Understanding the Enemy Within: Suicide in the Army

A Monograph

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14. ABSTRACT

The Army has failed to curb the issue of suicide within its formations, despite a renewed focus on the topic and increased emphasis by senior leaders. The goal of this monograph is to explore the environment surrounding suicide to identify potential reasons for this failing. Numerous revisions of the Army's suicide prevention programs have had limited impact on the rate of suicide and understanding the issues around suicide in the Army could help understand why these programs have not succeeded. The information used throughout this monograph is based on existing data and analysis of great research as well as experience with suicides in the Army and numerous suicide prevention boards and working groups. With a new review of the available data through the lens of personal experience, the intent is to determine if there is a disconnect between suicide and suicide prevention. As the suicide rates in the Army continue to rise the Army must strive to develop a better understanding of the problem and how to address it.

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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 US Army Command and General Staff College or any other government agency. (References to this study should include the foregoing statement.)

Abstract

Understanding the Enemy Within: Suicide in the Army, by MAJ William Hurt, 44 pages.

The Army has failed to curb the issue of suicide within its formations, despite a renewed focus on the topic and increased emphasis by senior leaders. The goal of this monograph is to explore the environment surrounding suicide to identify potential reasons for this failing. Numerous revisions of the Army's suicide prevention programs have had limited impact on the rate of suicide and understanding the issues around suicide in the Army could help understand why these programs have not succeeded. The information used throughout this monograph is based on existing data and analysis of great research as well as experience with suicides in the Army and numerous suicide prevention boards and working groups. With a new review of the available data through the lens of personal experience, the intent is to determine if there is a disconnect between suicide and suicide prevention. As the suicide rates in the Army continue to rise the Army must strive to develop a better understanding of the problem and how to address it.

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Acknowledgements

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Also of note, this monograph's focus on suicides in the active duty Army, is not done to belittle or denigrate the suicides in the Reserves, National Guard, or Department of the Army civilians. Unfortunately, the suicide data associated with these groups is not as standardized as that from active duty because of the variability in civilian suicide surveillance that will be discussed later in this monograph. The focus on the data about the active duty Army allows for a better-scoped analysis of the programs and procedures involving suicide and the weakness associated and provide more actionable recommendations on addressing the gaps in anti-suicide efforts in the active duty Army and the increasing rate of suicide among soldiers.

Finally, I want to dedicate this monograph to a fellow solider and friend, SFC Will DePew. I know that we failed you in life, but my hope is that this work honors your memory and serves as a step in the right direction for avoiding other soldiers from the pain of having to experience a loss by suicide.

Abbreviations

ACE-SI	Ask Care Escort- Suicide Intervention
AFMES	Armed Forces Medical Examiner System
CDC	Centers for Disease Control and Prevention
COVID-19	Coronavirus Disease of 2019
CPS	Current Population Survey
CY	Calendar Year
DA	Department of the Army
DoD	Department of Defense
DoDSER	Department of Defense Suicide Event Report
DSPO	Defense Suicide Prevention Office
GWOT	Global War on Terrorism
MOS	Military Occupational Specialty
NVDRS	National Violent Death Reporting System
OAFME	Office of the Armed Forces Medical Examiner
PHA	Periodic Health Assessment
SAMS	School of Advanced Military Studies
SFRB	Suicide Fatality Review Board
SPARRC	Prevention and Risk Reduction Committee
SPPM	Suicide-Prevention Program Manager
SRMO	Suicide Risk Management and Surveillance Office
SRT	Suicide Response Teams
TRADOC	Training and Doctrine Command
US	United States
USCB	United States Census Bureau

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Introduction

Suicide is a topic fraught with visceral emotional responses. This makes it even more necessary to approach the topic of suicide in as logical a manner as possible. Prior to developing an effective suicide prevention program, the Army must take a more holistic approach to understanding the issue of suicide in a broader context. The Army has made advancements in reducing the stigma associated with seeking help for risk factors associated with suicidal ideations. However, the Army is still failing to make an honest analysis of its suicide prevention programs in relation to the larger civilian populace. The first step is to understand the current environment surrounding suicide and what relevant variables affect the conditions of suicide in the Army. This will allow leaders to develop goals that are feasible, acceptable, and suitable within the given context. An appreciation for the larger context surrounding suicide will enable the Army to develop a deeper understanding of the suicide epidemic within the active duty force.[1] This appreciation is necessary prior to conducting an analysis of the Army's current anti-suicide approach.

A candid analysis of the Army's approach to reducing suicides must be broken down by examining prevention efforts as well as investigating reactions to suicide events. Reviewing the current efforts to prevent suicides and the reaction processes in the unfortunate event of a suicide attempt will enable the identification of the obstacles preventing the successful implementation of these efforts. Once the impediments to achieving anti-suicide goals are identified, then steps can be taken to reform the efforts and programs to increase their effectiveness.[2] The recommendations at the end of this monograph will be conceptual and mostly focus on actions

[1] Peter Chiarelli, *Army Health Promotion, Risk Reduction, Suicide Prevention: Report 2010* (Washington, DC: Government Publishing Office, 2010), 9.

[2] Deborah Khoshaba, "The Edge of Suicide," *Psychology Today*, March 5, 2012, accessed May 3, 2020, https://www.psychologytoday.com/us/blog/get-hardy/201203/the-edge-suicide.

designed to develop a better understanding of suicide, as well as how to change the manner in which the Army responds to suicide events and improve the reaction processes.

Understanding the Problem of Suicide

> Every loss to suicide is a horrible human tragedy--whether it's our teammate, a family member or our friend. Across the military, at all levels of leadership, our commitment to each other is unwavering and it takes all of us to prevent suicide. . . . Take care of each other--you are our Nation's most valuable resource and each and every one of you represents all that is good about America.
>
> —Mark Miley, *Twitter Post*

There is an emotional response to suicide, especially from soldiers personally affected by a suicide event. That same connection can often lead to the desire to develop a rapid approach to the problem, which may result in overcorrection with unintended consequences. Rapid solution development often happens at the expense of understanding the complexity of the issues surrounding suicide. The active duty US Army is experiencing a heightened awareness of suicide prevention and suicide response procedures because of the current increase in suicide rates. The Army must refocus grief and shock into motivation to improve its suicide prevention programs and suicide reaction policies. Suicide and the variables that impact it are not well understood because it is an intricate system of interdependent factors.

Under the Department of the Army (DA) personnel section, the Army Resiliency Directorate has a complex and wicked problem to develop a bureaucratic solution to a cultural issue that will require constant refinement. Most of the recent research into suicides in the Army centers around the stress on the active duty force since the start of the Global War on Terrorism (GWOT). However, an analysis of the last five years shows that most suicide victims in the active

duty Army have not had a GWOT deployment.[3] The data from the last published suicide report shows, in the aggregate, that active duty Army suicides actually decrease based on the number of GWOT deployments, up to two deployments.[4] The data does demonstrate an increase in suicide with soldiers who have three or more deployments. However, without access to the raw data there is not enough information to determine the correlation between suicides and the number of individual deployments past two; see Table 1.

Table 1. Deployment Demographic Characteristics of Active Army Suicide, CY18

Number of Deployments	Number of Suicides	Percent of Active Army
0	50	46.7
1	34	31.8
2	9	8.4
3 or more	14	13.1

Source: Created by author based on Jennifer Tucker, Derek J. Smolenski, and Carrie H. Kennedy, D*epartment of Defense Suicide Event Report: Calendar Year 2018 Annual Report* (Washington, DC: US Department of Defense, July 19, 2019), accessed August 28, 2020, 24, https://www.pdhealth.mil/sites/default/files/images/docs/TAB_B_2018_DoDSER_Annual_Report-508%20final-9MAR2020.pdf.

Since 2004, the active duty Army suicide rate has been trending upward. The active duty Army suicide rate passed the civilian populace's overall rate in 2008 and continues to increase at a rate higher than the civilian population, especially among combat arms branches.[5] There are an incalculable number of reasons soldiers develop suicidal ideations and attempt suicide, and they vary by individual, so it is difficult for the Army's current efforts to address every risk factor. The

[3] Leo Shane, "Historic data on military suicide shows no clear link with combat operations," *Military Times*, December 13, 2019, accessed November 17, 2020, https://www.militarytimes.com/news/pentagon-congress/2019/12/13/historic-data-on-military-suicideshows-no-clear-link-with-combat-operations.

[4] Jennifer Tucker, Derek J. Smolenski, and Carrie H. Kennedy. D*epartment of Defense Suicide Event Report: Calendar Year 2018 Annual Report* (Washington, DC: US Department of Defense, July 19, 2019), accessed August 28, 2020, 42, https://www.pdhealth.mil/sites/default/files/images/docs/TAB_B_2018_DoDSER_Annual_Report-508%20final-9MAR2020.pdf.

[5] Beth Griffin, Geoffrey E. Grimm, Rosanna Smart, Rajeev Ramchand, Lisa H. Jaycox, Lynsay Ayer, Erin N. Leidy, Steven Davenport, Terry L. Schell, and Andrew R. Morral, *Comparing the Army's Suicide Rate to the General U.S. Population: Identifying Suitable Characteristics, Data Sources, and Analytic Approaches* (Santa Monica, CA: RAND Corporation, 2020), 33, accessed September 9, 2019, https://www.rand.org/pubs/research_reports/RR3025.html.

environment and conditions involving suicide will never be static.[6] Therefore, the Army will never have a complete understanding of suicide in the force. The complex and ever-changing environment will require probing the situation with innovative solutions to find the best emergent practices.[7]

Continuing to approach suicide prevention and postvention in the same way as the past, given the continually changing environment, is a reactive and insufficient method. The Army must be willing to probe for new potential options and systematically measure the programs' effectiveness over time to determine which tactics are most beneficial in reducing suicide and its impacts. Given the complexity of the issues surrounding suicide in the active duty force, a linear problem-solving method will be inadequate at addressing the multitude of other critical factors that affect suicide. Taking a more comprehensive systems approach is necessary to understand the issue and design a more relevant program.

Current Conditions Involving Suicide

As suicide rates continue to increase in the general civilian population and across the Army, the issues with preventing and responding to suicide continue to be extremely sensitive and often contested. Different organizations and locations debate what qualifies as a suicide or suicide attempt. The Centers for Disease Control and Prevention (CDC) provides the technical definitions of suicide-related terminology. The CDC categorizes suicide as a subset of self-inflicted violence or deliberate actions that result in injury, with the implicit or explicit intent of self-harm. Additionally, the CDC clarifies a suicide attempt as a nonfatal self-directed behavior

[6] Holly Hedegaard, Sally Curtin, and Margaret Warner, *Suicide Rates in the United States Continue to Increase*, National Center for Health Statistics Data Brief no. 309 (Hyattsville, MD: National Center for Health Statistics, 2018), 14.

[7] Beverly G. McCarter and Brian E. White, *Leadership in Chaordic Organizations* (Boca Raton, FL: Taylor and Francis, 2013), 212.

with any intent to die, which may or may not result in injury.[8] However, the CDC definitions are not enforced equally across different jurisdictions, and each organization decides how strictly the data associated with the CDC's definitions are collected.

The issue of suicide has become increasingly important nationally because of rising suicide rates. The CDC identified suicide as the tenth leading cause of death in the United States since 2008 and the second leading cause of death for those between eighteen and forty years of age since 2014.[9] The modern Western, or European-centric, culture often associates suicide with mental health issues and depression. However, it is essential to understand that this is a unique cultural and generational approach, given that some cultures view suicide as an honorable option.

Understanding the trends in the current overall US civilian population regarding suicide can help contextualize and assist the Army in making better-informed judgments about suicide prevention programs and suicide response procedures. Based on national data, men die by suicide at a much higher rate than women, despite the number of reported attempts and suicidal ideations being remarkably similar between women and men. The most common explanation for this discrepancy is that men tend to use more lethal means of self-inflicted harm. Men are 72 percent more likely to use a firearm when attempting suicide.[10] On a national average, suicide rates have a marked increase during the teenage years and then mostly maintains a consistent rate until men see another marked rise that starts around seventy years of age.[11] There are significant differences

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[8] Alex Crosby, LaVonne Ortega, and Cindi Melanson, *Self-Directed Violence Surveillance: Uniform Definitions And Recommended Data Elements* (Atlanta: Centers for Disease Control and Prevention, 2011), 21–23, accessed November 13, 2020, https://www.cdc.gov/violenceprevention/pdf/Self-Directed-Violence-a.pdf.

[9] National Center for Health Statistics, "Adolescent Health," Centers for Disease Control and Prevention, last modified October 30, 2020, accessed November 12, 2020, https://www.cdc.gov/nchs/fastats/adolescent-health.htm.

[10] Michael F. Siegel and Emily F. Rothman, "Firearm Ownership and Suicide Rates Among US Men and Women, 1981–2013," *American Journal of Public Health* 106, no. 7 (2016): 34, accessed November 7, 2020, https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2016.303182)

[11] Rajeev Ramchand, *The War Within: Preventing Suicide in the U.S. Military* (Santa Monica, CA: RAND Corporation, 2011), 53–55.

in suicide rates based on race, educational level, and marital status; however, they are much more difficult to define clearly, so this monograph will rely on previously conducted analyses of the relevant data around these categories to determine the applicability to understanding the issue of suicide in the active to duty Army. A transparent and frequently updated methodical report that accounts for additional population risk factors, beyond just age and gender, and how they affect suicide rate, can help the Army make more informed decisions about the efficacy of their current programs and develop more effective anti-suicide approaches. Understanding the differences and similarities between soldiers and a comparable subset of the general US population can help the Army determine potential risk factors and where best to direct prediction efforts.[12]

It is necessary to combine several publicly available databases to have enough relevant data on suicides to compare civilian and active duty Army populations. The CDC's National Violent Death Reporting System (NVDRS) provides detailed information on suicide in several states. The US Census Bureau's Current Population Survey provides representative data of a state's general population. Used in conjunction, the two reports allow for an analysis that accounts for critical demographics such as age, gender, marital status, education level, and race. Conducting a useful comparison between the Army and the general US civilian population requires accounting for the core demographic difference between them.[13]

However, only accounting for one or two core demographic variables does not fully justify the differences between the two populations because of all the critical unmeasured factors that differ widely in the two populations. Crucial factors such as psychological resiliency, exposure to stressors, geographic location, childhood, occupation, and availability of lethal means

[12] Griffin et al., *Comparing the Army's Suicide Rate*, 59–63.

[13] Ibid., 41–49.

are difficult to measure.[14] There are very few data sets that account for more qualitative factors in a standard way to compare the differences between the civilian population and the active duty Army. There are other aspects to suicide that are easier to collect data on because it does not require cross-demographic comparisons.

A concern noted in new data is a recent increase in imitative suicide. The issue of imitative suicide has received greater attention because of some initial evidence seemed to indicate that one suicide had the potential to produce more suicides. Colloquially called copycat suicide, an imitative suicide is when someone emulates a suicide of which they have knowledge, a connection can also come from secondhand accounts or the media.[15] Signals of a suicide contagion effect come from documented data of when suicides cluster based on proximity in location or time from exposure to a suicide event. Young adults are at a higher risk of imitative suicide than those over thirty years old.[16] There are concerns that the societal and media normalization of suicide will lead to an increased the risk of imitative suicides. However, the link to suicidal ideations and preventative training is mainly unfounded. There are not enough studies about the impacts of suicide clustering and the availability of different methods of suicide on the internet to say that there is no correlation between the internet usage and imitative suicides.

Aside from imitative suicides, leaders have also voiced concerns that asking soldiers if they have suicidal ideations could lead to increases in suicide clustering. There is no evidence that supports this concern; in fact, the data suggests the opposite is true. Talking about suicide and asking directly about suicidal ideations is shown to educate and identify potential suicide issues.

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[14] Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012 *National Strategy for Suicide Prevention: Goals and Objectives for Action* (Washington, DC: US Department of Health and Human Services, 2012), 19, accessed November 17, 2020, https://www.ncbi.nlm.nih.gov/books/NBK109917/.

[15] Ramchand, *The War Within,* 77.

[16] Beverly Insel and Madelyn Gould, "Impact of Modeling on Adolescent Suicidal Behavior," *The Psychiatric Clinics of North America* 31, no. 2 (2008): 17, accessed September 9, 2020, https://pubmed.ncbi.nlm.nih.gov/18439450/.

The strongest correlation between suicides and imitative attempts is when individuals are exposed to a suicide event from within their close peer group. Therefore, individuals who have a close friend who attempts suicide are at a higher risk of being negatively influenced to develop suicidal ideations. The likelihood of imitative suicide is also most substantial for younger adults and adolescents. The rate of imitative suicide also increases in correlation to how substantial the relationship was between the at-risk individual and the suicide victim.[17]

An often-cited and outdated study suggesting there are six people impacted by each suicide that could benefit from support or clinical services is vastly underestimated based on more recent studies. One study from 2019, which defined a suicide impact as knowing the victim to a level where the event has a negative impact on the professional or personal life of the loss survivor, found that in a civilian populace, a single suicide event exposes an average of 135 people.[18] In a close-knit community, such as an active duty Army formation, it is reasonable that the number of people who could benefit from support after being exposed to a suicide event may be even higher than the civilian average. Despite evidence that surviving unit members exposed to a suicide event may be at increased risk for suicide, no efforts or policies currently exist to address what responses should be taken after a suicide death to mitigate possible imitative suicides.[19]

The risk of imitative suicide in the Army will continue to be an obstacle given the increase in suicide rates among younger generations. The DA's Inspector General Office has

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[17] Madelyn Gould, "Suicide and the Media," *Annals of the New York Academy of Sciences* 932, no. 1 (January 2006), accessed November 17, 2019, http://www.columbia.edu/itc/hs/medical/bioethics/nyspi/material/SuicideAndTheMedia.

[18] Julie Cerel, Margaret Brown, and Myfanwy Maple, "How Many People are Exposed to Suicide? Not Six," *Suicide and Life-Threatening Behavior* 42, no. 2 (April 2019): 531–5.

[19] Rajeev Ramchand, Lynsay Ayer, Gail Fisher, Karen Chan Osilla, Dionne Barnes-Proby, and Samuel Wertheimer, *Suicide Postvention in the Department of Defense: Evidence, Policies and Procedures, and Perspectives of Loss Survivors* (Santa Monica, CA: RAND Corporation, 2015), 14, accessed October 12, 2020 https://www.rand.org/pubs/research_reports/RR586.html.

recognized the need to better understand the cultural and generational changes that have destigmatized suicide. The rate of suicide among adolescents and young adults in the civilian population has been increasing faster than the rest of the general populace. In 2017, suicide became the second leading cause of death among individuals between ten to thirty-four years old and the fourth leading cause for people from thirty-five to fifty-four years old.[20] The increase in suicide rates among the potential pool of recruits for the Army means that suicide prevention methods will have to account for new risk factors with a younger generation that does not have the same level of stigma towards death by suicide.

The changing generational attitudes towards suicide will become more of a factor in how the military approaches suicide prevention. There are lessons learned from the civilian populace that can benefit the Army's efforts, but they require combining Army suicide data with the larger population. As discussed earlier, the difficulties in comparing active duty Army suicide numbers to the civilian population is partially due to the lack of standardization. The CDC has published guidance on the definitions and classification of suicide and the recommended socioeconomic demographic data to include in reporting. However, adherence to this varies among organizations because there is no enforcement mechanism to ensure organization follow CDC guidelines.

Also, the suicide data the CDC compiles is only based on the death certificate registries forwarded by each state. The reliability of suicide data varies between states, making cross comparison difficult. In the current suicide surveillance system, there is approximately a two-year delay before the National Center for Health Statistics publishes the injury mortality report for a Calendar Year (CY). The delay in the release of civilian national suicide data makes timely comparisons to the active duty Army difficult.[21]

[20] Ramchand, *The War Within*, 49–50.

[21] Ibid., 30–31.

Suicide in the Active Duty Army

The Army has been struggling with increasing rates of suicide among active duty personnel for the past fifteen years.[22] Given that Chief of Staff for the Army General James McConville's number one priority for the Army is its people, and there is a sharp increase in active duty suicide rates, analyzing suicides and prevention methods will continue to be an important topic. Identifying the gaps in the Army's current suicide prevention efforts will help save lives and create a more resilient force. The loss of a suicide victim negatively impacts the entire unit's combat readiness level, even affecting that unit's retention and morale. The issue of suicide prevention will continue to be a wicked problem for the Army. The Army has historically had the highest rate of suicide when compared to the other branches of the military; however, in CY18 the Marine Corps saw an increase that elevated their rate above that of the active duty Army (see Table 2). The largest demographic group represented in the active duty Army is young adult males and this is the same demographic with the highest rates of suicide in the civilian population.[23]

Table 2. Number and Rate per 100,000 of Death by Suicide

	CY16		CY17		CY18	
Active Component	Number	Rate	Number	Rate	Number	Rate
Air Force	61	19.4	63	19.6	60	18.5
Army	130	27.4	114	24.3	139	29.5
Marine Corps	37	20.1	43	23.4	58	31.4
Navy	52	15.9	65	20.1	68	20.7

Source: Created by author from Jennifer Tucker, Derek J. Smolenski, and Carrie H. Kennedy, D*epartment of Defense Suicide Event Report: Calendar Year 2018 Annual Report* (Washington, DC: US Department of Defense, July 19, 2019), accessed August 28, 2020, 31, https://www.pdhealth.mil/sites/default/files/images/docs/TAB_B_2018_DoDSER_Annual_Report-508%20final-9MAR2020.pdf.

[22] Eren Youmans Watkins et al., "Adjusting Suicide Rates in a Military Population: Methods to Determine the Appropriate Standard Population," *American Journal of Public Health* 108, no. 6 (2018): 770-771.

[23] US Department of Defense, "Department of Defense Suicide Event Report (DoDSER) and DoDSER Annual Report," Psychological Health Center of Excellence, accessed August 28, 2020, https://www.pdhealth.mil/research-analytics/department-defense-suicide-event-report-dodser.

Military suicide rates are often compared to the larger civilian populace, but there are many different ways to conduct the comparison. The Defense Suicide Prevention Office (DSPO) tracks suicide numbers in the Department of Defense (DoD), and the trend for the active duty Army has been an increase in numbers per 100,000 over the last twenty years.[24] Young enlisted soldiers account for over half of the 2019 suicides. The 17–29 year old population in the active duty Army accounts for just over 67 percent of the total suicides in the active force in CY18 (see Table 3). The rate for the Army grew to 29.8 suicides per 100,000 soldiers for CY 2019.[25] In CY 2020, the active duty Army had a 30 percent increase in deaths by suicide by September compared to all of CY 2019. There seems to be a correlation between increased suicides and the start of the coronavirus disease of 2019 (COVID-19) restrictions.

Table 3. Age Demographic Characteristics of Active Army Suicide, CY18

Age	Number of Suicides
17–19	5
20–24	57
25–29	32
30–34	18
35–39	18
40–44	6
45–49	3

Source: Created by author from Jennifer Tucker, Derek J. Smolenski, and Carrie H. Kennedy, D*epartment of Defense Suicide Event Report: Calendar Year 2018 Annual Report* (Washington, DC: US Department of Defense, July 19, 2019), accessed August 28, 2020, 9, https://www.pdhealth.mil/sites/default/files/images/docs/TAB_B_2018_DoDSER_Annual_Report-508%20final-9MAR2020.pdf

Unfortunately, the unconfirmed data from CY 2020 seems like it could be the worst year on record for active duty suicide, based on the raw numbers, with much of the increase again coming from soldiers without combat deployments. It is difficult to get an accurate number of active duty Army suicides in the current system until the data is published in the DoD Suicide

[24] Ramchand, *The War Within*, 10; Griffin et al., *Comparing the Army's Suicide Rate*, 54.

[25] Tom Vanden Brook, "Suicide Rate among Active-Duty Troops Jumps to Six-Year High, COVID-19 Stress Could Make It Even Worse," *USA Today*, last modified October 1, 2020, accessed September 11, 2020, https://www.usatoday.com/story/news/politics/2020/10/01/suicide-rate-among-active-duty-troops-jumps-six-year-high/5879477002/.

Event Report (DoDSER) because suicides are tracked differently at each echelon. The sharp increase in suicide deaths for 2020 in the active duty Army was a problematic development for Army leadership who track and analyze suicides given that the numbers of suicides were down during the first three months of the year compared to 2019.[26] However, the data is still too undeveloped to make any deductions about the relationship between COVID-19 and the increase in active duty Army suicides. The larger US population is also seeing a rise in suicides during the COVID-19 pandemic but not as high of an increase as the military.

The active duty Army's aggregate suicide rate is higher than the US civilian population's rate; however, the two populations are not necessarily easily comparable with a univariate analysis. There are several important reasons that might contribute to the active duty Army's suicide rates appearing to be higher than the overall civilian population. One of the most crucial factors is that the two populations differ on numerous critical demographic issues such as age, sex, race, and educational level. Furthermore, the comparison between military and civilian suicide numbers is nebulous because the definitions of what is classified as a suicide, and the procedures for reporting them, vary between local governments and differ from the DoD standards with varying levels of reliability. After adjusting the US population sample to an equivalent demographic profile based on age and sex, the overall DoD had a lower rate of suicide than their civilian counterparts from 2001–2008. However, the active duty Army rates surpassed the similar civilian population in 2008.[27]

Most comparisons between the Army and civilian population regarding suicide consider only age and sex based on CY and find that the suicide rate in the Army is comparable to the civilian population. However, studies that analyze additional relevant demographic factors such

[26] Lolita C. Baldor and Robert Burns, "Military Suicides up as Much as 30% in COVID Era," *Associated Press News*, last modified September 27, 2020, accessed October 9, 2020, https://apnews.com/article/virus-outbreak-air-force-stress-archive-army-2be5e2d741c1798fad3f79ca2f2c14dd.

[27] Ramchand, *The War Within*, 10–11.

as race, education level, and marital status find that the Army's rate of suicide is higher than the adjusted civilian population rate. The less commonly used but relevant demographic factors reveal that the Army's rate of suicide is higher than the comparable civilian populations.[28] Developing a better understanding how the suicide rate in the active duty Army is worse than the civilian population, depending on how the person analyzing the data compares the two groups, should ensure that Army leaders do not make an erroneous assumption that current suicide prevention efforts are adequate to address the issues. Understanding the gaps in knowledge about the data surrounding suicide is vital to prevent faulty assumptions, and one of the potential shortfalls in the data is how the Office of the Armed Forces Medical Examiner (OAFME) collects suicide related information.

The OAFME serves as the filter for all suicide determinations in the US military. The military did this by design to standardize the reporting data. However, attempting to funnel all the active duty military suicide data though a single office also comes with drawbacks. The OAFME is responsible for determining the cause of death for all service members and conducting an autopsy for all active duty soldiers, depending on local jurisdictions. Chapter 75 of Title 10 US Code covers deceased personnel and directs the OAFME to investigate the death of a service member if the cause of death appears to be unknown or from unnatural causes.[29] In the case of a suspected suicide, the medical examiner and a mental health expert are both responsible for determining if the cause of death was suicide. However, if the death of a soldier occurs outside of military installations, the civilian organization with jurisdiction is responsible for conducting the autopsy, and the OAFME must request to be involved in ongoing investigations. The

[28] Griffin et al., *Comparing the Army's Suicide Rate*, 49–52.

[29] Jeffrey Allen Smith, Michael Doidge, Ryan Hanoa, and B. Christopher Frueh, "A Historical Examination of Military Records of US Army Suicide, 1819 to 2017," *JAMA Network Open* 2 (December 2019): e1917448, accessed July 27, 2020, https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2757484.

inconsistencies of the data reported by civilian autopsies differ by city and state jurisdictions, and vary from the standardized reports from the OAFME, which leads to delays or even conflicts in determining the cause of death.[30] The National Guard and Reserves suffer from the same problems associated with suicide data from civilian suicide reports, primarily due to the differences in the investigations conducted in suspected suicides. The variations between jurisdictions also impacts how suicides are classified and what data is collected.[31] The DoD attempted to solve some of the complications around suicide reporting by implementing the DoDSER as a standardized suicide event report.

The DoDSER, which started in 2008, provides a common standard of suicide reporting for all U.S. military service members. The suicide prevention community widely regard the DoDSER as a rigorous and accurate report that is a vast improvement from the previously unintegrated military service reports. Despite the strengths of the DoDSER, there are still weaknesses in the report, there are several inconsistencies in tracking non-active component suicide-related data. Also, the DoDSER does not provide the raw data or the sources of the data, which makes cross-analysis and validation difficult.[32]

There is controversy around how much data involving a suicide should be made available and who should have access to it. There is a valid concern to honor and respect the soldier's privacy who dies by suicide and those impacted and grieving from the loss. The DoDSER must find a way to protect the privacy of service members while providing critical data to produce a report with more utility to inform Army policy and its leaders. The inclusion of a control group and the data collected from the psychological autopsies would be a good start in creating a more useful report. The DoDSER data could also be compared to the Defense Suicide Prevention Office statistics involving cases of suspected and confirmed nonfatal self-inflicted injuries within

[30] Ramchand, *The War Within*, 8–9.

[31] Ramchand et al., *Suicide Postvention in the Department of Defense*, 35–38.

[32] Ibid., 11–13.

the active duty force to determine if the military is already collecting information could be used as warning or indicators of potential suicide ideation. For example, from 2005–2010 there were approximately fifteen attempts per suicide in the active duty Army.[33] Understanding how these trends could provide a deeper understanding of some of the variables surrounding suicide.

The Army categorizes most active duty Army deaths by suicide as occurring in the line of duty. However, if the investigation finds the death to be the result of negligence or misconduct on behalf of the soldier, a suicide death can be found to be not in the line of duty. In the case of possible suicide, a mental health officer is required to evaluate the evidence provided in the line of duty investigation before an official determination. Determining whether a suicide death occurred in the line of duty is of critical importance because this usually determines if the soldier's dependents are eligible for benefits. If a service member's death is determined to not be in the line of duty, then loss survivors may not be eligible for benefits plans and compensation.

There are some concerns among Army leaders that the availability of benefits and compensation to suicide loss survivors incentivizes death by suicide for active duty soldiers. There have been recommendations to reevaluate eligibility criteria to receive benefits in the case of sponsor suicide.[34] However, there are limited studies with evidence if the availability of benefits incentivizes active duty soldier suicide and would have cascading effects on suicide loss survivors and the stigma associated with it. Currently, the regulations involving line of duty investigations are focused on determining the potential for criminal activities and not on the underlying causes of mental health-related deaths. The existing regulations require the investigator to provide overwhelming evidence that a suicide was not caused by mental

[33] US Department of Defense, Medical Management Activity, *2011 Health Related Behaviors Survey of Active Duty Military Personnel* (Washington, DC: Government Publishing Office, 2013), 209–210.

[34] Haley Britzky, "The Army Chief of Staff wants you to have work-life balance. Seriously," *Task & Purpose*, October 15, 2020, accessed December 19, 2020, https://taskandpurpose.com/news/army-chief-mcconville-people-priority/.

unsoundness prior to determining a suicide occurred not in the line of duty. This threshold causes most active duty suicides to be categized as in the line of duty, which results in the dependents of the deceased being eligible for compensations and benefits.[35]

Analysis of the Army's Anti-Suicide Approach

Prevention

Suicide Prevention Programs

The Army's current suicide prevention measures mostly rely on passive resilience training and fellow soldier intervention. It is difficult to measure the effectiveness of these programs because it would primarily depend on collecting data about preventing harm, proving a negative. The larger civilian public health sector continues to struggle with how to judge the effectiveness of prevention programs in general. A minimal number of programs are designed to teach strategies to help soldiers develop skills to help them care for themselves, including identifying when a self-referral is needed.[36] The Army's resiliency training focuses on developing skills for soldiers to recover from setbacks quickly. However, the quality of training varies widely between units. Also, the amount of positive support for the efforts has decreased since the suicide prevention programs have changed into a military training-the-trainer methodology. Also, the Army's resilience training is not focused on suicide prevention.

As a result, he emphasis in the active duty Army regarding suicide and suicidal ideation prevention remains the Ask Care Escort- Suicide Intervention (ACE-SI) training. The ACE-SI training is adapted from the civilian sector's Screening, Brief Intervention, and Referral to Treatment (SBIRT) method used to mitigate the risk of suicide and substance abuse in at-risk

[35] Ramchand et al., *Suicide Postvention in the Department of Defense*, 46–47.

[36] Ramchand et al., *Suicide Postvention in the Department of Defense*, 34; Griffin et al., *Comparing the Army's Suicide Rate*, 31-32.

individuals.[37] The ACE-SI training has evolved from its original intervention focus. The Army's ACE Card was originally the primary focus of suicide prevention training and relied primarily on the intervention of a fellow soldier (see Figure 1).

Figure 1. US Army ACE Card. US Army Public Health Center, *Army Suicide Prevention Program*, accessed March 19, 2021, https://ephc.amedd.army.mil/HIPECatalog/viewItem.aspx?id=106.

The ACE-SI program also teaches soldiers the skills necessary to know how to self-refer to the appropriate mental health professional or another service who can connect them with suicide prevention resources.[38] The American Foundation Best Practice Registry for Suicide Prevention and the Suicide Prevention Resource Center recognize the success of the Army's

[37] Jane Gervasoni, "ACE Suicide Prevention Program Wins National Recognition," US Army, September 1, 2010, accessed January 9, 2021, https://www.army.mil/article/44579/ace_suicide_prevention_program_wins_national_recognition.

[38] Ramchand, *The War Within*, 44.

ACE-SI training and its potential for more extensive applicability.[39] However, despite the ACE-SI program existing for over fifteen years, there were multiple revisions, and, more concerning, there was a gap in coverage in the ACE-SI program because of proprietary conflicts about the naming convention.

There is limited evidence that the current high-risk identification tools that the active duty Army uses are effective. This limited effectiveness also applies to the programs used to identify soldiers at high-risk of suicide or suicidal ideations. There are multiple reasons for the lack of understanding of the level of success in the current suicide prevention efforts. Primarily there are very few refined measures of effectiveness developed for ongoing programs. Additionally, many of the programs that fall into the suicide prevention category are frequently under revision, like the ACE-SI program discussed earlier. An example is the recent revisions to the Commander's Risk Reduction Dashboard (CRRD).

The CRRD was initially designed as a tool to improve readiness by increasing visibility into a service member's behavioral trends. The dashboard is supposed to collate data from multiple military databases and prevent soldiers with risk factors from falling through the cracks as they change units. However, the CRRD continues to have problems with integrating information from multiple sources. Also, different commands place varying levels of emphasis on using the tool, which prevents the desired utility of tracking at risk soldiers as they transfer between units. Another issue with the CRRD is who is allowed access to the information. Who has access to the CRRD information has varied between only commanders and entire command teams, which includes the senior enlisted advisor? There is a concerted effort to increase the amount of data senior enlisted advisors are allowed to access. Also, the amount of data from health providers is restricted to deployment limited issues, which varies between health providers.

[39] Gervasoni, "ACE Suicide Prevention Program."

At the company command level, commanders can access an individual's data at higher echelons. The commanders only see the data in aggregate.[40] The CRRD has much potential to be a valuable tool in combating suicide in the Army but needs to be implemented in a way to empower leaders with the information to care for their soldiers and not just as a check the block tool where the only pressure is to increase the deployability statistics of the unit. If the Army wants to be a people first organization, the emphasis needs to be on soldier care and not about trying to show positive statistics or turning a report green.

One of the Army's relatively new People First programs that is focused on suicide prevention is the A Life Worth Living initiative. The program is partially based on the Air Force's integrated approach of trying to actively change their organizational culture to one that considers suicide prevention a responsibility of the whole organization as opposed to solely a mental health issue.[41] A Life Worth Living program is part of a larger initiative the Army has enacted to increase the emotional well-being of the force and change how the organization approaches suicide. A more holistic and proactive mentally about suicide prevention will help reduce the associated stigma and create a more positive narrative to suicide prevention efforts in the Army.

Recently the Army made a concerted effort to change the narrative about how it addresses suicide. Several senior leaders are trying to change the umbrella term of suicide prevention to A Life Worth Living effort. The new A Life Worth Living effort attempts to change how leaders approach suicide prevention to have less of a reactionary connotation. A Life Worth Living focuses on the positive aspects surrounding soldiers and does not only rely on reacting after an obstacle is identified. The new approach addressed one of the most often cited complaints

[40] US Department of the Army, Army Resiliency Directorate, *Commander's Risk Reduction Dashboard* (Washington, DC: Government Publishing Office, 2019).

[41] Kerry Knox, David Litts and Eric Cane, "Risk of Suicide and Related Adverse Outcomes After Exposure to a Suicide Prevention Programme in the US Air Force: Cohort Study," *BMJ* 327, no. 7428 (2013): 19–23, accessed September 22, 2020, https://www.bmj.com/content/327/7428/1376.

about the Army's suicide prevention program being too reactionary. A Life Worth Living is designed as a more proactive method that uses a multi-prong approach involving leadership, education, community building, and policy changes to reinforce the individual soldiers' positive aspects of their unit comradery.[42] The holistic and bottom up approach of A Life Worth Living is similar to the This is My Squad initiative. This is My Squad is meant to improve the knowledge between soldiers and their first-line leaders to build more cohesive teams that have each other's best interests at heart.[43] The Life Worth Living and This is My Squad programs are complementary and should be mutually supporting efforts. However, currently, this is a missed opportunity because there is very minimal mention of the two programs together, or how they support each other. The This is My Squad effort helps to enable engaged leadership where soldiers know more about each other and their normal baseline behaviors. This creates the conditions to better implement A Life Worth Living initiative. Leaders can then proactively focus on the things that are vital to the individual soldiers in their span of control and identify if something is wrong, or potentially dangerous, with a fellow soldier before it devolves into a suicide ideation or risk factor.

GEN Paul E. Funk, Commander of the Army's Training and Doctrine Command (TRADOC), is also attempting to change how the Army views proactive suicide prevention. GEN Funk proposed that he will make it mandatory for all soldiers within his command to conduct an annual behavioral health appointment. The concept behind this initiative is to reduce the stigma associated with seeking help and to identify potential indicators of suicidal ideation earlier in the prevention process. However, there are concerns about the current behavioral health system's

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[42] Joseph M. Martin and Michael A. Grinston, hosted by Daniel Dailey, "Soldier Today: GEN Martin & SMA Grinston on Suicide, Cohesive Teams, and This Is My Squad, Association of the United States Army, September 7, 2020, podcast, 31:27, accessed September 27, 2020, https://podcast.ausa.org/e/soldier-today-gen-martin-sma-grinston-on-suicide-cohesive-teams-and-this-is-my-squad-tims/.

[43] Ibid.

ability to support the significant increase in appointments, decreasing the overall level in the quality of services provided.[44] An additional risk is that if behavioral health appointments are mandatory, they could become perfunctory in the same way some soldiers view the current mandatory Periodic Health Assessments (PHA).

Obstacles Impeding Progress Toward Achieving Fewer Suicides

The Army faces several hurdles in its approach to eliminating suicides though reducing the stigma associated with seeking behavioral health in the active duty force. Despite the recent emphasis from senior leaders on reducing stigma, there are still concerns throughout the soldiers in the Army. From the viewpoint of some soldiers, part of the issue comes from concerns about the level of confidentiality with Army behavioral health support, inhibiting soldiers from utilizing such services.[45] The fears about the level of discretion between soldiers and behavioral health providers also restricts what soldiers are willing to disclose to the provider when they overcome the initial stigma to seek support. Most active duty Army suicide prevention methods rely on intervention from an individual, such as a fellow soldier, chaplain, or medical personnel who recognize signs in a potentially suicidal fellow soldier.[46] However, as mentioned earlier, the stigma limits the likelihood of people who notice suicidal signs to intervene on someone else's behalf. A soldier could identify a potential suicidal ideation in a teammate but not take action out of fear of damaging that person's military career.

There is no effective way to measure if the Army's current suicide prevention efforts are causing a decrease in the overall number of suicides in the active duty force. Similar to the difficulties in proving the effectiveness of military deterrence, it is nearly impossible to measure

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[44] Matthew Cox, "General's Proposal to Curb Suicide: Require Every Soldier to Visit Behavioral Health," Military.com, September 29, 2020, accessed January 9, 2021, https://www.military.com/daily-news/2020/09/29/generals-proposal-curb-suicide-require-every-soldier-visit-behavioral-health.html.

[45] Courtney Buble, "Pentagon Struggles to Address Service Member Suicides," The Government Executive, August 28, 2019, accessed August 24, 2020, https://www.govexec.com/defense/2019/08/pentagon-struggles-address-service-member-suicides/159518/.

[46] Ramchand, *The War Within*, 108.

negative effects because the data cannot determine direct causation between prevention efforts and the absence of an event. Despite the active duty Army placing increasing emphasis on suicide reduction efforts, the number of suicides that these programs and initiatives have prevented cannot be calculated. There is extremely limited data on the relationship between prevention programs and suicide. The majority of the data on suicide prevention efforts focuses on prevention efforts directed to someone who already displayed suicidal ideations and received support through some form of intervention. Measuring suicidal ideation, suicide attempts, or other suicidal behavior is even scarcer and less consistent than data on suicides itself. The relative rareness of suicide and suicide data make it difficult to evaluate the effectiveness of prevention programs. The lack of ability to accurately predict suicides means most studies' findings focus on if they prevented a suicide instead of a correlation to suicide rates. Longitudinal studies that observe prevention efforts are required to determine the effectiveness of suicide reduction efforts.[47] The continuous modifications to suicide prevention efforts in the Army make a longitudinal study more difficult.

There are also valid ethical concerns about preventing the improvement in suicide prevention programs just to evaluate the programs' efficacy more effectively. If leaders have good reason to believe an effort is not effective there is an ethical requirement to makes changes that could potentially saves lives. However there needs to be an understanding that even if leaders are focusing on beneficence and helping soldiers, changing suicide prevention programs without can lead to more confusion. Another complication in evaluating the effectiveness of suicide prevention programs is that most of the active Army prevention efforts are multifaceted, which complicates the data and makes it more difficult to discern the individual components responsible for the observed outcomes.[48] The DoD has made improvements in data collection regarding

[47] Paul T. Wong and Adrian Tomer, "Beyond Terror and Denial: The Positive Psychology of Death Acceptance," *Death Studies* 35, no. 2 (2011): 9.

[48] Ramchand, *The War Within*, 114.

suicide, but there is still much room for improvement to better understand the environment around the suicide problem in the military.

The DoD's use of the CDC suicide data collection guidelines and the Armed Forces Medical Examiner System (AFMES) to capture data in the annual DoDSER is a start in standardizing the information around suicide and providing the data to analyze it. However, some of the precautions set in place to ensure the accuracy of the report limit the visibility of useful information at levels below the DA. The process of producing the DoDSER is not transparent, and the people responsible for publishing the DoDSER work for the highest echelons of the military. This is done to protect the privacy and control the integrity of the report. However, there are unintended negative consequences to this method of producing the DoDSER. Most commanders at echelons below DA are unaware of how the Army tracks suicides and where the information is stored.[49] To reduce the stigma around suicide and increase awareness of suicide data and the current gaps in the information, the DoDSER process needs to be more transparent and designed with lower echelon leaders to make it a more helpful tool for empowering leaders in suicide prevention. Making these changes will also address how differently units see the issue of suicide and what actions they take within their organization.

There is an extremely wide variance in how commands across the Army address the issue of active duty suicide. Each division, corps, and higher-level command approaches suicide prevention in different ways and commands do not see the issue of suicide in the same way. Some see it as a cultural problem, while others see it as a religious issue and assign different levels of priority on suicide prevention according to their interpretation. The difference in how commands approach suicide prevention is not just limited to the interpretation of the issue and how high of a priority the issue is given. The suicide prevention efforts are structured differently at each command, with some major commands (four star level) only having one person designated to

[49] Ramchand, *The War Within*, 109.

suicide prevention, while some divisions and corps have robust suicide prevention teams. The diverse interpretations around suicide and the different suicide prevention structures complicates how the Army addresses suicide prevention programs across organizations.[50] The lack of similarity between commands in suicide prevention degrades effective communication and impedes the transfer of lessons learned between organizations.

Vague and dispersed guidance about suicide also hinders prevention efforts across organizations. The current organizational responsibilities and guidelines for prevention and the requirements after a suicide related event are challenging to find and difficult to navigate. The unclear guidance contributes to the wide variance between how different organizations approach suicides and suicide prevention. The lack of clear understanding about suicide prevention programs and the associated data makes it almost impossible for the Army to understand the environment around suicides, much less analyze the relevant variables to understand the efficacy of current preventative measures. If the Army is going to improve its suicide prevention efforts, it must remove the ambiguity in the requirements for commands, recognize the gaps in knowledge to understanding suicide, and empower leaders with the data to save the lives of their soldiers. The current method of approaching suicide in terms of combat readiness levels is inadequate to address the difficulties. The impacts on readiness rates are only one risk factor. Army leaders should be focusing their efforts on mitigation and not focusing on one measure of performance with readiness levels.

Reaction

Post-Suicide Reaction Procedures

Unfortunately, there are limited scientifically based studies on how to best respond to suicide events. The Army does have several different resources available for leaders to use even

[50] John Bateson, *Last and Greatest Battle Finding the Will, Commitment, and Strategy to End Military Suicides* (New York: Oxford University Press, 2015), 34.

though the efficacy of these programs is unclear or not recorded. The response to a suicide event varies by both instillation and unit, which makes a comprehensive review of suicide response procedures impracticable, and any findings would have limited utility across the larger force. There are efforts to improve how the Army measures its procedures after a suicide event. However, they involve several data sources throughout the military enterprise, and unfortunately, the information between the data sets often does not match.[51] Unit-based line of duty investigations, criminal investigations, and the OAFME are three such sources of information that do not always align with each other. Therefore, what little resources are allocated towards suicide prevention at units is spent tracking down the discrepancies in the data sets, leaving less time for analysis, prevention, and post suicide event efforts.

The inefficiencies and lack of transparency in the reporting processes diverts the limited resources allocated for suicide away from programs that benefit the soldiers and mitigate the effect on readiness levels. In addition, the current suicide reaction requirements place most of the responsibility on command teams, even down to the company level, where they are often held accountable for the suicides and suicide attempts within their organizations.[52] Although taking responsibility for the success and failures within an organization is a critical aspect of leadership in the Army, this paradigm has negative consequences on how units track at risk soldiers and implement postvention efforts. There is a myriad of tracking tools that company-level commanders are required to use, and they are often not user-friendly and change frequently. In addition, commanders have an inherent incentive to hide suicide related information. Omitting risk factor information from reports allows for better readiness or deployability statistics. Conversely, this mentality creates a counterproductive climate and prevents soldiers from getting the services and support they need. The perception is, outside of suicide-related lawsuits

[51] Ramchand et al., *Suicide Postvention in the Department of Defense*, 7–9.

[52] US Department of the Army, *Applied Suicide Intervention Skills Training* (Washington, DC: Government Publishing Office, 2018), 29.

regarding liability, the Army holds commanders responsible for the suicide events in their unit, to a level that is even above that of certified mental health professionals.

Obstacles and Inefficiencies in Post-Suicide Requirements

After a death by suicide of an active duty soldier, the focus is on the administrative requirements. These organizational requirements extend beyond the unit leadership, unfortunately the administrative burdens fall on the members within the unit as well. The processes overtax the suicide loss survivors in the midst of their grieving process, when the soldiers are more vulnerable to high-risk behavior. The fact that suicide loss survivors also feel that a suicide death is not treated the same as other forms of death, such as training accidents and combat, because of the stigma associated with suicide exacerbates the risk during the grieving process.[53] The procedures are complex and not intuitive. The Army requirements after a suicide are not centered on caring for the people impacted. The requirements are laborious bureaucratic tasks designed to determine if the command team followed all the correct protocols. Completing these administrative tasks often devolves into assigning blame, causing command teams to become defensive instead of caring for their grieving unit. The feeling of blame and need for self-justification does not stop at lower echelons. Even senior level leaders are often defensive and combative when required to brief major commands on a suicide event. The Army hinders its own efforts in suicide prevention by creating an adversarial environment after a suicide event where the focus is on bureaucratic and redundant tasks with strict timelines.

One aspect that prevents command teams and units from being fully trained to deal with a suicide or suicide event is the relative rarity with which they occur. The unfortunate side effect of this is that it means a unit's leadership rarely has experience dealing with more than one suicide event, and, therefore, there is a steep learning curve for the unit. The likelihood of only being

[53] Ramchand et al., *Suicide Postvention in the Department of Defense*, 51–55.

involved in one, or no, suicides is even higher at the company and battalion levels where most of the responsibility for post suicide action resides. The lack of experience increases the importance of easily understand procedures that do not overburden the grieving unit or its leadership.[54]

An additional complication in addressing post suicide reaction procedures is the complexity when an Army suicide does not happen in a garrison setting. The majority of the Army's current reporting analysis focuses on the active duty Army force while not deployed. When a soldier is deployed or under a Combatant Command Authority, the post-suicide event reaction process differs between each Geographic Combat Command. There is a need for each command to have the flexibility to adapt their suicide responses to the specific needs of their formations.[55] However, the lack of continuity in the reaction process hinders access to resources for grieving units and places additional stress on the command team.

Recommendations

The primary change that could benefit the Army's suicide prevention efforts is to conduct a more thorough assessment of the current programs. There must be a systematic process to holistically and strictly evaluate the current campaigns directed toward suicide prevention. The level of awareness soldiers have about the Army's suicide prevention efforts is only one measure of performance. To truly understand the effectiveness of the suicide prevention programs, there must be bottom-up feedback from leaders about the programs - are they producing the desired results and, if so, how. If the bottom-up feedback can be conducted in a systematic way, it will provide senior leaders with knowledge about their suicide prevention efforts to know if their assumptions are valid and where the program needs refinement. However, refining how the Army assesses its suicide prevention efforts does not address its response after a suicide event.

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[54] Ramchand et al., *Suicide Postvention in the Department of Defense*, 54.

[55] US Army, *Applied Suicide Intervention Skills Training*, 41.

The active duty Army could benefit from developing a robust postvention response to suicides and suicide attempts to mitigate the risk of imitative suicides and suicidal ideations. The initial focus of refining the post-suicide response process should be to streamline and clearly define reporting procedures. The current reporting requirements for suicides are convoluted and too focused on administrative tasks. The response procedures have a minimal emphasis on postvention and protecting the force, especially the grieving unit. Also, the suicide response teams' primary focus on is aiding the command teams in navigating bureaucratic tasks for which they are responsible after a suicide. The focus on administrative tasks limits the practical knowledge gleaned for each suicide.

The Army's post suicide event reaction process must collect the necessary data required for the DoDSER. However, the reaction procedures should also respond to the grieving unit and address how to glean knowledge from the specific conditions unique to every suicide incident. As discussed earlier, no two suicides are the same, and the data centric focus of the Army hinders understanding the nuances of the situation to gain understanding and knowledge about suicide in favor of just gathering information. A more nuanced approach that treats each suicide as unique would enable leaders to understand better where the disconnects are and build more confidence in the suicide prevention programs. Leaders must be able to provide their grieving units with unique applicable tools to take away from the event instead of generic suicide prevention techniques. The generic approach to suicide prevention does not take generational differences into account and this is another aspect the Army must address in how it approaches the problem.

The younger generations in the Army, who are most at risk of suicide, do not receive information in the same way as the older senior leaders. In the same way that not everyone has the same style of learning, there are also generational differences in preferred ways and mediums to receive information in a meaningful way. Understanding how soldiers prefer to receive information is critical in how leaders package suicide prevention information that most impacts the high-risk populations. There is an effort to reach soldiers in the mediums they spend most of

their time. Some examples are the Army's development of phone-based applications and virtual behavioral health appointments with information about tools and resources for suicide prevention. However, there is much room for improvement such as developing partnerships with relevant social media organizations. Coordination with social media platforms could serve as a way quickly provide valuable information to soldiers. Also, to coordination with tech companies could assist the Army in developing algorithms to identify potential at-risk individuals when they are developing suicidal ideations prior to taking physical action. There are many difficulties in approaching partnerships with civilian organizations; however, the topic of suicide requires having difficult and uncomfortable conversations, including what the goal of suicide prevention programs should be.

Developing a realistic desired end-state that accounts for trends within the recruitment pool given the different relevant demographics would significantly improve the Army's suicide prevention efforts. Also, refining the current official guidance, intended to prevent active-duty suicide by streamlining processes and removing ambiguity, can help the Army better understand the gaps in its current suicide prevention efforts. The Army will always have to work with an incomplete understanding of suicide and its associated risk factors; however, understanding gaps in the current prevention efforts and improving postvention processes can enable the Army to make more informed and effective policy decisions to prevent suicide and minimize the negative impacts on the readiness of the force.

Conclusion

Trying to understand the disconnects between suicides in the Army and current prevention efforts is a highly emotional subject. Unfortunately, the heightened awareness around suicides within the Army has not been able to quell the terrible increase in suicide rates. The Army must find a way to be comfortable operating in the fog of ambiguity that will always be around the environment of suicides. The Army has a challenging role of finding the balance

between overacting to an emotional problem set or not acting because of the unknowns surrounding the multitude of variables within each suicide event. Finding the balance between caring for the unit grieving from a suicide and navigating the bureaucratic requirements will require constant refinement as the conditions around suicide continue to change.

The Army will have to consider the younger generations' view of suicide to make any meaningful progress in preventing suicides and cannot afford to continue approaching suicide prevention and postvention in the same way as in the past. This includes establishing realistic goals for suicide based on the data about the environment surrounding suicides. The Army must accept having difficult and uncomfortable conversations about suicide and understand that, unfortunately, this is a war that the Army will always be fighting.

Understanding the war within each soldier and their battles with suicide is a herculean understanding that will never be complete. However, an honest assessment of where the Army is in relation to the civilian population is a necessary start. Most importantly, the Army must not explain away the issues of suicide or underplay the severity of the issue by selectively choosing the variables to include in the analysis. Next, examining the current efforts of suicide prevention to determine their effectiveness is essential. There are currently considerable gaps in knowledge about the effectiveness of Army programs, and before meaningful and lasting reforms can be made to the suicide prevention efforts, these gaps in knowledge must be addressed.

The lack of knowledge about the effectiveness of the current suicide prevention programs in the Army does not mean that the current efforts need to be abandoned. It only means that the current methods for suicide prevention and the measurements of the programs are not sufficient. The rising rate of suicide will continue to decrease the level of combat readiness throughout the Army; unfortunately, it is easy to take a cynical approach when viewing the Army's recent shortfalls in suicide prevention. However, like the wars the Army is told to fight to defend freedom, Army leaders do not get to give up or blame their performance of past failures. It is the

responsibility of every leader to care for each of their soldiers' overall well-being, and keeping soldiers safe, even from themselves, is part of that responsibility.

However, placing all the responsibility concerning suicides on the leader's shoulders is also not the way ahead to address suicide prevention. Understanding the underlying causes of suicide is clearly a much larger issue than one for the Army by itself. The Army needs to make the most of the recent more holistic approach to resiliency, and suicide prevention in the forms of A Life Worth Living and This is My Squad initiatives. These efforts must be refined using bottom-up feedback from leaders as well as a systematic collection of data that can be analyzed with the civilian populace to determine efficacy. Despite that, the Army will never be able to address all the underlying causes surrounding suicide among soldiers. At least this is the first step in acknowledging those issues to develop a better way to address them in the future.

The majority of the Army's senior leadership understands how the systemic issue of suicide negatively impacts the whole organization and its ability to deploy combat power. Most senior leaders in the Army also seem to appreciate that curbing the suicide epidemic requires a focus on individual high-risk soldiers' needs. However, there continues to be a significant disconnect between the implementation of tailored approaches to suicide prevention and how the effectiveness is measured, or even defined, at higher echelons. The Army must reframe how it approaches suicide within the context of the broader environment before it can make lasting change that impacts the whole organization. Better awareness of trends in the overall civilian population that will influence the Army's suicide prevention programs will also improve effectiveness. Army leadership will also have to recognize that engaged leadership will not prevent all suicides and do a better job of caring for the soldiers impacted by a suicide event. Bridging the gaps between how the Army measures the effects of suicide and its prevention efforts will be vital to get to a reasonable and appropriate desired future with fewer suicides and associated adverse effects.

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