified personality disorders, abused substances, or had suffered from traumatic brain injury (TBI).

Table 5. 2011, 2010, and 2009 Army DoDSER Behavioral Health Disorders

		2011		2010	2009
		Count	Percent	Percent	Percent
DX W/PERSONALITY DISORDER	Yes	3	1.89%	3.40%	4.58%
	No	122	76.73%	78.23%	83.01%
	Don't Know	34	21.38%	18.37%	12.42%
DX W/PSYCHOTIC DISORDER	Yes	3	1.89%	0.00%	1.31%
	No	122	76.73%	81.63%	86.93%
	Don't Know	34	21.38%	18.37%	11.76%
HX SUBSTANCE ABUSE	Yes	40	25.16%	27.89%	22.88%
	No	72	45.28%	48.98%	60.13%
	Don't Know	47	29.56%	23.13%	16.99%
DX W/ TRAUMATIC BRAIN INJURY	Yes	7	4.40%	4.08%	
	No	117	73.58%	77.55%	
	Don't Know	35	22.01%	18.37%	

Note: Traumatic Brain Injury data unavailable prior to 2010.

Source: David D. Luxton, Janyce E. Osenbach, Marc A. Reger, Derek J. Smolenski, Nancy A. Skopp, Nigel E. Bush, and Gregory A. Gahm, *DoDSER Calendar Year 2011 Annual Report* (Washington, DC: Government Printing Office, 15 November 2012), 138.

Regardless of proof or mere opinions on whether suicidal tendencies are genetic or are a result of other factors such as alcoholism or TBI or any other reason, the fact remains that the US Army's Suicide Prevention Program in its current state may not be the solution to preventing Soldier suicide.

Substance Abuse

Substance abuse has been directly linked to an elevated risk of suicide (Center for Substance Abuse Treatment 2008, 10). According to the DoDSER’s 2011 annual report, “one-fourth of decedents for whom information was available used alcohol during the suicide event” (Luxton 2012, 131). As illustrated in table 6, fewer Soldiers used drugs than alcohol during suicide, and four Soldiers used both alcohol and drugs during suicide either as the method or in addition to the method used to commit suicide.

Table 6. 2011, 2010, and 2009 Army DoDSER Substance(s) Used During Suicide

		2011		2010	2009
		Count	Percent	Percent	Percent
ALCOHOL USED	Yes	34	21.38%	22.45%	21.57%
	No	38	23.90%	38.10%	39.22%
	Don’t Know	87	54.72%	39.46%	39.22%
ANY DRUGS USED	Yes	12	7.55%	8.84%	5.88%
	No	52	32.70%	44.90%	46.41%
	Don’t Know	95	59.75%	46.26%	47.71%
Illegal drugs	Overdose	0	0.00%	1.36%	0.00%
	Used, no overdose	1	0.63%	1.36%	0.65%
	Were not used	63	39.62%	51.02%	51.63%
	Don’t know	95	59.75%	46.26%	47.71%
Prescription drugs	Overdose	4	2.52%	2.72%	3.92%
	Used, no overdose	4	2.52%	3.40%	0.00%
	Were not used	56	35.22%	47.62%	48.37%
	Don’t know	95	59.75%	46.26%	47.71%
Over the counter drugs	Overdose	5	3.14%	2.04%	1.31%
	Used, no overdose	0	0.00%	0.00%	0.00%
	Were not used	59	37.11%	51.70%	50.98%
	Don’t know	95	59.75%	46.26%	47.71%
BOTH ALCOHOL AND DRUGS USED	Yes	4	2.52%	4.08%	1.31%
	No	57	35.85%	46.94%	47.06%
	Don’t Know	98	61.64%	48.98%	51.63%

Note: Categories are not discrete.

Source: David D. Luxton, Janyce E. Osenbach, Marc A. Reger, Derek J. Smolenski, Nancy A. Skopp, Nigel E. Bush, and Gregory A. Gahm, *DoDSER Calendar Year 2011 Annual Report* (Washington, DC: Government Printing Office, 15 November 2012), 131-132.

Causes of Suicide

Correlation does not prove causality. While there may be a high correlation between one issue and another, a causal relationship cannot (necessarily) be proved or linked to the rising rates of suicide. Many wonder what experience(s) could provoke a Soldier to feel so hopeless that they are convinced that the best course of action is committing suicide. As Vice Chief of Staff of the Army General Peter Chiarelli stated in his testimony before the House Armed Services Committee on 29 July 2009:

Every suicide is as different and as unique as the people themselves. And, the reality is there is no one reason a person decides to commit suicide. That decision reflects a complex combination of factors and events. (DA 2010b, 11)

It would be simple to surmise, albeit without proof, that the increase in the rates of suicide is due to the high operational tempo of our Soldiers deploying to and from Afghanistan and Iraq, or because of the external or internal combat wounds from which they suffered. However, that theory is challenged when, according to Jacqueline Garrick in her sworn testimony, “Less than half had deployed, and few were involved in combat.” In 2012, more Soldiers died by suicide than were killed in combat (Briggs 2013). Although there are multiple causes of suicide, studies name combat stress, financial trouble, prescription medication misuse, and post-traumatic stress as some of the more notable causes (CBN News 2012). Although the exact cause of a suicide may be known because the Soldier told someone their reason either verbally or through a note, it is imperative to point out that one cause may be linked to another. In other words, financial problems may have led to relational problems; or combat stress led to poor work performance which led to disciplinary action; and the list goes on.

Financial Trouble

According to Medill Reports of Chicago, experts claim the nation's economic hardships have contributed to the national suicide rate steadily increasing since 2000, reaching the highest rate in 15 years (Gallucci 2012). As the next table illustrates, many Soldiers who died by suicide in 2011 had a history of considerable debt. In addition, as shown in table 7, several Soldiers who died by suicide in 2011 had a history of experiencing instability in or loss of a job, poor evaluations at work, or workplace strife, which may have led to financial difficulties directly or indirectly (Luxton 2012, 144).

Table 7. 2011, 2010, and 2009 Army DoDSER Financial and Workplace Difficulties

		2011		2010	2009
		Count	Percent	Percent	Percent
EXCESSIVE DEBT/BANKRUPTCY	Yes	13	8.18%	11.56%	7.84%
	No	60	37.74%	46.94%	55.56%
	Don't Know	86	54.09%	41.50%	36.60%
HX JOB LOSS/INSTABILITY	Yes	34	21.38%	21.09%	25.49%
	No	54	33.96%	45.58%	47.06%
	Don't Know	71	44.65%	33.33%	27.45%
HX SUPERVISOR/COWORKER ISSUES	Yes	18	11.32%	13.61%	13.07%
	No	64	40.25%	51.02%	54.90%
	Don't Know	77	48.43%	35.37%	32.03%
HX POOR WORK EVALUATION	Yes	24	15.09%	14.29%	15.69%
	No	62	38.99%	51.70%	58.82%
	Don't Know	73	45.91%	34.01%	25.49%
HX UNIT/WORKPLACE HAZING	Yes	3	1.89%	2.72%	2.61%
	No	72	45.28%	63.27%	62.09%
	Don't Know	84	52.83%	34.01%	35.29%

Source: David D. Luxton, Janyce E. Osenbach, Marc A. Reger, Derek J. Smolenski, Nancy A. Skopp, Nigel E. Bush, and Gregory A. Gahm, *DoDSER Calendar Year 2011 Annual Report* (Washington, DC: Government Printing Office, 15 November 2012), 144.

Failed Relationship

Relationship and family issues may also be attributed to Soldier suicide (Luxton 2012, 140). As stated in the US Army Gold Book, “Failed relationship (intimate or other) was associated with 49 percent of the suicides and 60 percent of the suicide attempts” (DA 2012b, 57). According to the DoDSER, “almost one-half of Service Members who died by suicide in 2011 had a known failure in a spousal or intimate relationship, 29 experienced the failure within the month prior to suicide.” The following table (table 8) illustrates the statistics of Soldiers who died by suicide between 2009 and 2011 that had a history of a failed intimate relationship, history of a failed other relationship, or history of any failed relationship (intimate and/or other) (Luxton 2012, 140).

Table 8. 2011, 2010, and 2009 Army DoDSER Failed Relationships Prior to Suicide

		2011		2010	2009
		Count	Percent	Percent	Percent
HX FAILED INTIMATE RELATIONSHIP	Yes	71	44.65%	51.02%	50.33%
	Within 30 days	36	22.64%	27.89%	27.45%
	Within 90 days (inclusive)*	51	32.08%	33.33%	35.29%
	No	25	15.72%	23.13%	21.57%
	Don't Know	63	39.62%	25.85%	28.10%
HX FAILED OTHER RELATIONSHIP	Yes	13	8.18%	14.29%	15.03%
	Within 30 days	6	3.77%	8.84%	10.46%
	Within 90 days (inclusive)*	10	6.29%	10.88%	11.76%
	No	54	33.96%	42.86%	46.41%
	Don't Know	92	57.86%	42.86%	38.56%
HX ANY FAILED RELATIONSHIP (INTIMATE AND/OR OTHER)	Yes	75	47.17%	53.74%	54.90%
	Within 30 days	38	23.90%	32.65%	31.37%
	Within 90 days (inclusive)*	55	34.59%	38.10%	39.22%
	No	21	13.21%	20.41%	18.95%
	Don't Know	63	39.62%	25.85%	26.14%

*Data presented for “Within 90 days” includes all individuals with history “Within 30 days.”

Source: David D. Luxton, Janyce E. Osenbach, Marc A. Reger, Derek J. Smolenski, Nancy A. Skopp, Nigel E. Bush, and Gregory A. Gahm, *DoDSER Calendar Year 2011 Annual Report* (Washington, DC: Government Printing Office, 15 November 2012), 140.

Post Traumatic Stress Disorder (PTSD)

Psychological wounds are indisputable, although they are frequently unseen by simply observing a Soldier. According to the US Army Gold Book, behavioral health issues, which include PTSD, are rising (DA 2012b, 12). “PTSD is defined based on three sets of symptoms: “re-experiencing, avoidance or emotional detachment, and physiological hyper arousal. There may also be guilt or a strong urge to use alcohol or drugs (“self-medication”) to try to get sleep or not think about things that happened downrange” (DA 2012b, 22). Symptoms that impair function and continue for at least 30 days are considered to have reached the clinical disorder threshold (DA 2012b, 22).

Figure 6 highlights the number of US Army Soldiers with identified PTSD during the years 2003 through 2010.

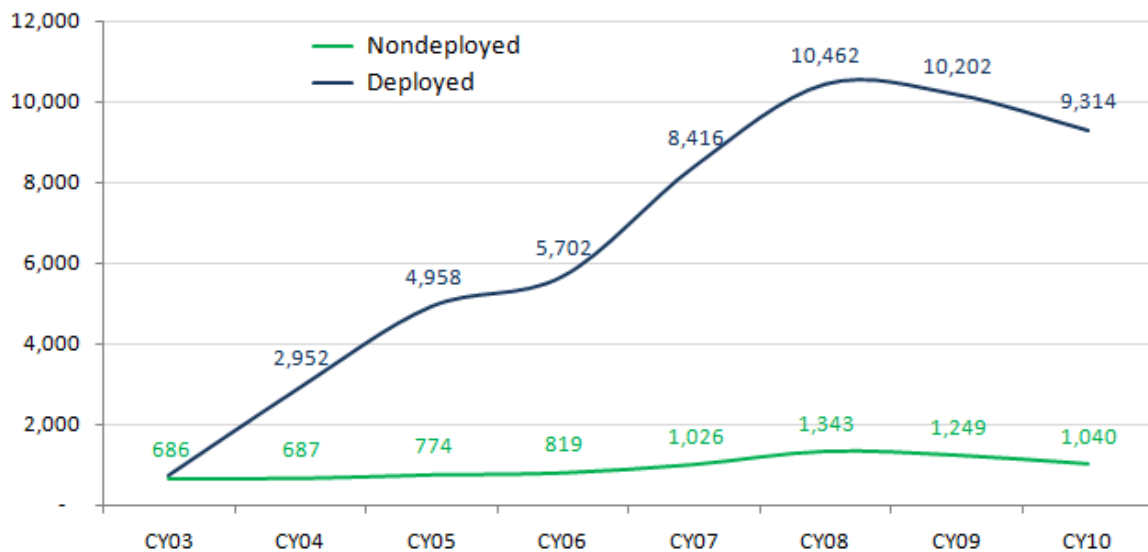


Figure 6. Number of US Army Soldiers With Identified PTSD

Source: United States Army Medical Command, WTC/WTU/MEDCOM services for TBI and PTSD: Overview, 2011, <http://dtf.defense.gov/rwtf/m02/m02pa05.pdf> (accessed 6 May 2013), 5.

Traumatic Brain Injury (TBI)

“Evidence also indicates that persons with concussions, cranial fractures, or cerebral contusions or traumatic intracranial hemorrhages had higher rates of suicide mortality than the general population,” according to Teasdale and Engberg in 2001; and also Simpson and Tate in 2002 and 2005 (Ramchand et al. 2011, xvi). Various events or matters can cause TBI such as bullets, shrapnel, or a blast from an explosive, oftentimes leaving no external physical damage. Many Soldiers suffered from TBIs while deployed to a combat zone from the blast of an improvised explosive device or other type of explosion (Ramchand et al. 2011, 32). Figure 7 illustrates the traumatic brain injury trend for the US Army from 2000 to 2010.

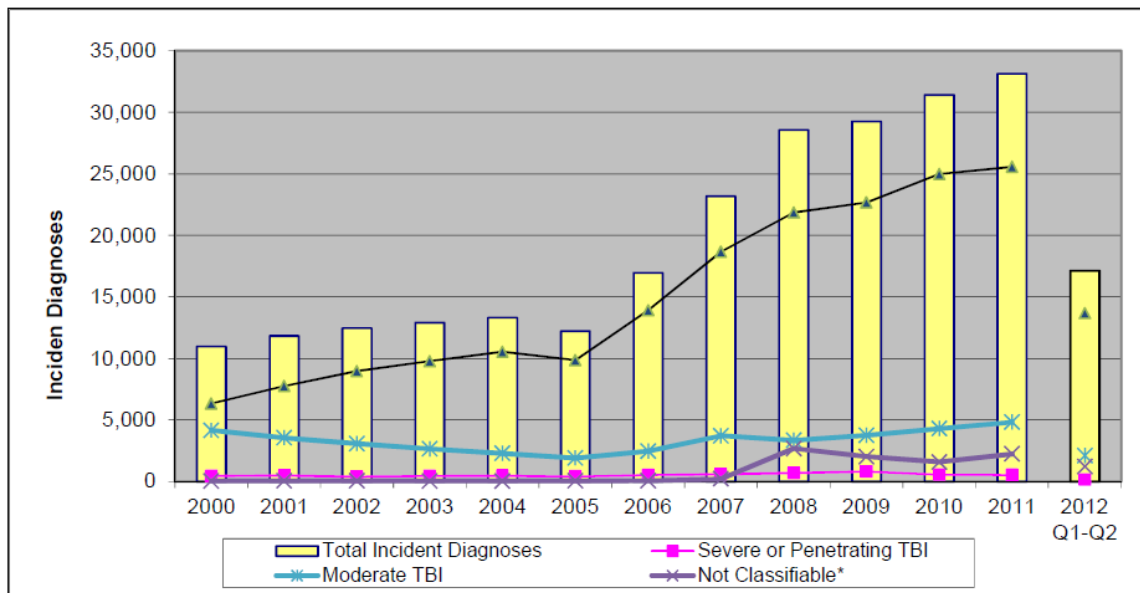


Figure 7. Traumatic Brain Injury 2000-2012

Source: Hannah Fischer, US Military Casualty Statistics: Operation New Dawn, Operation Iraqi Freedom, and Operation Enduring Freedom (Washington, DC: Congressional Research Service, 5 February), <http://www.fas.org/sgp/crs/natsec/RS22452.pdf> (accessed 5 February 2013), 9.

According to the RAND study, “traumatic intracranial hemorrhages each had at least three times the incidence rate of suicide mortality of the general population after adjusting for age and sex” (Ramchand et al. 2011, 32). The US Army screens Soldiers for TBIs, and treats those who have been identified as having suffered from a TBI. Whereas behavioral health issues cannot be detected or diagnosed simply by taking an x-ray photograph, physical brain injuries can and as a result are easier to detect. As of 2011, US Army Medical Command stated there had been over 110,000 diagnosed cases of TBI in the Army (all components) since 2000, the severity ranging from 83,600 mild cases, 17,400 moderate cases; and 3,100 severe/penetrating cases (US Army Medical Command 2011, 21).

Lack of Spirituality

Retired Army Reserve Chaplain (Friar) Peter Sousa, in a phone interview with The Christian Post, shared his viewpoint of young people in the military.

I am speaking from experiences in my perspective, but I do believe that the young people coming into the military today do not have the firm foundation in religious belief that previous generations had. More and more soldiers are saying they have no religious preference. It is very much a spiritual issue, and the Army is aware of this. They have contacted chaplaincies to help our soldiers. They can’t promote a specific religion, but they can promote what they call ‘spiritual fitness’ or ‘spiritual well being.’ (The Christian Post 2012)

The American Journal of Psychiatry published a study in December 2004 entitled, “Religious Affiliation and Suicide Attempt.” The researchers theorized that individuals who considered themselves “religious” objected morally to suicide. The study asked the participants to provide views to statements such as, “I believe only God has the right to end a life,” “My religious beliefs forbid it,” “I am afraid of going to Hell,” and “I consider it morally wrong” (Dervic et al. 2004). The study concluded that “religious

affiliation is associated with significantly lower levels of suicide compared to religiously unaffiliated people, atheists and agnostics” (Dervic et al. 2004). Does this proclamation insist that individuals that are “religious” never commit suicide? Absolutely not; but it asserts that those with religious beliefs are less likely to commit suicide than those with no religious affiliation or foundation.

The military, as an extension of society, has become increasingly more concerned about offending others for their personal beliefs, or lack thereof. “The emphasis has become less on religion and more on spirituality” (Kem 2005, 54). As a result, Soldiers may be afraid of sharing their faith with those that are suicidal for fear of being ridiculed or even punished for doing so. However, sharing one’s faith with a Soldier who is considering suicide may be a way to stop them from doing so. At a minimum, sharing one’s spiritual (or religious) beliefs could get the suicidal Soldier to seek counsel from a mental health professional or Chaplain.

Mental Illness

Research indicates mental illness as a major cause of suicide, as expressed by an individual who suffered from it to the extent that he made a compulsive decision that almost cost him his life. Kevin Hines at the time was a 19-year old from California who attempted to commit suicide on 25 September 2000 when he jumped off the Golden Gate Bridge landing in the water over 200 feet below (Weiss 2005). He declared it to be the “single-worst decision of [his] entire life.” He made his decision while he was suffering from bipolar disorder, and “not in [his] right mind.” According to Suicide.org, 25-50 percent of people with bipolar disorder attempt suicide, which causes individuals with

bipolar disorder to be at high risk for attempting suicide, making diagnosis and treatment crucial to those with the illness (Caruso 2013b).

Genetics

Opinions vary regarding whether people are predisposed to suicidal tendencies. “There is no genetic predisposition to suicide—it does not “run in the family” (University of Notre Dame 2013). “People who want to kill themselves will not always feel suicidal or constantly be at a high risk for suicide. They feel that way until the crisis period passes” (University of Notre Dame 2013). In contrast, according to Genome News Network, there are many medically documented genetic links to suicide in medical literature. A 1985 study in the *American Journal of Medical Genetics* researched the suicide rates of the Southern Pennsylvania Amish (Guynup 2000). Researchers found that 73 percent of all suicides within the population occurred in four of the families, although they made up just 16 percent of that population (Guynup 2000). Psychiatrist Kay Redfield Jamison wrote in her book on suicide, *Night Falls Fast*, “Genes are, of course, only part of the tangle of suicide, but their collision with psychological and environmental elements can prove...to be the difference between life and death” (Guynup 2000).

The Army has developed a suicide prevention program which includes various training methods for Soldiers and leaders. The programs include Applied Suicide Intervention Skills Training (ASIST); Ask, Care, Escort (ACE); and an assortment of videos. The upcoming sections will explain the various mechanisms available to the US Army as part of its suicide prevention efforts, while answering the question, “What gaps can be identified in the US Army’s Suicide Prevention Program.”

Army Suicide Prevention Program

AR 600-63, *Army Health Promotion*, states the purpose of the Army Suicide Prevention Program as “Supports the Army’s goal to minimize suicidal behavior by reducing the risk of suicide for Active Army and Reserve Component Soldiers, Army civilians, and Army Family members. Suicide-prevention programs implement control measures to address and minimize risk factors for suicide while strengthening the factors that mitigate those risks” (DA 2007, 14).

Being the proponent charged with managing the US Army’s Suicide Prevention Program, the Army G-1 has been devoted and fervent in its approach to preventing suicide. Although suicide prevention training is not a new concept to the US Army, the suicide intervention training currently used was approved and implemented in 2009, “for Army leaders and other key personnel who are on the front lines of suicide prevention across the service” (Army Public Affairs 2009). Approximately four years later, the Army’s suicide rates have continued to rise with no clear indicator of where the failure lies in spite of the prevention efforts.

The program focused toward Soldiers, leaders, DA civilians and families is titled ACE Training. The training is approximately one and one half hours long, and is concentrated on awareness training (risk factors and warning signs). ACE training is conducted every year in accordance with AR 600-63 (Army G-1 2013).

The term ‘gatekeepers’ refers to “individuals who, in the performance of their assigned duties and responsibilities, provide specific counseling to Soldiers and [DA] civilians in need” (DA 2009, 86). They are described further as formally trained individuals who serve as the first line of defense to mitigate risk against self-harm of a

Soldier or DA civilian. Gatekeepers are trained to recognize individuals with suicide-related symptoms or issues and assist them. A table of primary and secondary gatekeepers as listed in AR 600-63 is provided in table 9.

Table 9. Primary and Secondary Gatekeepers

Primary Gatekeepers	Secondary Gatekeepers
Chaplains and chaplain assistants	Military police
Army Substance Abuse Program counselors	Trial defense lawyers
Family Advocacy Program workers	Inspectors general
Army Emergency Relief counselors	DoD school workers
Emergency-room medical technicians	Red Cross workers
Medical and dental health professionals	First-line supervisors

Source: Department of the Army, Army Regulation 600-63, *Army Health Promotion* (Washington, DC: Government Printing Office, 7 May 2007), 17.

The Army G-1 program for gatekeepers is the Applied Suicide Intervention Skills Training (ASIST). Gatekeepers attend a two-day training session where they are taught identification and intervention skills. The ASIST Train the Trainer program is a five-day course that provides gatekeepers with the tools needed to train ASIST methods to others, followed by the trained individual conducting three 2-day ASIST classes within the first year and one each subsequent year (Army G-1 2013).

Suicide Prevention Resources

General George W. Casey stated in 2008:

The Army is committed to providing the best resources for suicide awareness, intervention, prevention, and follow-up care – all of which are critical in helping Soldiers and Family members prevent unnecessary loss of life. (Lopez 2008)

An extensive number of Army and non-Army resources are available to Soldiers when it comes to the topic of suicide prevention, which may leave those seeking help confused or cause them delays in getting treatment. Secretary of the Army John McHugh acknowledged the overwhelming number of programs. With all the resources available, if an individual seeks help they have options, but streamlining the process could help Soldiers facing a crisis, and possibly prevent them from being forced from office to office in a time of crisis. The Army G-1 website lists a multitude of references and resources available for those experiencing suicidal thoughts, or to assist if a friend or colleague displays suicidal signs or behaviors. Some of the available programs are described in the following paragraphs.

Army Suicide Prevention Resources

Training Videos

The US Army has a number of videos posted on the Army G-1 website that are available for viewing from the internet. The titles of the videos are:

1. Beyond The Front
2. Home Front
3. Chaplain Notification Online Training (for Army Chaplains performing casualty notification duties)
4. Shoulder to Shoulder-Finding Strength and Hope Together
5. Shoulder to Shoulder: I Will Never Quit (DA Civilian Training)
6. Shoulder to Shoulder: No Soldier Stands Alone
7. SOLDIERS, Stress and Depression: Profiles in Personal Courage
8. Suicide Prevention & Stigma Reduction Message from the Sergeant Major of

the Army

9. Suicide Prevention Month Public Service Announcement from General George Casey (Chief of Staff of the Army) and Sergeant Major Kenneth Preston (Sergeant Major of the Army)
10. Suicide Prevention Vignettes: “US Armed Forces-The Courage to Care”
11. Best Friend
12. Graveyard
13. Suicide Situation
14. Warning Signs

Several of these videos, such as “Beyond the Front,” are referred to as Virtual Experience Immersive Learning Simulation, intended to provide information and generate thoughts about how to react when faced various situations that may occur to Soldiers. The Virtual Experience Immersive Learning Simulation is not designed to provide guidance or policy, but to serve as a tool the US Army can use to conduct training. Through this highly accessible method, Soldiers who are not comfortable asking for help, or those that perceive a Soldier in need of behavioral help can watch the videos from a personal computer or other internet-capable device, and be provided with immediate information or ideas on how to react.

The Army’s training video series title “Shoulder to Shoulder” is an interactive video intended for units to use to get the message to Soldiers that “it’s a sign of strength and courage when you seek help when feeling distressed or intervene with those at risk” (Army G-1 2013). The Army has made viewing this training video a mandatory annual requirement for all Soldiers and DA civilians.

Army Study to Assess Risk and Resilience in Service members (STARRS)

Army STARRS is the largest study of mental health risk and resiliency ever conducted among military personnel. Army STARRS investigators are looking for factors that help protect a Soldier's mental health and factors that put a Soldier's mental health at risk. Army STARRS was designed as a five-year study that will run through 2014; however, research findings are reported as they become available so that they may be applied to ongoing health promotion, risk reduction, and suicide prevention efforts. Because promoting mental health and reducing suicide risk are important for all Americans, the findings from Army STARRS will benefit not only Service members but the nation as a whole.

Commanders Tool Kit for Soldiers and Leaders

The Commanders Tool Kit is designed to assist Leaders at all levels as they implement their Suicide Prevention Program. This Tool Kit was developed so that leaders can incorporate these resources into existing training or create new training. However, this Tool Kit is not meant for leaders only; all Soldiers are encouraged to use the materials (Army G-1 2013). The multiple resources available in the Commanders Tool Kit are:

1. Commander's Suspected Suicide Event Report
2. Army Campaign Plan for Health Promotion
3. Risk Reduction and Suicide Prevention
4. Suicide Prevention Training Aids List
5. US Army Public Health Command
6. Public Health Command Products

7. Public Affairs Guidance for Installation PAO
8. Themes and Trends and Lessons Learned Volumes I-XVII
9. Health Promotion
10. Risk Reduction and Suicide Prevention Talking Points
11. VCSA Sends: Recent Army Suicide Trends
12. Release of Protected Health Information to Unit Command Officials
13. Suicide Prevention and Stigma Reduction Message from the Sergeant Major of the Army
14. Army 2020: Generating Health and Discipline in the Force Ahead of the Strategic Reset, Report 2012 (Gold Book)
15. Department of Defense Suicide Event Report, CY 2010
16. Tri-Signed Letter – Army Gold Book

Commanders play a critical role in the health and well-being of their Soldiers, and therefore require sufficient information to make informed decisions about fitness and duty limitations. I am directing several changes to policy and regulation in order to improve communication between patients and providers, commanders and patients, and commanders and providers. (DA 2012b, 65)

Combat Stress Control Units

Combat stress control detachments or companies are made up of small mobile teams designed to be mobile, and are able to move forward to augment tactical or combat service support units in combat. One unit is comprised of an 11-person combat stress fitness team to run the “combat fitness center,” and three 4-person combat stress control preventive teams that move forward as requested. Combat stress control units practice the five mental health disciplines, including psychiatric nursing and occupational therapy.

Non-Army Suicide Prevention Resources

Americas Heroes at Work

Many Soldiers who sustain TBI and/or suffer from behavioral health concerns, such as post traumatic stress disorder, are no longer able to serve in the US Army. The Americas Heroes at Work program is a US Department of Labor project that addresses some of the challenges veterans face when returning to the civilian workforce. Its focus is predominantly on Soldiers who have returned from Iraq or Afghanistan (Army G-1 2013).

Coaching Into Care

Coaching Into Care provides a “coaching” service for family and friends of veterans who see that their veteran needs help. Coaching involves helping the caller figure out how to motivate their Veteran to seek services. The service is free and provided by licensed clinical social workers and psychologists. The goal of the service is to help the Veteran and family members find the appropriate services in their community (Department of Veterans Affairs 2013).

Grace After Fire

Grace After Fire’s program, *Table Talk: Color Me Camo*, serves as a peer support system designed specifically for women veterans. Table Talk focuses on gender specific aspects through structured interaction with trained facilitators and fellow peers while identifying and addressing barriers women veterans face on the path to positive change. The program provides educational materials and activities that promote self-knowledge,

self-understanding, self-development and self-renewal for the woman veteran (Grace After Fire 2013).

General Chiarelli stated to an audience ranging from family members to members of Congress at an American Red Cross Great Hall of Service event, “There’s absolutely no reason for anyone to suffer in silence. A Soldier who is hit and injured by an [improvised explosive device] would never go untreated, and there’s no difference” (Cronk 2011). Often, Soldiers suffer in private when they are suffering internally or externally. There is a stigma that exists among some in the US Army that if a person gets treatment for a psychological issue, then that person is either weak or mentally unstable (DA 2012b, 69). Further aggravating the problem, Soldiers with security clearances may be afraid of losing their clearance status if they receive treatment, causing them to do nothing, self-medicate, or attempt to end their lives (Terhakopian 2013). Soldiers applying for security clearances must complete a Standard Form 86, Questionnaire for National Security Positions. The form requires disclosure of psychological and emotional health information by answering if health care had been required by the applicant in the past seven years. Officials said surveys have shown that troops feel if they answer “yes” to the question, they could jeopardize their security clearances, required for many occupations in the military” (Baker 2008). To avoid possible negative perceptions by some applicants, the revised questionnaire provides the following disclaimer:

Mental health counseling in and of itself is not a reason to revoke or deny eligibility for access to classified information or for a sensitive position, suitability or fitness to obtain or retain Federal employment, fitness to obtain or retain contract employment, or eligibility for physical or logical access to federally controlled facilities or information systems. (Standard Form 86 Questionnaire for National Security Positions 2010)

Section 21 of the revised Standard Form 86 asks the following question: “In the last seven (7) years, have you consulted with a health care professional regarding an emotional or mental health condition or were you hospitalized for such a condition?” Guidance for the question instructs applicants to answer “no” for counseling that was strictly for marital or family reasons, for grief unrelated to violence by the applicant, or for adjustments strictly related to service in military combat environments, given all those criteria were not court-ordered. If applicants answer “yes,” the Soldier must indicate by whom the treatment or counseling was conducted, and additionally must provide a completed Authorization for Release of Medical Information Pursuant to the Health Insurance Portability and Accountability Act form.

This chapter has provided a review of literature focusing on the reports on suicide, causes, and resources and programs available to address suicide prevention. The next chapter will discuss the research methodology used to answer the primary question, “Does the US Army’s Suicide Prevention Program effectively prevent or reduce the rate of suicide?”

CHAPTER 3

RESEARCH METHODOLOGY

DoD fervently believes that every one life lost to suicide is one too many, and prevention is everybody's responsibility. This fight will take enormous collective action and the implementation of proven and effective initiatives.

— Jacqueline Garrick, Acting Director of Suicide Prevention,
On Military Suicide Prevention

This thesis addresses the research of the effectiveness of the Army's Suicide Prevention Program. The first two chapters introduced the topic and provided a literature review of the study, whereas this chapter will highlight how the analysis will be performed. This research methodology addresses the question "Does the US Army's Suicide Prevention Program effectively prevent or reduce the rate of suicide?" Answering the primary question, while determining with great certainty if the Army's program is effective at minimizing suicidal behavior, can only be accomplished by learning about those that attempted or considered suicide, but chose not to as a result of the program, whether directly or indirectly. Since the act of suicide is considered futile and largely incomprehensible, the most effective method in its prevention cannot be easily ascertained. Therefore, in order to determine the effectiveness of this program, a meta-analysis based on a review of the existing literature of US Army Soldiers suicide rates and the US Army's Suicide Prevention Program will be conducted to analyze existing data and issues in order to reveal whether or not the US Army's Suicide Prevention Program is meeting its intent.

The information gathered is both qualitative and, at times, subjective in nature, and uses recent testimony and data for analysis which includes websites and speeches.

Substantiating if the Army's suicide prevention program is successful can only be measured through statistical analysis of proven suicides in comparison to those that are truthful in admitting they chose not to commit suicide as a result of the Army's Suicide Prevention Program. Furthermore, analysis of this program cannot be confirmed without discrepancy, in that some Soldiers who seriously considered suicide but decided not to as a result of the Army's suicide prevention program cannot be verified with absolute assurance. Much of the evidence lies within the numbers, taking into consideration the population.

In addition to existing quantitative suicide data, this research will focus on the following questions:

1. What statistics can be used to measure the true effectiveness of the US Army's Suicide Prevention Program?
2. What training techniques does the US Army Suicide Prevention Program incorporate and are these methods effective across demographics?
3. How does the Army's Suicide Prevention Program impact preventing or reducing the rate of suicide?
4. What gaps can be identified in the US Army's Suicide Prevention Program?
Are the gaps manageable?
5. Why has the amount of reporting increased since the implementation of the current Army Suicide Prevention Program?
6. How would incorporating life skills training into annual training requirements help reduce suicides in the US Army?

Meta-Analysis

Studies chosen as part of the meta-analysis were those with criteria that assessed the effectiveness or acceptance of suicide prevention techniques. These studies included incidence trends analysis; program examinations; and an evaluation of the efficacy of the prevention measures on individual prevention and receptivity, as well as on institutional or collective reduction and implementation through an assessment of the results. Studies of suicide prevalence and suicide prevention programs in colleges and throughout the civilian population were explored, but not included in the meta-analysis as the demographics are incomparable to those of the US Army, generally speaking.

Literature Review

Through the process of performing the literature review, this research will focus on commonalities shared by Soldiers who committed suicide, and on determining if leaders are able to observe or identify if a Soldier is in need of mental health intervention, ultimately to answer the primary research question, “Does the US Army’s Suicide Prevention Program effectively prevent or reduce the rate of suicide?”

Two by Two Analyses

In this study, the term acceptance refers to whether or not Soldiers are receptive to implementing techniques taught through the US Army Suicide Prevention Program, and if Soldiers apply what they have learned. In order to measure the efficacy of the program, an evaluation will be conducted of the effectiveness of the prevention measures in terms of acceptance to the program. A two by two chart will illustrate the effectiveness of the US Army’s Suicide Prevention Program on individual prevention and receptivity, as well

as on institutional or collective reduction and implementation. The table below frames the assessment to be used during the research.

Table 10. Two by Two Analyses

Unit of Analysis	<u>Effectiveness</u>	<u>Acceptance</u>
Individual (Prevent/Receptive)	2 – Individual level	4 – Individual level
Collective (Reduce)	3 – Collective level	5 – Collective level

Source: Created by author.

Aggregation

The research will evaluate the effectiveness and acceptance of the US Army’s Suicide Prevention Program, both at the individual and collective levels, and present an aggregate of the two.

Threats to Validity

In order to determine if the US Army’s Suicide Prevention Program is effective at preventing suicide, the impact of the program on the acceptability and implementation of it will be considered, causing the research to be primarily qualitative. “Few evaluation methods can be used to measure a program’s effectiveness, where effectiveness is understood to mean the impact of the program” (White House 2013).

The first threat to validity is history. The fact that there were multiple deployments by some Soldiers poses a threat to validity as an atypical circumstance.

The population studied poses a second threat to validity due to the demographics being incomparable to that of the general population. Much of the data available compares Soldiers to the US general population, which skews the data since the general population is comprised demographically different than that of the US Army.

The third threat to validity is intervening effects. Soldiers, who have considered, attempted, or committed suicide may have experienced intervention, while others had not. That fact alone should be taken into consideration when determining the effectiveness of the US Army's Suicide Prevention Program.

A fourth threat to the validity of this thesis is the author's individual judgment; having experienced a close family-member's suicide creates an emotional tie to this topic which might cause a personal bias.

The fifth and final threat to the validity of this thesis is the inherent threat simply because the research performed is a meta-analysis. This research is purely qualitative in nature, and is not a scientific study. Because this research is not quantitative, differences cannot thoroughly be accounted for, and as a result is based primarily on the judgment of researchers.

Summary

This chapter described the manner in which the research will be conducted in order to conclude if the US Army's Suicide Prevention Program is effective at preventing or reducing the rate of suicide. Chapter 4 will consist of the data presentation and analysis of three testimonies from the HASC hearing held on 21 March 2013 by the Subcommittee on Military Personnel entitled, "Update on Military Suicide Prevention." The chapter discusses effectiveness and acceptance of the US Army's Suicide Prevention

Program, both at the individual and collective levels, and will include an aggregation of the two, and an analysis of the testimonies. Subsequently, the final chapter will conclude this thesis with the presentation of conclusions and recommendations regarding the US Army's Suicide Prevention Program.

CHAPTER 4

DATA PRESENTATION AND ANALYSIS

While we have made tremendous strides over the past decade, there is still much work to be done. This war, as we often hear it described, is a marathon, not a sprint. And, as mentioned, many of our biggest challenges lie ahead after our Soldiers return home and begin the process of reintegrating back into their units, families and communities.

— General Peter Chiarelli, *Army 2020 Generating Health and Discipline in the Force Ahead of the Strategic Reset*

Suicide prevention has undeniably gotten the attention of top leaders across the DoD. The previous chapter described how the analysis of the US Army's Suicide Prevention Program would be performed in order to help answer the primary research question, "Does the US Army's Suicide Prevention Program effectively prevent or reduce the rate of suicide?" This chapter will expound on the literature review and discuss further the research methodology applied. The chapter begins with the presentation of three testimonies, followed by presenting an analysis of a study completed by the RAND Corporation. These components served as compelling evidence during the meta-analysis of this research in determining if the Army's program is, in fact, effective. Finally, a two-by-two chart will be presented in order to answer the primary question.

HASC Testimonies

DoD officials testified during the HASC hearing conducted on 21 March 2013 by the Subcommittee on Military Personnel entitled, "Update on Military Suicide Prevention." Three of the testimonies that will be highlighted in this chapter were given by LTG Howard B. Bromberg, Ms. Jacqueline Garrick, and Dr. Jerry Reed, Jr.

Testimony of LTG Howard Bromberg

Army leaders at all levels are committed to eliminating the negative stigma associated with seeking help; building physical, emotional and psychological resilience in our Soldiers, Army Civilians and Families; and ensuring that anyone who may be struggling gets the help he or she needs. (US Senate 2013b, 1)

LTG Howard Bromberg assumed the role as the US Army Deputy Chief of Staff, G-1, on 21 July 2012. LTG Bromberg's testimony to the Committee clearly demonstrates the Army's absolute dedication to caring for its Soldiers, which includes the prevention of Soldier suicide. The Deputy Chief of Staff, G-1, began his statement by contrasting physical injuries that can be seen to the unseen "invisible wounds" that haunt many Soldiers. These unseen wounds include depression, anxiety, and post-traumatic stress. In his statement, LTG Bromberg highlighted the increase in the number of suicides by those who had not deployed, as well as an increase in those who had deployed one or more times from calendar years 2009 through 2012. The increase in both groups further complicates the problem because if the increase occurred in just one of those groups, it could help experts pinpoint where the problem lies, and provide a starting point to focus prevention methods.

LTG Bromberg further acknowledged that suicide is not only a problem the military faces, but one that is a national matter. Comparing the demographically-adjusted 2010 national suicide rates of males between the ages of 17-60, the national suicide rate in 2010 was slightly higher at 25.1 per 100,000 (civilians) compared to the Army Active Duty rate of 22.2 per 100,000. The adjusted rates cannot be used without discretion as differences in the populations do exist, but can, however, serve as an observation to provide insight between the two groups. As noted in the RAND study, although suicide rates are higher for males than females in the general population, the military is

predominantly made up of males, and as a result the comparison may be slightly skewed (Ramchand et al. 2011, 22).

As outlined in LTG Bromberg's statement, key elements the Army's approach are: prompt access by Soldiers to quality behavioral health care; multi-points screening and documentation of mild Traumatic Brain Injuries/Post Traumatic Stress Disorders, improved leader and Soldier awareness of high-risk behavior and intervention programs; and finally, increased emphasis on programs that support Total Force (Soldiers, Army Civilians, and Family Members) readiness and resilience. Getting a Soldier treated immediately after they ask for help or are identified as needing help is absolutely critical to preventing suicide (Caruso 2013a). The warrior ethos is fostered within the Army profession; Soldiers are expected to fight, defend, and be tough physically and mentally. LTG Bromberg, however, stressed the importance of changing the Army's culture from one where asking for help is considered as weakness to one where the stigma has dissolved and Soldiers feel confident getting the help they desperately need. LTG Bromberg emphasized to the Committee, "A comprehensive Stigma Reduction Campaign Plan is being developed to identify and eliminate institutional and cultural barriers and promote seeking help" (Vergun 2013).

A Sample Survey of Military Personnel from 1999 to Fall 2012 indicated that the negative perception toward seeking help for behavioral health issues had improved significantly during that time, either directly or indirectly as a result of the Army's aggressive approach to changing the culture. This good news report gives further incentive for the Army to keep progressing toward a viable solution to this problem until the trend reverses and the suicide rates decrease.

LTG Bromberg goes on to explain the various campaigns and programs currently being used by the Army, of particular note, the Army Study to Assess Risk and Resilience in Service members (STARRS). Soon to be in its fifth year, STARRS will end in 2014. This extensive study is used to identify factors that put a Soldier at risk for suicide, factors that help protect their mental health, and identify those factors that provide resilience, both at certain points of service and while experiencing ongoing issues.

Testimony of Jacqueline Garrick

Jacqueline Garrick has served in a number of positions within the DoD, to include serving as an officer in the US Army as a social work officer. She now serves as the Acting Director of the DSPO. In her statement to the HASC, Ms. Garrick accounted for the suicide statistics and highlighted the DoD Suicide Prevention initiatives. She reported that the DoD collects these statistics along with other data and annually publishes the DoD Suicide Event Report (DoDSER). “The DoD Suicide Event Report (DoDSER) standardizes suicide surveillance efforts across the Services (Air Force, Army, Marine Corps, and Navy) to support the DoD’s suicide prevention mission” (National Center for Telehealth and Technology 2013). The DoDSER provides demographic data, cause of death, method of death or attempted suicide. It tracks suicide-related behaviors, such as suicidal ideation or self-harm, attempted suicides, and completed suicides (National Center for Telehealth and Technology 2013).

In her testimony to the House Armed Services Subcommittee on Military Personnel, Jacqueline Garrick stated that, “by the end of September [2013], it [the DSPO] should complete its comprehensive inventory of all the services’ programs and will have

identified gaps and overlaps in the various efforts” (McCloskey 2013). She further stated that after that was completed, the DSPO “will begin to streamline and unify what is offered across the services” (McCloskey 2013). DoD, with the assistance of the DSPO, appear to be doing everything possible that can and needs to be done for suicide prevention of the armed forces, but in their quest what remains to be seen is if the root of the problem will be identified, and therefore addressed.

Testimony of Dr. Jerry Reed

The final testimony presented in this thesis was given by Dr. Jerry Reed, Director of the Suicide Prevention Resource Center which is operated by the Education Development Center. In addition to that title, Dr. Reed also serves as the Director for the Center for the Study and Prevention of Injury, Violence, and Suicide, as well as being Vice President of the Education Development Center. Dr. Reed earned a Doctor of Philosophy degree in Health Related Sciences. His career resume includes considerable experience, which includes his service as a Department of the Army civil servant for 15 years where he dealt with an assortment of social service issues. Some of his background includes substance abuse prevention and treatment, family advocacy, and child and youth development programs. Additionally, Dr. Reed served as Executive Director of the Suicide Prevention Action Network USA prior to being appointed to his current position, and has sixteen years of experience working in suicide prevention.

According to the transcript, Dr. Reed began his testimony by highlighting “that suicides by service members represent less than one percent of suicides in the nation” (US Senate 2013d 1). Furthermore, Dr. Reed states that suicide is an American problem instead of being simply a defense or veteran problem (US Senate 2013d, 1). He explained

that suicide is not only a problem affecting the younger generation, but that according to the Veterans Affairs 2012 Suicide Data Report, male veterans aged 50 and older are the majority of veterans committing suicide, and male veterans between 50-59 call the Veteran Crisis line more frequently than other groups (US Senate 2013d 1). Dr. Reed stated this fact is comparable to the general population (US Senate 2013d, 1).

Dr. Reed further explained the suicide statistics among the US population, and then asked, “Is the suicide problem in the military different than it is for the general population?” (US Senate 2013d, 2). He went on to discuss that suicide rates have increased both among the American population as well as those of the military (US Senate 2013d, 2). Dr. Reed acknowledged that during the accessions process the military screens for mental illness, military members are healthier than the general civilian population, screens for drug abuse upon accession and throughout service, military members are employed, as well as medical needs for themselves and their families are provided (US Senate 2013d, 2). In addition, the military life offers “structure, well-defined roles, a community, housing, and health care,” according to Dr. Reed (US Senate 2013d, 2). Although he recognized the distinct pressures and demands placed on military members that are unlike the general population, he could offer no explanation for the increase in suicides among service members in spite of their fundamental needs being met. Dr. Reed expressed that the media reports could lead some to believe that military suicide is a direct result of stresses of combat, but according to him, that should not be the case since the National Strategy for Suicide Prevention revealed that “the overwhelming majority of suicides occurred in a non-deployed setting, and more than half of those who died by suicide did not have a history of deployment.” Conversely, the

Army STARRS study revealed that service members with combat experience had higher rates of suicide than those with no combat experience (US Senate 2013d, 3).

Dr. Reed explained the need for a comprehensive approach to effectively reduce the rate of suicidal behavior, and was optimistic about reducing the level of suicide within the military as a result of research, understanding, and practice (US Senate 2013d, 3). He congratulated the US Air Force and the command leadership at Fort Bliss, Texas, for taking a comprehensive approach with their suicide prevention programs and initiatives (US Senate 2013d, 3-4). Dr. Reed rationalized that there is no need to “start from scratch” with the military’s approach to suicide prevention. Instead, he made a suggestion based on a review performed in 2005 that showed the importance of two strategies that the research has shown will reduce the rates of suicide: training physicians to recognize and treat depression, and restrict access of people at high risk for suicide to lethal means (US Senate 2013d, 4).

Conclusion of HASC Testimonies

What is missing from all three testimonies is that, although the national suicide rate may be higher than that of the US Army, the fact remains that the general population does not have a suicide prevention program that is mandatory for all individuals to undergo annually. To make a statement that suicides by service members represent a small amount of the population attempts to make the problem appear not as bad as it seems. Indeed, these testimonies did not “make light” of the situation, but the comparison is, nevertheless, unjust. The fact that the US Army has poured resources into its program only for the rates to increase should cause leaders to ask the question, “Does the US Army’s Suicide Prevention Program effectively prevent or reduce the rate of suicide?”

Cynefin Framework

The (Snowden) Cynefin framework classifies problems facing organizations or leaders into five domains: simple, complicated, complex, chaotic, and disorder. The first four domains require leaders to determine which domain the problem the organization is facing falls into in order to determine a suitable course of action. When the domain is indistinguishable, the problem falls within the disorder domain (LaChapelle 2008, 102). In *The Structure of Concern: A Challenge for Thinkers*, Neil LaChapelle describes the complicated, or as he identifies it, knowable, as follows:

This order requires pragmatic solutions, analytical thought and scenario planning. There are things we don't know but could probably figure out. However, we often don't have time or money to spare for re-inventing this wheel, so we call an expert. Besides expert opinion, trial and error and fact-finding can get us to our goal: to figure out cause-effect relationships and get things done. Sensing data, analyzing it and getting an expert to interpret it and recommend a course of action are good techniques here. Habit can lead us astray, and plans have to remain flexible for updating. Ultimately they will reflect what finally seems to have worked. (LaChapelle 2008, 102-103)

LaChapelle explains the complex domain as follows:

Patterns in this domain emerge from the complex interactions of many different people. Cause and effect relationships are visible, but they are so many that their logic can only be perceived in retrospect, not predicted from the present. A history of this event will be writeable, but the next step is not predictable. There may be a stable pattern for now, but the number of factors at play keep the situation always unpredictably close to major changes. Decisions should be made by sending out probes to assess the prevailing patterns, and seeking multiple perspectives on the significance of unfolding events. Action is best taken by stabilizing and supporting desirable patterns of activity and destabilizing undesirable ones. (LaChapelle 2008, 103)

The US Army has seemingly regarded the rising rate of suicide as if it falls within the complicated domain, but instead should consider treating suicide as it should be-a complex issue. In the Cynefin framework, cause and effect is only discernible in retrospect, therefore, the approach is to Probe–Sense–and Respond to the problem.

The US Army's Suicide Prevention Program, although great conceptually, could be nothing more than "check the block" training if not given the appropriate level of importance by leaders, or if the Soldiers being trained are not receptive to or accepting of the training. With all the demands on Soldiers' time and a heavy emphasis on mission completion, suicide prevention training may be viewed as nothing more than just another mandatory class, or worse, even a distraction. In other words, when a Soldier commits suicide, the leadership can make the statement in the suicide investigation that they "told them not to." Furthermore, leaders who go through the training have bullets for their evaluations. These training programs cost the Army greatly, but is the Army getting a return on its investment? The measurable return on investment of the Army's suicide prevention program would be a decline in suicide rates, or ideally, to completely eradicate it from our military altogether.

The effectiveness of the Army's suicide program is being scrutinized by the DoD. In order to determine the effectiveness of the program, information was obtained from the RAND Corporation, and analyzed as potential measures of effectiveness and acceptance. Six tenets described by RAND as the "six broad goals of a comprehensive suicide prevention strategy" are: raise awareness and promote self-care; identify those at high risk; facilitate access to quality care; provide quality care; restrict access to lethal means; and respond appropriately to suicides and suicide attempts (Ramchand et al. 2011, 56, 58).

How Many Soldiers Attempted Suicide in 2012?

To understand the impact that the increase of suicide has made on the Army's formation, the total number of suicides that have occurred since 2003 is examined. The next table (see table 11) illustrates the Army suicide rates per 100,000.

Table 11. Army Suicide Rates
2006* (17.3 per 100K Soldiers)
2005 (12.8 per 100K Soldiers)
2004 (10.8 per 100K Soldiers)
2003 (12.4 per 100K Soldiers)
* 2006 rate includes two cases pending final determination by the Armed Forces Medical Examiner.
Army Suicide Numbers (Total per year):
Total number of suicides:
2006 (99)
2005 (87)
2004 (67)
2003 (79)
Total number of deployed suicides**:
2006 (30)
2005 (25)
2004 (13)
2003 (26)
** Figures include both OIF and OEF

Source: Army Public Affairs, Army Suicide Prevention Program Fact Sheet, 17 August 2007, <http://www.army.mil/article/4474/army-suicide-prevention-program-fact-sheet> (accessed 14 May 2013).

Individual (in terms of) Prevention

Raising awareness and promoting self-care is the first tenet RAND named in their study as a broad goal of suicide prevention. Their researchers stated that the military uses three methods to meet this goal which are used in this thesis as evaluation methods that result in individual prevention techniques (Ramchand et al. 2011, 56). These strategies are: “media campaigns, training and educational courses, and messages from key personnel to raise awareness and promote self-care” (Ramchand et al. 2011, 56). The study suggested that efforts taken to reduce risk factors “can be seen as part of suicide-prevention planning” (Ramchand et al. 2011, 56). RAND observed that, according to their research, skill building should be focused on during suicide prevention, as it has been proven to reduce suicide attempts, even for individuals who had previously attempted suicide (Ramchand et al. 2011, 56). Using the aforementioned criteria to assess the effectiveness of the US Army’s Suicide Prevention Program led to the conclusion that, although the program has components that address raising awareness and promoting self-care, the program is not meeting this particular goal. Lack of self-care may be directly attributed to the stigma that (still) exists in the Army. The Army has attempted to counteract the stigma through the development of a comprehensive Stigma Reduction Campaign Plan, which is aimed at reducing the stigma associated with seeking behavioral health care (Army Medical Command 2013, 1). Evaluating the effectiveness of the US Army’s Suicide Prevention Program on an individual level leads to the next evaluation criteria for discussion: individual effectiveness in terms of acceptance or receptivity. To evaluate the effectiveness of these criteria, the two areas of raising awareness and promote self-care, and facilitate access to quality care were considered.

Individual (in terms of) Acceptance/Receptivity

Raising awareness is a primary message of the Army's program (Ramchand et al. 2011, 110). It is generally done through awareness campaigns RAND identifies as "noteworthy" since they may influence the knowledge and attitudes of the individuals that observe them. However, their researchers claim merely raising awareness has yielded limited evidence of creating behavior change, and that service members instead should be taught skills needed to self-refer when they need help (Ramchand et al. 2011, 106). Additionally, awareness campaigns alone fail to teach skills to effectively prevent suicides (Ramchand et al. 2011, 111). Furthermore, RAND states that programs that focus only on raising awareness could actually be detrimental due to lack of follow-up (Ramchand et al. 2011, 44). RAND researchers discovered that across the military, the message of promoting self-care was not as publicized as raising awareness, with the exception of those intended for individuals preparing to deploy, or individuals recently returned from a deployment (Ramchand et al. 2011, xxii). According to RAND, only some of the suicide prevention programs they examined actually teach Soldiers strategies to build skills that give them the ability to self-refer (Ramchand et al. 2011, 106), with the exception of the Army's ACE campaign, which involves a training seminar that includes exercises designed to build such skills. The Army also uses an interactive video entitled, "Beyond the Front" that allows Soldiers to assume the role of a Soldier considering suicide while deployed or the role of a commander concerned about a friend. These two approaches foster in the development of skill-building, possibly leading to self-referral. Other than these two initiatives, this critical component of suicide prevention is one area where the US Army's Suicide Prevention Program may fall short.

Facilitating access to quality care is the second piece of assessing the effectiveness of a program on an individual in terms of acceptance or receptivity. According to RAND, evidence supports the relationship between individuals at high risk for suicide and mental health care providers (Ramchand et al. 2011, 56). However, barriers, or stigmas, may prohibit Soldiers from seeking the help they need. Table 12 highlights some of the barriers to mental health care in the general population and among formerly deployed military personnel.

Table 12. Barriers to Mental Health Care in the General Population and Among Formerly Deployed Military Personnel

In the General Population (Kessler, Berglund, et al., 2001)	Among Formerly Deployed Military Personnel (Schell and Marshall, 2008)
Lack of perceived need	Negative career repercussions
Unsure about where to go for help	Inability to receive a security clearance
Cost (too expensive)	Concerns about confidentiality
Perceived lack of effectiveness	Concerns about side effects of medications
Reliance on self (desire to solve problem on one's own or thoughts that the problem will get better)	Preferred reliance on family and friends
	Perceived lack of effectiveness

Source: Rajeev Ramchand, Joie Acosta, Rachel M. Burns, Lisa H. Jaycox, and Christopher G. Pernin, *The War Within: Preventing Suicide in the US Military* (Santa Monica, CA: RAND Corporation, 2011), 49.

In order to reduce stigma and facilitate access to quality care the US Army, along with the Army Medical Command has taken innovative action:

Embedded Behavioral Health moves behavioral health personnel out of large hospitals, forms them into teams, and places them in smaller clinics much closer to where Soldiers live and work in each installation. This model creates working relationships between behavioral health providers and unit leaders to better understand the specific challenges that Soldiers face and tailor clinical services to serve them. (Army Medical Command 2013)

According to RAND, “Although reducing barriers to mental health care has not been directly correlated with reducing suicides except as part of broad, integrated programs, facilitating access to effective care will help ensure that those at increased risk will receive quality care and thus reduce suicides” (Ramchand et al. 2011, xix).

Collective/Institutional (in terms of) Reduction

Prevention is dependent upon caring and proactive unit leaders and managers who make the effort to know their personnel, including estimating their ability to handle stress, and who offer a positive cohesive environment which nurtures, and develops positive life-coping skills. (DA 2009, 1)

To assess the effectiveness of the US Army’s Suicide Prevention Program, an evaluation of the collective, or institutional, effectiveness was completed by assessing its effect on reduction of Soldier suicide. Two goals suggested by RAND which were applied in this thesis as evaluation criterion were: identify those at high risk, and restrict access to lethal means (Ramchand et al. 2011, 56, 58).

Understanding there are individuals who are considered “high risk” for committing suicide is the beginning of treatment (Ramchand et al. 2011, 56). Some groups, for example individuals with mental illness or those who have experienced a negative-life event, are considered higher risk for committing suicide (Ramchand et al. 2011, 56). Therefore, it is imperative the US Army identifies individuals at high risk as early as possible, and takes all possible measures to prevent suicide from occurring. The Army’s approach to doing exactly this is through the use of gatekeepers. As discussed in chapter 2, gatekeepers serve as the Soldier’s first line of defense to mitigate risk against self-harm. Another way the US Army attempts to treat individuals that may be at high-risk is by implementing mild TBI screening for Soldiers while still in theater (Army

Medical Command 2013, 1). Additionally, the US Army has “increased screening efforts to improve the diagnosis and treatment of Soldiers through pre- and post-deployment health assessments” (Army Medical Command 2013, 1). Soldiers are screened up to five times prior to deployment to theater for potential behavioral health conditions, and again within 30 days prior to redeployment, upon return to garrison, and once again 180 days of returning. Soldiers are also screened annually for possible behavioral health issues (Army Medical Command 2013, 1). Another way the Army has responded to the need for identifying those at high risk is by implementing a command notification procedure for Soldiers who are involved in law-enforcement incidents to secure their safety and mitigate risks for suicide attempts (Army Medical Command 2013, 1).

According to RAND researchers, evidence supports that by restricting access to lethal means, suicides can be prevented (Ramchand et al. 2011, 58). As Dr. Matthew Miller, Associate Director of the Harvard Injury Control Research Center at the Harvard School of Public Health states, “There are two ways to reduce suicide: You can make it harder for them to die in an attempt, or you can heal underlying distress.” (Montgomery 2012). It may be more difficult and take longer to heal underlying distress in Soldiers, and restricting access to lethal means, if only for individuals that have been identified as being at high risk, could allow time for Soldiers to seek help, and prevent Soldiers from making a decision that cannot be undone. The Israeli Defense Forces had experienced years of suicides among young men serving in their ranks. According to a 2010 study, in 2006, authorities began prohibiting troops from taking rifles home on weekends, which was followed by a decline in suicides by 40 percent (Montgomery 2012). Guns are not the only means Soldiers commit suicide, although almost 50 percent of Soldiers who

committed suicide in 2011 used non-military issue firearms to kill themselves while nearly 11 percent used military-issue firearms. While the majority of Soldiers committed suicide by using firearms, almost 21 percent died by hanging, while nearly four percent used drugs to end their lives. The following table (table 13) illustrates the methods used in Soldier suicides during the years 2009 through 2011.

Table 13. 2011, 2010, and 2009 Army DoDSER Event Method

		2011		2010	2009
		Count	Percent	Percent	Percent
EVENT METHOD	Firearm, non-military issue	141	49.13%	48.40%	40.74%
	Firearm, military issue	31	10.80%	13.88%	17.51%
	Hanging	59	20.56%	24.56%	22.90%
	Drugs	11	3.83%	4.63%	3.03%
	Alcohol	0	0.00%	0.00%	0.34%
	Gas, vehicle exhaust	3	1.05%	0.36%	3.70%
	Gas, utility (or other)	3	1.05%	2.14%	1.68%
	Chemicals	2	0.70%	0.00%	0.00%
	Drowning	1	0.35%	1.07%	0.00%
	Fire, steam, etc.	1	0.35%	0.36%	0.00%
	Sharp or blunt object	2	0.70%	0.71%	2.69%
	Jumping from high place	4	1.39%	0.71%	1.68%
	Lying in front of moving object	1	0.35%	0.71%	0.67%
	Crashing a motor vehicle	0	0.00%	0.00%	0.00%
	Other	4	1.39%	0.36%	3.03%
	Don't Know	24	8.36%	2.14%	2.02%

Source: David D. Luxton, Janyce E. Osenbach, Marc A. Reger, Derek J. Smolenski, Nancy A. Skopp, Nigel E. Bush, and Gregory A. Gahm, *DoDSER Calendar Year 2011 Annual Report* (Washington, DC: Government Printing Office, 15 November 2012), 16.

Collective/Institutional (in terms of) Implementation

The RAND tenets used to evaluate the effectiveness of the collective/institutional implementation were: provide quality care, and respond appropriately to suicides and suicide attempts (Ramchand et al. 2011, 58).

The US Army has taken a number of steps in developing its prevention methods, which include providing quality care. RAND researchers stated quality mental health services, although critical to suicide prevention, are often overlooked (Ramchand et al. 2011, 58). The Army's steps toward improved health promotion initiatives include, "increased access to and availability of behavioral health care, decentralized behavioral health treatment down to brigade level" (Army Medical Command 2013, 1).

In 2012, the Army began to implement Embedded Behavioral Health Teams, an evidence-based behavioral health delivery model, in support of every operational Army unit. The Embedded Behavioral Health Teams provide multidisciplinary community level behavioral health care to Soldiers in close proximity to their unit area and in close coordination with unit leaders. Utilization of this model has shown statistically significant reductions in 1) acute inpatient psychiatric admissions 2) high risk behaviors and 3) Soldiers in combat units with serious [behavioral health] conditions. (Army Medical Command 2013)

In order to evaluate the effectiveness on the institution in terms of acceptance and reduction, the goal of "respond appropriately to suicides and suicide attempts" was evaluated. The RAND study suggests a strategy must be prepared to respond to completed suicides in order to mitigate potential imitative attempts (Ramchand et al. 2011, 58). It is important that the US Army's response to suicide does not influence others to emulate the suicide by "glorifying" the act of suicide. On 16 March 2010, the US Army established a Specialized Suicide Augmentation Response Team, designed to provide assistance and support to organizations and "unit commanders in the event of a cluster of suicides events" or to commanders with "concerns, issues, and challenges

associated with suicide” (DA 2010a). According to the Army Medical Command, five visits from these response teams had been conducted since its inception (Army Medical Command 2013, 2).

Aggregation

This chapter completed a meta-analysis in order to answer the primary question, “Does the US Army’s Suicide Prevention Program effectively prevent or reduce the rate of suicide?” The meta-analysis was completed using the literature review, three testimonies from the HASC hearing by the Subcommittee on Military Personnel entitled, “Update on Military Suicide Prevention,” evidence provided during the RAND study entitled, *The War Within: Preventing Suicide in the US Military*, followed by a two-by-two chart with the analyses.

In all, the discovery of this thesis is that the US Army’s Suicide Prevention Program is having a positive impact on the US Army. Leaders have taken this job seriously, and much has been done to address this growing crisis. The US Army has multiple experts involved in finding a solution to why the suicide rates have continued to rise. There is an accumulation of information provided on the US Army G-1 website with training, resources, and links to other helpful suicide prevention resources. To assert the US Army, as an institution, has been complacent with its suicide prevention measures would be untrue.

The Findings

Researchers of the RAND study assessed how the military performed in each of the areas they identified and referred to as the “six domains of a comprehensive suicide-

prevention program,” (Ramchand et al. 2011, 109). These areas were considered in this thesis as measures of effectiveness and acceptance. Table 14 illustrates their findings of the Army’s Suicide Prevention Program.

Table 15 illustrates the assessment of the evaluation conducted during this research. The completed two-by-two chart lists the criteria used during the assessment, and presents the results tied to the criterion.

Table 14. Assessment of Army Suicide Prevention Activities

GOAL	
Raise awareness and promote self-care	Primarily awareness campaigns, with fewer initiatives aimed at promoting self-care
Identify those at high risk	Expansive but mostly rely on gatekeepers
Facilitate access to high-quality care	Stigma addressed primarily by locating behavioral health care in nontraditional settings
	No policy to assuage privacy or professional concerns
	No education about benefits of accessing behavioral health care
Provide high-quality care	Not considered in domain of suicide prevention
Restrict access to lethal means	No current policies exist
Respond appropriately	Personnel/teams available, but limited guidance
Present in program Present to some degree Not present	

Source: Rajeev Ramchand, Joie Acosta, Rachel M. Burns, Lisa H. Jaycox, and Christopher G. Pernin, *The War Within: Preventing Suicide in the US Military* (Santa Monica, CA: RAND Corporation, 2011), 106.

Table 15. Two by Two Analysis

<u>Unit of Analysis</u>	<u>Effectiveness</u>	<u>Acceptance</u>
Individual (Prevent/Receptive)	-Raise awareness and promote self-care =NO	-Raise awareness and promote self-care -Facilitate access to quality care =NO
Collective (Reduce)	-Identify those at high risk -Restrict access to lethal means =NO	- Provide quality care -Respond appropriately to suicides and suicide attempts =YES

Source: Created by author, data from Rajeev Ramchand, Joie Acosta, Rachel M. Burns, Lisa H. Jaycox, and Christopher G. Pernin, “The War Within: Preventing Suicide in the US Military” (Santa Monica, CA: RAND Corporation, 2011), 105-109.

Conclusion

As stated by Jacqueline Garrick:

The challenge is that suicide prevention is not a one size fits all. I think the thing we see that really works is when we do involve everybody. This is not just a one-person issue. This is a leadership issue, a community issue, a family issue. At every level, we want to make sure people know how to reach out for help, how to be able to talk to somebody, how to recognize the signs. (Wong 2012)

In conclusion, the answer to the primary research question “Does the US Army’s Suicide Prevention Program effectively prevent or reduce the rate of suicide?” is “unknown.” Statistically speaking, the program is not successful at reducing the rate of suicide. Since the induction of the current Suicide Prevention Program the rates have not declined, but have increased. Taking the statistics strictly at face value could be reason to believe that the program is a failure, and cause some to blame Army leaders for failing their Soldiers. However, a caveat to regard is that there are many variables to consider when making a declaration based solely on the statistical data. These variables start and

end with the fundamental point that suicide is a people issue, and generally speaking, people are complex. There are far too many factors that contribute to the make-up of individuals to determine why people behave in a particular way, do certain things, or even commit suicide.

One can question instead, “Has the US Army Suicide Prevention Program changed the rate (either increased or decreased) of suicide in terms of more “buy in” from senior leadership, or has the program become more acceptable? The answer concluded from this research is “yes.” Therefore, to question if the US Army’s Suicide Prevention Program is effective, the answer may be “yes,” but there are still a number of issues that need to be worked out. There was no evidence found in this research that directly linked the US Army’s Suicide Prevention Program to reducing the rates of suicide, but one can assume it has (certainly) prevented some suicides from occurring. What can also be concluded is that there are gaps in the current program that must be addressed and corrected in order for the program to reach Soldiers who are susceptible to committing suicide.

Chapter 4 discussed the data presentation and analysis of the literature review and the two-by-two analysis completed. The final chapter will provide conclusions and recommendations in terms of the effectiveness of the US Army’s Suicide Prevention Program.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The objective of this thesis was to answer the question “Does the US Army’s Suicide Prevention Program effectively prevent or reduce the rate of suicide?” The first four chapters laid out the problem, provided a review of existing literature, and analyzed the program and the US Army Suicide Prevention Program in its current state. This final chapter will present recommendations and provide suggestions for policymakers to improve the US Army’s Suicide Prevention Program in order to increase its effectiveness.

Albert Einstein defined insanity as doing the same thing over and over again and expecting different results. When a program is designed to produce certain results and is not producing those results, to continue with the current program with no alterations may be considered insane by some. To illustrate: if an individual invested in a weight-loss program, but instead of maintaining their current weight or losing, their weight increased instead of decreased, that individual would likely change or quit the program altogether, or at a minimum attempt to determine why they were not losing weight. Although this analogy may be considered simplistic or not in the same category as suicide prevention, as physical health and mental health are two very different concerns, it is not entirely different when comparing the outcomes.

This researcher cannot determine with absolute certainty through the research completed that the US Army’s current Suicide Prevention Program is preventing suicide. Conversely, nor can it be determined that it is not [preventing suicide]. If continuing to

use the current program (as is) is not the answer because it is not preventing suicide, then what is the answer to this crisis? Discontinuing the US Army Suicide Prevention Program altogether is simply not an acceptable option. The Army must take preventative measures to reduce the level of suicide within its ranks, but the program as it currently is being implemented is simply not effectively reducing the rate of suicides.

It may be easy for some to take a cynical attitude towards the program and to be skeptical of Army leadership because instead of the suicide rate declining, it has risen. In the author's opinion, this crisis keeps a number of Army leaders awake at night. Nevertheless, that is precisely the job of Army leaders: to care for the overall health and wellbeing of Soldiers, and take every precaution in ensuring Soldiers are safe (even from themselves) whenever possible.

Analysis

There is a greater societal issue, in the author's opinion, concerning the rising rate of suicide which is proven through the rising rates across the national population. The root cause of suicide goes deeper than a Soldier getting in trouble or having a bad day and taking their life. In the author's opinion, the basic fundamentals have all but left society-fundamental beliefs in a Creator, in a life after this life. It is also the author's opinion that some people simply "snap," act nonsensically, or go insane, albeit temporarily. Many people have suicidal ideation but never act on their urges or follow through with suicide because they are still thinking clearly and rationally. Unfortunately, that is not always the case.

Obviously, suicide is a bigger problem that faces many more groups than the US Army alone. This thesis did not discuss, but deserves recognition and special research of

its own in addition to veterans, is the group of DA civilians and military technicians that support and are dedicated to the Soldiers defending the nation. This group of people experiences their own unique trials, often unlike those of the general US population, and is certainly not immune to suicide. They are very much a part of the Army ranks, and are irreplaceable to maintaining consistency within the organizations. Many of these civilians served honorably in the military, and many were career Soldiers who now bear their own invisible wounds. Although this research did not discuss that particular group, this research leads to the recommendation that further research be focused on DA civilians and military technicians in order to maximize prevention efforts across the service.

Recommendations

Kevin Hines made his recommendations clearly known when he stated,

Look, we've got to trend down these rates, and we've got to do it now. I'm of the opinion that, you know, we've spent over \$720 billion on the Iraq war, and it's just—the number keeps adding up every day. We need to spend a fraction of that on mental health in the military. You know, sometimes you go to a base that has one psychiatrist per 5,000 to 10,000 servicemen and women. That needs to be one per every 10, so we can adequately help these individuals and aid them to safety, and so they can stay in the military, do their service, and do good for this country. They can't do that when they're not well. And we can't keep sliding it under the rug. Something needs to change. (Democracy Now! 2012)

Assess the Current Program

The US Army needs to thoroughly and stringently evaluate the awareness campaigns aimed at suicide prevention. It is not enough for Soldiers to be aware of prevention methods. Leaders need to ask the questions: Is the campaign producing results? Is it valid as it is? Does it need enhancement? What feeds into the conclusions of keeping them as they are (in regards to continuing implementation of awareness campaigns)?

Meeting Soldiers “Where they Are”

Just as everyone does not learn in the same manner, not all individuals accept training or can be taught by common methods. Some people are visual learners while others learn simply by reading. The way Soldiers learn or apply information taught into knowledge is an issue itself. The same goes for understanding that Soldiers come from many different backgrounds and had totally different upbringings. This definitely matters to the way leaders either reach or do not reach Soldiers. Perhaps the Army should be assuming more innovative tactics with those that are committing most of the suicides-Soldiers in their late teens and twenties. “We’re finding some great success in the virtual world with tele-behavioral health, where we’re able to allow the individual to talk virtually to some of these behavioral health specialists and have the privacy but get the care that they need,” stated LTG Bostick. It is imperative that leaders know their Soldiers, and especially when it comes to suicide prevention, know how to meet them and ultimately reach them “where they are.”

Teach Life Skills

In his phone interview with The Christian Post, Friar Peter Sousa further stated:

Young people today are less prepared and society has extended their adolescence. They are not maybe really mature until their mid 20s. Fifty years ago, people were at that maturity level at 18. They may not have the same coping skills. As young people come in, an awful lot is expected of them. Some of the young soldiers have been at two or three different bases, have been deployed halfway across the world, and have had to go through a lot of hard training – besides the combat aspect. Compared to the civilian sector, young people in the military have had to deal with a lot more. (The Christian Post 2012)

Oftentimes, Soldiers are not equipped upon arrival to a unit of assignment. Many Soldiers do not possess the multitasking skill-set necessary for functioning in the Army.

Incorporating life skills training as an annual training requirement, instead of simply making the training “available” to those that request it or are recommended to attend, could benefit Soldiers as much as staying trained on how to properly wear Mission Oriented Protective Posture gear, or perhaps even more so. Although Soldiers are considered adults, many have not been taught even basic skills that are considered common and very simple by many. For example, because some Soldiers do not have even a basic understanding of finance or managing their pay, they may end up in financial trouble which could lead to second and third-order effects such as problems at work or with relationships.

Program Acceptance

The Army’s Suicide Prevention Program should be focused on the importance of knowledge over information. Leaders should be developing pillars that support a sustainable foundation. Additionally, leaders should concentrate on building confidence in a program identified as relevant and non-negotiable, one that will be lasting, getting better as leaders and Soldiers apply it. It is imperative that the US Army provide tools (knowledge, skills, and abilities) to its formations to equip leaders and Soldiers with something to take away if signs are observed.

Mental Health Intervention and Care

According to Kevin Hines:

Single most important thing I feel needs to happen is very simple. The government—somebody needs to fund mental health for the entire—every military sector. We need to reach out to these individuals on a broader basis. They need to have more therapists, more psychiatrists on hand, more chaplains. And we need to have the ability, like the Marines are doing—and they’re doing it, and they’re doing it well. (Democracy Now! 2012)

With effective suicide prevention, mental health care is key. Researching this topic has led this researcher to believe that suicide can truly be prevented by those that are qualified to care for a suicidal individual be it with medication or counseling. This is not saying that everyone cannot play a part in preventing suicides from occurring. Prevention can start with friends, family, or first line leaders among other ways. But when a Soldier is to the point that they have decided to act on their desire to die, it is imperative to have a trained individual intervene to take the emergent precautions to prevent a suicide from occurring.

In closing, to quote the US Public Health Service Surgeon General, Dr. Regina Benjamin, from the *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*:

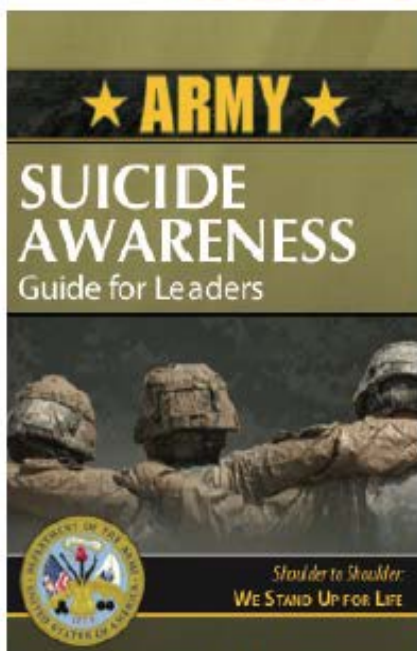
No matter where we live or what we do every day, each of us has a role in preventing suicide. Our actions can make a difference. While a document alone will not prevent a single suicide, I hope that this document will help spur and leverage all of our actions so we can make real progress now in preventing suicide. We have no time to waste. (United States Department of Health and Human Services, Office of the Surgeon General, and National Action Alliance for Suicide Prevention 2012, 4)

APPENDIX A

ARMY SUICIDE AWARENESS GUIDE FOR LEADERS

Now Available in eGuide

Army Suicide Awareness Guide for Leaders



Critical resources are included for individuals at-risk, who may be experiencing a crisis. Leadership involvement is crucial when combating the increased rate of suicides in the Army.

The Army is committed to providing leaders with a holistic approach of addressing the physical, mental, social, and spiritual aspects of taking care of Soldiers, Army Civilians, and Family members.

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The e-guide is in support of the suicide prevention ASK, CARE, ESCORT (ACE) module. The purpose of this e-guide is to demonstrate suicide awareness for all leaders.

This e-guide provides leaders the knowledge and skills necessary to recognize suicidal risk factors, warning signs, and how to utilize the basic intervention techniques.

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Screenshot 1



Screenshot 2



Screenshot 3



Installation Instructions

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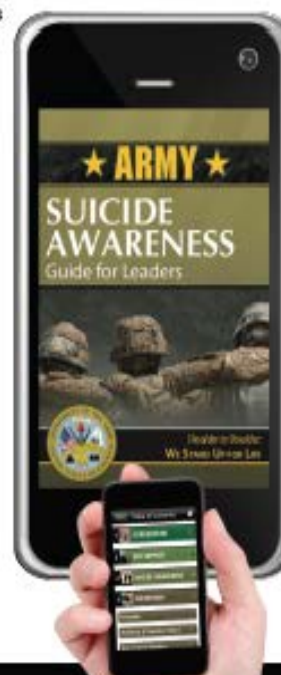
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ARMY - Suicide Awareness Guide for Leaders



Having Problems?

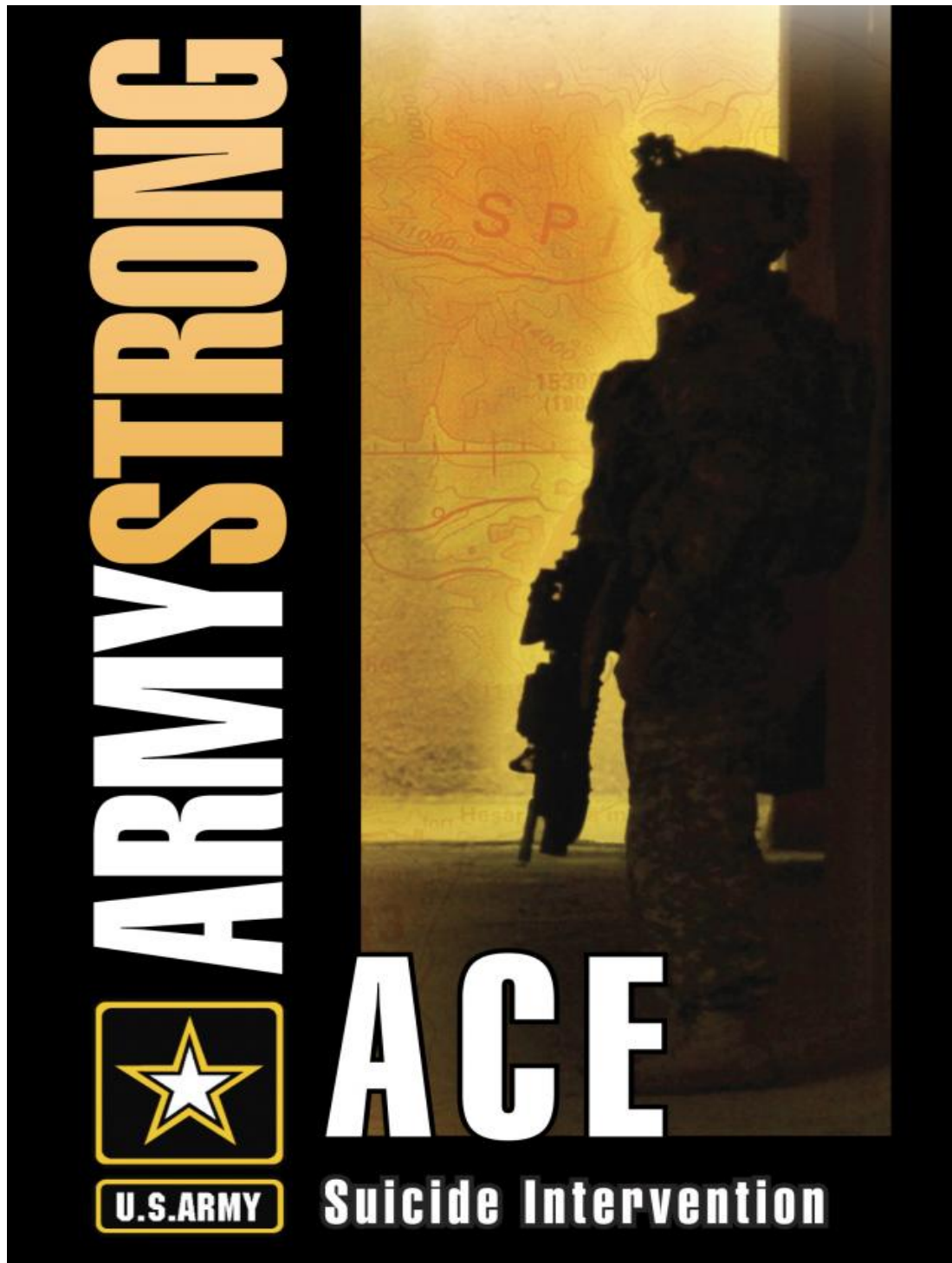
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www.quickseries.com/faq
or by telephone at: 1-800-161-4653 (toll-free)

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Source: Army G-1, Army Suicide Prevention Program, <http://www.armyg1.army.mil/hr/suicide/default.asp> (accessed 10 June 2013).

APPENDIX B

ASK CARE ESCORT CARD





National Suicide Prevention Lifeline:
1-800-273-8255(TALK)

Ask your buddy

- Have the courage to ask the question, but stay calm
- Ask the question directly:
Are you thinking of killing yourself?

Care for your buddy

- Calmly control the situation; do not use force; be safe
- Actively listen to show understanding and produce relief
- Remove any means that could be used for self-injury

Escort your buddy

- Never leave your buddy alone
- Escort to chain of command, Chaplain, behavioral health professional, or primary care provider
- Call the National Suicide Prevention Lifeline

TA - 095 - 0510

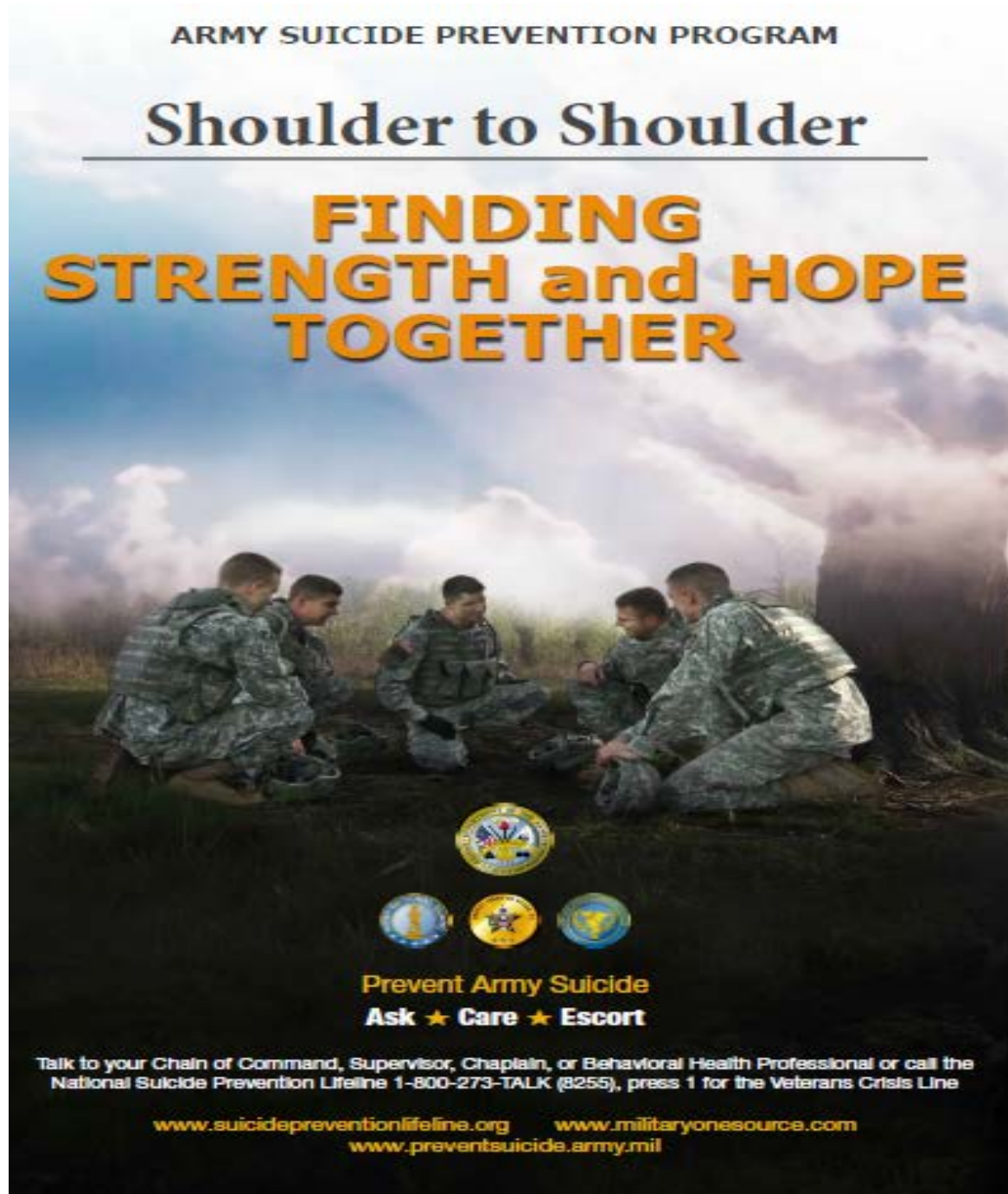
USAPHC <http://phc.amedd.army.mil/>



Source: Army G-1, *Army Suicide Prevention Program*, <http://www.armyg1.army.mil/hr/suicide/default.asp> (accessed 10 June 2013).

APPENDIX C

SHOULDER TO SHOULDER POSTER



Source: Army G-1, *Army Suicide Prevention Program*, <http://www.armyg1.army.mil/hr/suicide/default.asp> (accessed 10 June 2013).

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