

# Chapter 25

## SUICIDE PREVENTION IN THE US ARMY: LESSONS LEARNED AND FUTURE DIRECTIONS

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## INTRODUCTION

The goal of all the military services is to provide the serving men and women the best available support to assist them in overcoming the stressors that military service entails. The services utilize training and education, counseling, intervention, and postvention measures to help them find alternative and appropriate ways of dealing with stress and minimize the risk of suicide.

The spectrum of suicide behaviors (which ranges from gestures to serious attempts to completed suicides) and stress from the high operational tempo continue to have an effect on readiness and mission accomplishment. The Army Suicide Prevention Program's mission is to preserve readiness for soldiers, families, and Department of the Army civilians by continuing to develop policies and procedures that are designed to minimize suicidal behavior. Unfortunately, the Army-wide suicide rate has been trending

upward every year since 2004. The total Army suicide rate in 2009 was 21.7 per 100,000, an increase from the rate of 9.8 per 100,000 observed at the beginning of hostilities in 2001.<sup>1</sup>

This chapter first describes the history of suicide prevention in the Army, then delineates current initiatives and some recent results of the Epidemiological Consultation Teams, and provides a theater update. This chapter is focused mainly on the Army because the authors are all affiliated with that service. However, all the military services have robust suicide prevention programs and the suicide prevention managers meet regularly. For example, there is a regular Suicide Prevention and Risk Reduction Committee meeting, formerly hosted by Health Affairs and more recently by the Defense Center of Excellence. Likewise, there is an annual Suicide Prevention Conference, which in recent years has included the Department of Veterans Affairs.

## HISTORY OF SUICIDE PREVENTION IN THE US ARMY

Psychological characteristics and ideas that can lead a soldier to engage in a heroic disregard of personal safety on the battlefield can also lead to self-destructive behaviors when not at war. In 1897, Emile Durkheim advanced the first theories of suicide in the military. He defined suicide as those cases of death that resulted either indirectly or directly from something that the victim had done, knowing that death would result from this action.<sup>2</sup> Of note were those individuals who were not sufficiently bound to social groups, alienated, and who were said to engage in *egoistic suicide*. At the opposite end of the psychological spectrum, Durkheim proposed the idea of *altruistic suicide*, said to be a result of excessive integration, in which individuals become so immersed into social groups that they lose sight of individuality and are willing to sacrifice themselves to the group's interests, even at the cost of their own lives. Not surprisingly, the most common cases of altruistic suicide were said to occur among members of the military.<sup>3</sup>

The idea that at least some suicides were preventable evolved slowly throughout the 20th century. In the 1930s, Karl Menninger, a psychiatrist, wrote the influential book *Man Against Himself*,<sup>4</sup> which extended Freud's concept of the death instinct. In the 1950s, two psychologists, Norman L Farberow and Edwin S Schneidman, introduced several key concepts in suicide research and prevention. These concepts led to the opening of the Los Angeles Suicide Prevention Center, which provided a model for immediate consultation, guidance, and assistance to the suicidal person.<sup>5</sup>

This activity spurred the Los Angeles County coroner to first engage mental health professionals in determining cause of death via a "psychological autopsy,"<sup>6</sup> which is a methodology for determining not just how a person died, but why. It is a diligent process that requires gathering information from all available records as well as extensive interviews with those who knew the deceased.<sup>7</sup> The US Army relied on psychological autopsies during the 1990s, but that process has now been replaced by the Army Suicide Event Report,<sup>8</sup> which will be covered in more detail in this chapter. Currently, psychological autopsies are principally used to help determine the manner of death in equivocal cases, that is, when there is a question as to whether it was an accident, suicide, or homicide.

The American Association of Suicidology (AAS), founded in 1968, was the first national organization aimed at understanding suicide and its prevention.<sup>9</sup> Coincident with this national presence, publications dealing with the problem in the military began to appear, although no formal suicide prevention program was yet established.<sup>10</sup>

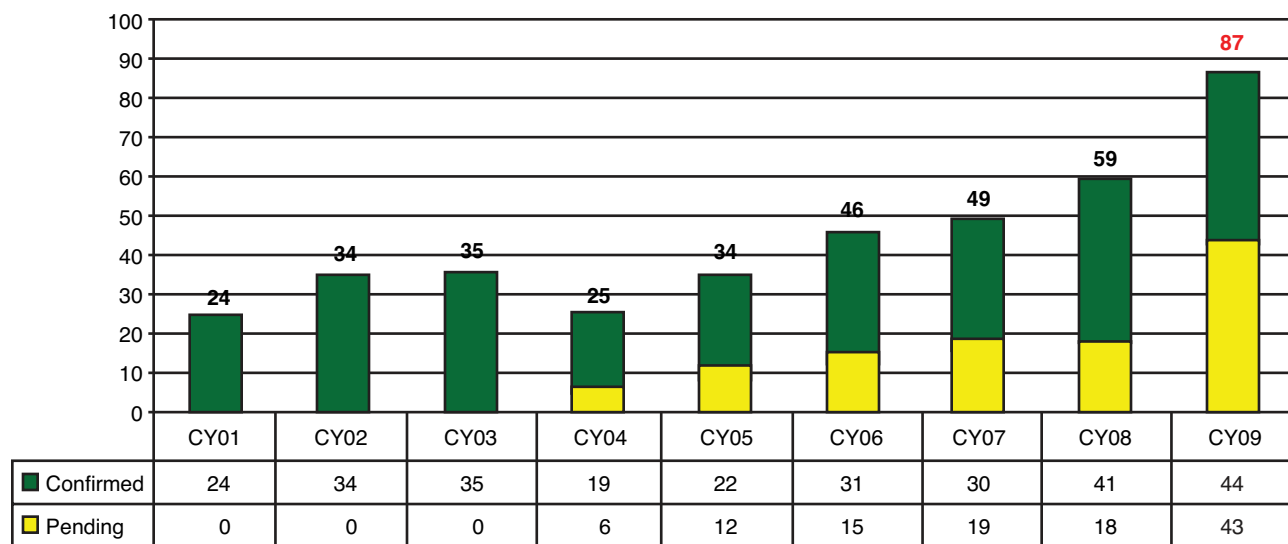
Army research psychologists and psychiatrists at the Walter Reed Army Institute of Research (WRAIR) in Washington, DC, became interested in the causes of suicide among Army personnel and began several influential reviews of suicide deaths.<sup>11</sup> In 1988, Colonel Nicholas Rock published an influential 10-year review of suicide and suicide attempts in the Army.<sup>12</sup> A number of articles by Dr Joseph Rothberg and others followed.<sup>13-20</sup>

The 1980s were a time of increased interest and dramatic progress in military suicide prevention efforts. On November 1, 1985, the Department of the Army (DA) published DA Pamphlet (PAM) 600-70, *Guide to the Prevention of Suicide and Self-Destructive Behavior*,<sup>21</sup> which discussed many of the myths of suicide and suggested a strategy to prevent self-destructive behavior. This was followed on September 30, 1988, by DA PAM 600-24, *Suicide Prevention and Psychological Autopsy*,<sup>22</sup> which detailed many of the principles of suicide prevention first suggested by Farberow and Schneidman, and later the AAS. This pamphlet set forth policy and procedures for establishing the Army Suicide Prevention Program (ASPP) and conducting psychological autopsies. It provided guidance for all suicide-prevention activities of the Army and it also provided the rationale, circumstances of use, and guidance for reporting psychological autopsies.

In 1999, the Army contracted with the AAS to produce *Suicide Prevention: A Resource Manual for the United States Army*,<sup>9</sup> which used principles of community mental health to establish prevention programming “intended to save lives and reduce the impact of self-harm behaviors using a three-tiered approach to achieve the best-coordinated prevention possible.”<sup>9(p3)</sup> In general, the first level—primary prevention—consisted of those command programs

designed to anticipate critical junctures in a person’s career and make these less stressful. The next level—secondary prevention—included those command programs of special support and crisis counseling needed when persons encounter times of crisis and may be helped by a caring professional. The final level—tertiary prevention—was designed to provide immediate care for a potentially life-threatening crisis, and required care by a mental health professional. These common suicide prevention strategies are still in use today.

In December 1999, the chief of staff, US Army, directed a review of the ASPP. In 2000, the Army G-1 (formerly the Army Deputy Chief of Staff for Personnel), in collaboration with the Office of The Surgeon General (OTSG) and the Office of Chief of Chaplains, completed a review and determined that the program was basically sound, but needed to emphasize leadership involvement and offer more advanced training. In 2001, the Army implemented the Suicide Prevention Campaign Plan, which emphasizes preventive and intervention measures, directs commanders to take ownership of the program, and synchronizes and integrates resources at installation level. More recent efforts by the Army Suicide Prevention Task Force have built upon these actions. Despite these efforts, the rate of suicide in the Army has continued to rise (Figure 25-1).



**Figure 25-1.** Active duty suicides in the US Army January 1, 2001, through June 15, 2009. Data includes active duty, Army Reserve, and Army National Guard. “Pending” data not available for 2001 through 2003.

CY: calendar year

Data source: US Army G-1, Human Resources Policy Directorate.

## ARMY SUICIDE PREVENTION PROGRAM

### Initiatives and Efforts to Minimize Suicidal Behavior

#### *Army G-1*

The Army G-1 is the Army's proponent for the ASPP and collects demographic data on completed suicides. These data assist the Army G-1, commanders, program managers at the installation level, and "gatekeepers" Army-wide in the identification of trends and the development of new initiatives, tailored and targeted training, and policies to minimize suicidal behavior. The ASPP, as detailed in DA PAM 600-24,<sup>22</sup> also established a Suicide Prevention Task Force at each installation. In 2006, the Army G-1 formed an "Integrated Product Team" to integrate and synchronize efforts at the Headquarters, Department of the Army level. The team met regularly to identify ongoing initiatives, gaps in resources, and trends. Of main concern was the implementation of tailored and targeted training for soldiers and leaders.

Army programs have focused on training the gatekeepers—leaders, chaplains, behavioral health officers, and others. In the October 26, 2005, issue of the *Journal of the American Medical Association*, Mann and colleagues noted:

Where the roles of gatekeepers are formalized and pathways to treatment are readily available, such as in the military, educating gatekeepers helps reduce suicidal behavior. Demonstration projects for other gatekeepers with intermediate outcome measures, such as referral rates and psychiatric treatment rates, should be conducted.<sup>23</sup>

To educate gatekeepers, the Army G-1 has contracted with outside organizations like Living Works Education and the QPR (Question, Persuade, Refer) Institute from Spokane, Washington, to provide suicide awareness training.

For several years, the mainstay of Army suicide intervention was the "Applied Suicide Intervention Skills Training" (ASIST) program,<sup>24</sup> a commercial product of LivingWorks, Calgary, Alberta, Canada. In 2002, the Army funded service-wide ASIST workshops<sup>25</sup> with accompanying computer interactive-training software. In 2005, the Army G-1 funded QPR workshops<sup>26</sup> Army-wide to provide additional resources in suicide-prevention awareness training, prevention, intervention skills, and risk identification to installations throughout the Army. Organizations have the option to use the training resource that best meets their needs; many continue to use Living Works Education, which has certified over 700 "gatekeepers" in suicide

prevention and intervention,<sup>25</sup> as their primary training resource. In addition, QPR Institute has certified hundreds of trainers in suicide prevention.<sup>26</sup>

The G-1 also conducts many other training activities, to include:

- Ensuring suicide-prevention training is provided to all deployed soldiers as part of the deployment cycle support process.
- Revitalizing the Installation Suicide Prevention Committee/Task Force to adopt Army key strategies for suicide prevention and actively coordinate with efforts of major subordinate units.
- Developing and distributing suicide awareness cards that focus on buddy care, warning signs/risk factors, and resources (the card is a graphic training aid [GTA #12-001-01] that can be ordered through the installation and community Training Audiovisual Support Center).

#### *The Medical Command and The Surgeon General*

The OTSG and the US Army Medical Command (MEDCOM) support the ASPP by providing medical care, research and data analysis, and assessment of medical support systems. In 2007, OTSG established a dedicated Suicide Prevention Office within MEDCOM to ensure greater visibility of programs, obtain data, identify trends, and provide timely information to leaders. This office sought to standardize methods and procedures for future epidemiological consultation (EPICON) teams, improve behavioral health surveillance methods for postmortem review, and continue Department of Defense Suicide Event Reports (DoD-SER) for suicide attempts and/or completions, which are reported to the installation suicide prevention program manager. However, currently its functions were subsumed under a new suicide surveillance cell managed by the former US Army Center for Health Promotion and Preventive Medicine (CHPPM), recently renamed Public Health Command (Provisional) or PHC(P). In the subsequent discussion, CHPPM will be used for past efforts and PHC(P) for current and future efforts.

CHPPM also supported the ASPP by focusing on continuous research and the development of awareness and training resources. For example, during calendar year 2006, CHPPM's main effort was to distribute 2,000 suicide awareness training kits to chaplains. Topics in this training program include suicide awareness, warning signs of suicidal thinking and behavior, and

intervention skills development.

These suicide prevention activities are part of an ongoing effort, which includes suicide awareness briefings tailored for populations, tip cards, and warning signs and risk factors cards for distribution during training. CHPPM developed the acronym ACE — “Ask,” “Care,” and “Escort” — to serve as the intervention centerpiece idea to assist buddies who may be suicidal (Figure 25-2). “Ask” centers around the idea of asking the buddy about state of mind and whether the buddy is suicidal (ie, “Are you thinking about suicide?”). “Care” focuses on employing active listening skills and understanding the situations to provide the right mix of resources or help. “Escort” involves not leaving the buddy alone, but rather either escorting or finding someone to take this soldier to a professional for help.

Awareness is a key piece of the ASPP. CHPPM took the lead in promoting awareness by the development of posters for dissemination throughout the Regular Army, the Army National Guard (ARNG), and the US Army Reserves (USAR). In 2007, CHPPM finalized and initiated distribution of suicide awareness briefing content, via chaplains’ channels, to enhance soldiers’

skills in identifying personnel at risk, to assist interventions with the individual, and to provide guidance for referring or escorting the soldier to professional help. Chaplains and other facilitators can obtain all supporting materials (ie, tip cards, brochures, posters, briefings) through CHPPM’s suicide prevention Army Knowledge Online (AKO) Web site (<https://www.us.army.mil/suite/page/334798>) and their Health Information Operations Web site ([http://chppm-www.apgea.army.mil/hio\\_public/orders.aspx](http://chppm-www.apgea.army.mil/hio_public/orders.aspx)).

MEDCOM’s Suicide Risk Management and Surveillance Office (SRMSO) managed the primary tool for surveillance of Army suicide, the DoDSER, which is a reporting and tracking mechanism for completed suicides and nonlethal events that result in hospitalization and/or evacuation. The original Army Suicide Event Report (ASER) was developed, with initial validation conducted by the US Army Medical Research Unit, Europe, as a means to track in near, real-time, suicides and suicidal behaviors of Army personnel within the US Army, Europe.<sup>27</sup>

Following the recommendation of the Mental Health Advisory Team (MHAT) I,<sup>28</sup> MEDCOM issued a policy directing that the ASER be used throughout the Iraqi Theater of Operations. The SRMSO, located at Fort Lewis, Washington, had operational oversight of the ASER, and conducted routine data analyses and published reports of these findings. In 2008, all the services began using this report form, which became the DoDSER. The SRMSO also has responsibility for updating changes to the DoDSER.

The SRMSO has directed that the DoDSER should be completed for all fatalities, hospitalizations, and evacuations where the injury or injurious intent is self-directed. It is not meant to replace the psychological autopsy, which is limited to fatalities in which the manner of death is equivocal, (eg, it is unclear whether it is an accident, suicide, or homicide). The DoDSER is available at: <https://dodser.t2.health.mil/dodser/>. (Chapter 24 in this volume discusses suicide surveillance programs.) CHPPM (now PHC [P]) assumed operational control of the Army suicide surveillance program in 2009.

### Chief of Chaplains

The Army Chaplaincy continues its “Strong Bonds” program (enriching and developing lasting relationships for both married and single personnel through the use of relationship-building seminars and workshops) Army-wide through the efforts of its 1,500 active duty chaplains and 1,200 reserve component chaplains. Suicide prevention awareness and intervention training continues to be its main effort in support of the ASPP. The Chaplaincy provides extensive counseling

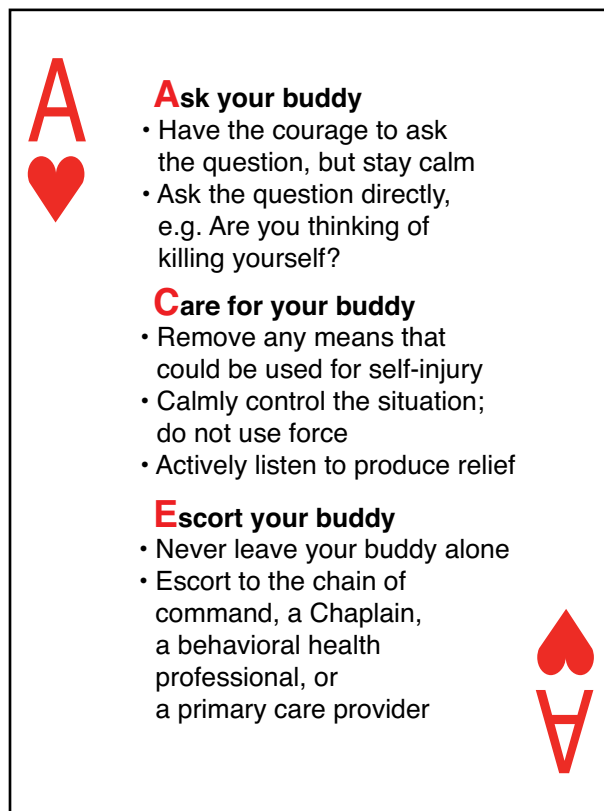


Figure 25-2. “ACE” card developed by US Army Center for Health Promotion and Preventive Medicine.

to soldiers and family members, some of whom may need to see a mental health professional. The Office of the Chief of Chaplains has worked very closely with CHPPM to develop a standardized suicide prevention awareness briefing for all chaplains and leaders. This training support package was completed in 2007, and is now available to all Army chaplains. Furthermore, the ACE (Peer) Suicide Intervention Program for soldiers and junior leaders is now being taught at the Chaplain Annual Sustainment Training course. Approximately 200 chaplains received this training in 2008.

### ***Installation Management Command***

Garrison commanders provide support to tenant units at the installation level. As such, they are charged with coordinating suicide prevention activities at the installation level. The Installation Management Command (IMCOM) has established the garrison director of human resources as responsible for ASPP execution at the installation levels. One of the initiatives is to eliminate confusion about the roles and responsibilities in support of the ASPP. Senior leaders throughout IMCOM support the program by engaging the leadership at the region and installation levels. An additional support to the Army's ASPP is the establishment of community health promotion councils (CHPCs) on every Army installation. The Army, via Army Regulation (AR) 600-63, *Army Health Promotion*,<sup>29</sup> has directed each Army installation to create a CHPC. The CHPC will ensure a proactive, coordinated, and synchronized local program. It will be the responsibility of each CHPC to ensure that suicide prevention activities are carried out in accordance with guidance from the Army's ASPP plan.

### ***Army National Guard***

The ARNG coordinates extensively with the active Army for training and policy development, workshops, conferences, and marketing. The ARNG Suicide Prevention Program reflects the active Army's program, with several differences due to the nature of the ARNG. The main differences and challenges involve data collection and availability of resources.

Like the active Army, the ARNG program takes a holistic approach that addresses suicide prevention, intervention, and postvention. Leaders and program managers initiate proactive measures to prevent suicide within their states by enhancing life skills in areas such as alcohol and drug abuse prevention, stress and anger management, communication, and conflict resolution training. In addition, personnel receive training

in suicide risk identification and learn procedures for crisis intervention and referral. And finally, considering the devastating impact a suicide has on those who knew the deceased, the ARNG suicide prevention program includes postvention, which is also known as "prevention for the next generation."

In April 2007, the ARNG directed that all states appoint a suicide prevention program manager (SPPM) at each Joint Forces Headquarters. Having a program manager at the state level will allow a greater degree of suicide surveillance for states, as well as more accurate national oversight. The SPPM administers a statewide ARNG Suicide Prevention Program for both military and civilian leaders, managers, supervisors, soldiers, and family members. Administering a program of this magnitude requires coordination with commanders, surgeons, chaplains, personnel officers, mental health staff, health promotion staff, and public affairs personnel throughout the state, as well as local agencies and helping services, local law enforcement, civilian coroners, and hospitals. The SPPMs receive suicide intervention training and conduct suicide prevention, intervention, and postvention training and awareness activities throughout their respective states.

The ARNG goal is to provide intervention skills training to at least one soldier per company-sized unit. All soldiers will receive annual suicide awareness training. To maximize valuable resources, the ARNG SPPM has compiled a directory of all ASIST-trained National Guardsmen to share with active Army and USAR. The services often collaborate to provide training to the different components. The state SPPM tracks and reports all attempted and completed suicides to its state's Joint Forces Headquarters and to the National Guard Bureau SPPM. The state SPPM identifies trends and provides decision support when possible factors lead to an increase of suicides.

The challenges inherent in collecting accurate data about the suspected suicide of a soldier serving in a traditional status ("M Day," or one weekend a month) lie in the fact that the details of the suicide are contingent upon reports by family members, medical authorities, and local law enforcement investigations. Most ARNG soldiers who died by suicide had been in a traditional drilling status, rather than on active duty in a Title 10 status. Although AR 600-63, *Army Health Promotion*, requires a review to be conducted by a mental health officer for any active or reserve component soldier on active duty whose death meets specific criteria for suicide or suspected suicide,<sup>29(chap5, para5-8)</sup> there is no such requirement for ARNG soldiers not on active duty.

In addition to tracking and reporting, the ARNG

differs from the active Army in terms of resources available. Whereas active duty soldiers deploy from and return to a post where all resources for support are usually available without charge, easily identifiable, and in a designated geographic area, the ARNG deploys from and returns to communities across the state. Resources available to each ARNG member are dependent on what the local community provides, and therefore vary from member to member. Because the state SPPMs are from the local community, they will be familiar with these local resources. They will ensure soldiers and families are aware of these resources and are able to identify problems and refer personnel in crisis to an appropriate source of help. This information is included in annual suicide prevention briefings and published in Army suicide prevention policies and guidelines.

An increasing number of benefits have become available to all ARNG soldiers. The TRICARE Transitional Assistance Membership Program is available for 6 months to ARNG soldiers returning from deployment, with the option to buy in to the TRICARE program for a length of time determined by the amount of time the soldier was deployed. In addition, all soldiers, regardless of whether they were ever deployed, can take advantage of Military OneSource (available at [www.MilitaryOneSource.com](http://www.MilitaryOneSource.com)), which will contract with a local mental healthcare professional to provide six counseling sessions at no cost to the soldier.

The ARNG SPPM has created two suicide-prevention Web sites for soldiers and families. One is public and can be found at <http://www.virtualarmory.com/WellBeing/suicide>. The other site is restricted to members of the ARNG who have a Guard Knowledge Online (GKO) account and password and is located at <https://gkportal.ngb.army.mil/C15/C5/SuicidePreventionProgram>.

### ***Army Reserves***

The USAR faces all of the challenges described by the ARNG. Furthermore, their regions are large, and soldiers are often “cross-leveled” from one area of the country into another. Thus gathering accurate data is an enormous challenge. Recent initiatives in the USAR have included: (a) implementing suicide-awareness training into family programs, (b) appointing ASPP managers at major subordinate commands, (c) forming community health promotion councils, (d) develop-

ing policy guidance for referral of soldiers to mental health, and (e) directing chaplains to develop reporting requirements for suicide prevention training.

### **Recent Initiatives**

#### ***The Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention***

The vice chief of staff for the Army established the Army Suicide Prevention Task Force (ASPTF) in March 2009 in response to the Army’s increasing suicide rate. The ASPTF’s effort has resulted in approximately 250 tasks throughout the Army that are currently being executed. The resultant effort of the ASPTF has been published as the “Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention,” which is directly monitored by the vice chief of staff for the Army; the tasks identified will substantially change the way the Army provides care to its extended family. This campaign plan reaffirms the Army’s commitment to care for its greatest strategic assets—soldiers, families, and civilians.

#### ***Behavioral and Social Health Outcomes Program***

The Army has established an epidemiological surveillance program that will utilize the public health process approach to developing a behavioral health and social outcomes capability. The mission of the PHC(P) Behavioral and Social Health Outcomes Program is to protect combat readiness and soldier health by addressing psychological and social threats through surveillance and in-depth analysis of behavioral health and disease outcomes; tracking rates and changes in trends in deployed and nondeployed populations; and projecting BH epidemiology. In addition, working with the Army G-1, a specialized suicide analysis cell was funded to conduct suicide-specific analysis and surveillance in support of the ASPP.

In 2008, the Army contracted with the National Institute of Mental Health to assist the Army in a comprehensive research effort that will lead to better prevention strategies and fewer suicides. This memorandum of agreement spans over 5 years and represents an Army investment of \$50 million. The Behavioral and Social Health Outcomes Program and National Institute of Mental Health are collaborating to provide and analyze these data.

## **OPERATION IRAQI FREEDOM THEATER SUICIDE ASSESSMENT**

The previous MHATs have reviewed the status of the Operation Iraqi Freedom (OIF) theater’s suicide

prevention and surveillance program, including an analysis of completed suicides (see Exhibit 25-1 for

## EXHIBIT 25-1

### OPERATION IRAQI FREEDOM AND SUICIDE PREVENTION

In 2003, the Office of The Surgeon General (OTSG) deployed a Mental Health Advisory Team (MHAT) to Kuwait and Iraq to assess soldiers' mental health issues. Every year since then, an MHAT team has visited the theater of operations and produced a comprehensive report. MHAT II and V included Afghanistan. The full reports are available on the [www.armymedicine.mil](http://www.armymedicine.mil) Web site. Recommendations that are especially relevant to suicide prevention include:

1. Establishing a behavioral health consultant position in theater that will synchronize and coordinate behavioral health resources needed across the area of operations.
2. Establishing a modified theater suicide prevention program based on both current installation-based strategies and lessons learned from epidemiological consultations and MHAT visits to the theater of operations. These strategies include:
  - a. Designating proponents to manage the suicide prevention program. (The proponent for the Operation Iraqi Freedom theater of operations was appointed in June 2006.)
  - b. Establishing a command climate that encourages help-seeking behavior.
  - c. Maintaining vigilance by leaders and soldier-peers (buddy care).
  - d. Conducting continuous training throughout the deployment cycle.
  - e. Implementing the surveillance of completed suicides/suicide attempts using the Army Suicide Event Report .

Nonetheless, military suicide continues to be a significant problem in Iraq. Theater rates of suicide have trended upward since 2004, and remain elevated compared to both the total Army rate and rates observed in the civilian population.

a discussion of the first MHAT). The MHAT V conducted a similar review of Multi-National Force-Iraq's prevention and surveillance program and a detailed analysis of completed suicides.

A team was requested by the Multi-National Corps-Iraq (MNC-I) commander to do a theater assessment in the fall of 2007. The team worked in parallel with MHAT V and with information from the Criminal Investigations Division (CID) and a review by SRMSO. A detailed "Summary of Theater Suicides" for 2007 was presented by the forensic investigator, MNC-I CID, on October 2, 2007.<sup>30</sup> A similar review, limited to Army personnel, was performed by the SRMSO at Fort Lewis, Washington, 2 weeks later, with a focus on soldiers in Iraq and Iraq suicides. The results of all studies are similar, and thus will be examined together.

As has been consistently true for reviews going back as far as 20 years,<sup>12</sup> military suicide is most often precipitated by the loss of a relationship—either a spouse or other intimate partner. The SRMSO study reflected that 68% of Iraq suicides had had an intimate relationship failure, compared to 56% of the suicides in the non-Iraq population. This highlights the importance of the "Dear John" letter or e-mail, or other messages communicating the end of a relationship, as

an implicated factor in the deployed setting.

A second major cause implicated in suicide is loss of career, usually through the Uniform Code of Military Justice (UCMJ) or other criminal charges. Approximately 35% of Army suicide cases in the Iraqi theater of operations had recent UCMJ charges—higher than the suicides in the continental United States. The CID review for all services found a 24% incidence of UCMJ charges.<sup>30</sup> These two factors alone—loss of relationship and loss of career—appear to account for the majority of the suicides seen in the Iraqi theater of operations.

The Iraq CID review suggests that 60% of the 2007 suicides showed behavioral changes or signs of depression prior to their suicides. The SRMSO review of DoD-SER data also suggests that a substantial percentage of Army personnel who commit suicide sought help: 50% of all suicides presented to a medical treatment facility (MTF) for care within 30 days of the event. This supports research literature, which suggests that although people considering suicide may not be able to accurately identify their problems as emotional in nature, or marshal the right resources to help them, they manifest an awareness that something is wrong and may seek out primary care.<sup>31-35</sup> This highlights the importance of suicide prevention and awareness in the primary care and pastoral settings.



## Discussion

The US Public Health Service considers suicide risk and prevention in terms of relative *risk factors* and *protective factors* for suicide.<sup>36,37</sup> These factors have been adopted by the Centers for Disease Control and Prevention (CDC) and are used to frame the discussion of suicide in Iraq.

### Risk Factors

Risk Factors most relevant to Army suicide in Iraq include:

1. *Loss (relational, social, work, or financial)*. This has consistently been the key variable associated with suicide. It appears that long tour duration, in itself, does not increase rate of suicide, but rather serves as a secondary factor in provoking marital disruption and in kindling the loss of relationships.
2. *Isolation, a feeling of being cut off from other people*. The Soldier Survey assesses this directly by asking whether soldiers are “feeling distant or cut off from people.” Results note that 51.8% of all soldiers surveyed have experienced these feelings of isolation. Morale, Welfare and Recreation efforts to deliver mail and enhance Internet and phones, have probably helped, but this variable should continue to be monitored over time, and efforts to keep soldiers feeling engaged in what is going on “back home” should be encouraged.
3. *Barriers to accessing behavioral health treatment*. As the troop footprint in Iraq surged, the supply of behavioral healthcare providers in theater expanded less robustly in 2006 and 2007.
4. *Easy access to lethal methods*. It has been proposed that the ready availability of weapons is a contributory factor for the elevated suicide rate in theater. Although firearms do increase the lethality of suicide attempts, epidemiological studies do not clearly support a finding that either gun ownership, in general, or living in a country that bans firearms result in a lower population suicide rate. Furthermore, the troops that have been deployed in Iraq since 2003 have had weapons readily available. Any rise in this rate cannot solely be attributed to weapons availability.
5. *Unwillingness to seek help because of the stigma attached to mental healthcare*. Stigma contin-

ues to be a major issue in the willingness of service members to seek care. Soldier and leader interviews indicate first-line supervisors are the primary barriers to seeking care. This is fueled by a perception that seeking behavioral healthcare is “shamming” or attempting to avoid duty. A need for further efforts to educate these first-line supervisors is indicated (Exhibit 25-2).

#### EXHIBIT 25-2

#### STIGMA ASSOCIATED WITH SEEKING BEHAVIORAL HEALTHCARE

Four types of stigma are generally seen: (1) career, (2) leadership, (3) peer-to-peer, and (4) personal. Stigma was reported differently across rank groups; lower enlisted were more concerned about peer and self-perceptions, senior enlisted were most concerned about their careers and perceived leadership abilities.

##### Career

- On permanent record, affects future promotion and employment
- End career, lose retirement
- Lose security clearance
- “Boarded out” rather than rehabilitated

##### Leadership

- Some “old school,” senior NCOs, and early promoted NCOs create/maintain stigma
- More stigma for senior enlisted, others think they can’t lead, fear of affecting retirement
- Many squad/platoon leaders don’t support
- Treated differently; doubt “warrior” abilities; ridicule those with a profile

##### Peer-to-Peer

- Peer stigma is the worst
- More stigma if never deployed
- Treated differently, ridiculed
- Gossiped about/perceived as faking

##### Personal

- Weak, isolated, embarrassed
- Profile makes them feel worthless
- Pride/denial
- Don’t want to be viewed as a “bad” soldier

### Protective Factors

Protective factors for suicide buffer individuals from suicidal thoughts and behavior. To date, protective factors have not been studied as extensively or rigorously as risk factors. Identifying and understanding protective factors is, however, equally as important as researching risk factors. Protective factors that act to reduce suicide probability in Iraq include:

1. *Lack of intoxicants.* Alcohol is a known risk factor for both civilian and military suicides. The relative lack of availability of intoxicants in the theater of operations should therefore act to lower the rate of suicide. It has long been known that intoxicants make the act of suicide more likely through disinhibition effects. (The National Violent Death Reporting System examined toxicology tests of those who committed suicide in 13 states, and 33.3% tested positive for alcohol; 16.4% for opiates; 9.4% for cocaine; 7.7% for marijuana; and 3.9% for amphetamines.<sup>38</sup>)
2. *Effective clinical care for mental, physical, and substance abuse disorders.* Certain units within the theater of operations deployed with a comprehensive plan for deployment cycle support, and a number of best practices for effective soldier support, which appear to have produced a significant decrease in aberrant behaviors, including suicide, after the program was implemented.<sup>39</sup> These results suggest wider adoption of the deployment cycle support model for the brigade combat team.
3. *Easy access to a variety of clinical interventions and support for help seeking.* Recent redistribution of troops in the battle space calls for equally agile shifts in behavioral health support, which is a strong argument for locating the theater mental health consultant at the MNC-I level. This also calls for increased efforts to destigmatize the act of seeking mental healthcare services.
4. *Family and community support.* Efforts to strengthen family and unit bonds should be encouraged, and the definition needs to be broadened to include significant others

regardless of marital status.

5. *Skills in problem solving and conflict resolution.* Relationship enrichment and training, at both the soldier and the family readiness group level, designed to improve communication will assist in reintegration and strengthening relationships. All available evidence supports stabilizing relationships as the single most effective suicide prevention intervention.
6. *Cultural and religious beliefs that discourage suicide and support instincts for self-preservation.* There have long been observed differences in suicide rates across gender, as well as racial and cultural lines.<sup>40</sup> This illustrates the powerful basis of cultural beliefs for acceptable and socially appropriate behavior. For example, certain cultural beliefs support the idea of suicide in response to dishonor. Similar idea threads permeate the military culture (ie, death before dishonor, respect for the Samurai as portrayed in the media, popularity of movies in which suicide or death is seen as a logical approach to failure.) This opens up the possibility of “suicide-proofing” the military culture with carefully crafted messages against soldier suicide (ie, “Don’t let the enemy win,” “Don’t let your buddies down,” “Make it home alive”).

### Summary of Theater Suicide Assessment

The Multi-National Force-Iraq has an active suicide prevention committee, chaired by the chief of clinical operations for the command surgeon. This has recently been augmented by the MNC-I Suicide Prevention Board, which is chaired by the corps chief of staff. The current suicide training program is being completely reconfigured into a much more robust program, which, once established, will require further review to gauge effectiveness.

The DoDSER is being widely used in the theater by behavioral healthcare providers, but only for suicides or suicidal gestures by Army personnel. Although numerous service-specific mental health tracking systems exist, a single, joint tracking system capable of monitoring suicides, mental health evacuations, and use of mental health/combat stress control services in a combat environment does not exist.

## PSYCHIATRIC EPIDEMIOLOGICAL CONSULTATIONS IN THE US ARMY

### Description and Background

Sending a behavioral health EPICON team to investigate an apparent suicide cluster is an emerging

strategy in the US Army (Table 25-1). An epidemiological consultation is analogous to any other medical consultation in that the existence of a problem is verified through history and examination/investigation of the

**TABLE 25-1**  
**COMMON BEHAVIORAL HEALTH EPIDEMIOLOGICAL CONSULTATION THEMES**

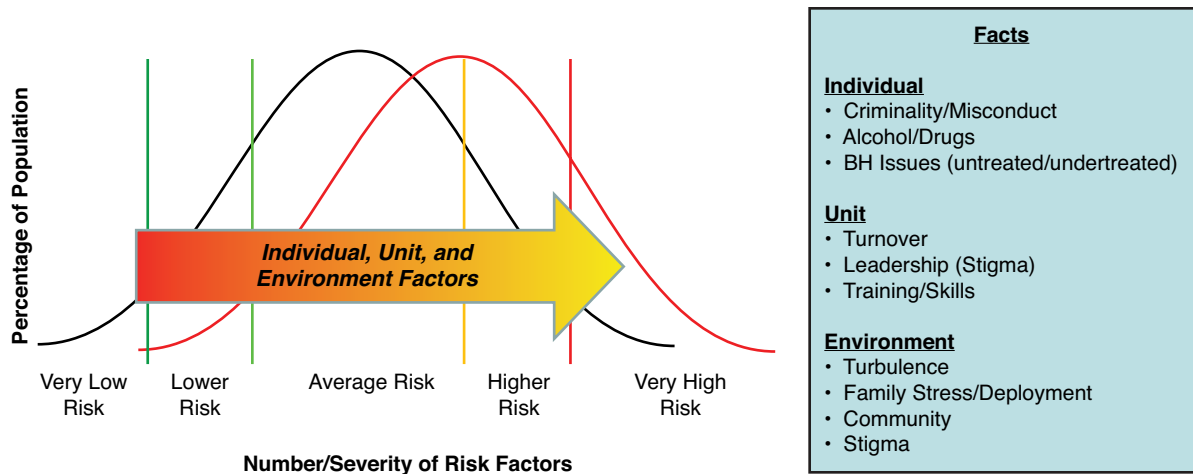
Theme	Ft Leonard	Ft Bragg	Ft Riley	Ft Hood	Ft Campbell	Ft Carson
	Wood 2001 (suicide)	2002 (homicide)	2005 (suicide)	2006 (suicide)	2008 (suicide)	2009 (homicide)
<b>Individual Risk Factors</b>						
Deployment: length, multiple, unpredictability		✓	✓	✓	✓	
Combat intensity						✓
Family separation, relationship stress, lack of support		✓	✓	✓	✓	✓
Increased violence against persons including spouse/family		✓	✓	✓	✓	✓
Increased use of alcohol and drugs, and related offenses			✓	✓	✓	✓
Previous gestures/attempts/BH contact	✓	✓	✓	✓	✓	✓
Manipulating, malingering	✓		✓		✓	✓
Legal and financial issues		✓	✓	✓	✓	✓
History of misconduct						✓
<b>Systems Issues</b>						
Stigma: personal, leadership, career		✓	✓	✓	✓	✓
Poor service delivery for dependents		✓	✓	✓		
Transition, reintegration (one size fits all)		✓	✓	✓	✓	✓
Problems with BH services, FAP, ASAP	✓	✓	✓	✓	✓	✓
Lack of standardized screening, tracking, intervention, data collection	✓	✓	✓	✓	✓	✓
Leadership/management climate	✓	✓	✓	✓	✓	✓

ASAP: Army Substance Abuse Program  
 BH: behavioral health  
 FAP: Family Advocacy Program  
 Data source: US Army Center for Health Promotion and Preventive Medicine.

problem, a differential list of potential causes may be established, and data analysis is used to generate recommendations for remedy and prevention. EPICONS are public health investigations of clusters, outbreaks, or epidemics of symptoms or illnesses. They are modeled after the CDC’s “EPIAID,” which is a service that CDC provides to state and local health departments. The concepts behind an EPICON are drawn from the public health literature and are adapted to behavioral health. The EPICON mission was originally established at the WRAIR in 1969 and transferred to CHPPM in 1994. In the Army, EPICONS were originally limited exclusively to infectious diseases and environmental exposures. However, this mechanism was expanded to

include clusters of behavioral health problems after an outbreak of suicidal behaviors at Fort Leonard Wood, Missouri, in 2000.

Every suicide case in the US Army receives a thorough investigation, with participation from multiple organizational entities on an installation, to collect data to determine if current factors or conditions exist that may be mitigated to prevent future suicides (Figure 25-3 and Figure 25-4). It is occasionally necessary to replicate this process using the population-based approaches of an EPICON to look at communities and organizations in a similar manner. The authors and others have participated in the five EPICONS that have been performed since 2000: (1) Fort Leonard

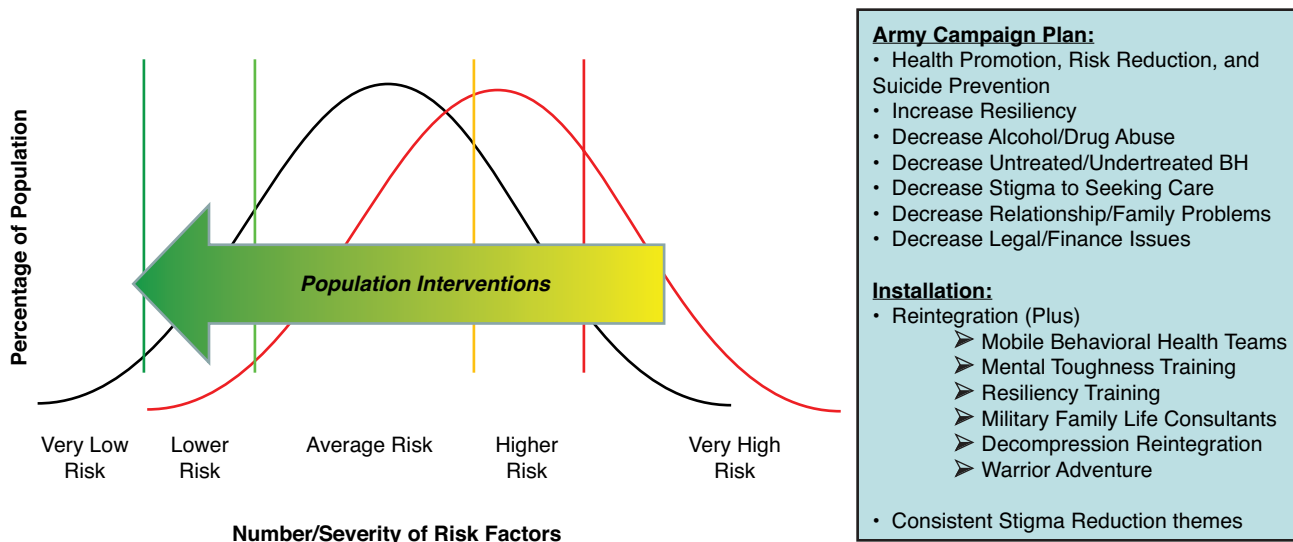


**Figure 25-3.** Causal factors. Multiple individual, unit, and community factors appear to have converged to shift the population risk to the right. This would put more soldiers in the “very high risk” category, making clustering more likely. BH: behavioral health

Wood, Missouri, in 2000, following the deaths of two recruits by suicide; (2) Fort Bragg, North Carolina, in 2003 following two murders and two murder-suicides; (3) Fort Riley, Kansas in 2005, following six suicides in 14 months; (4) Fort Hood, Texas, which had 22 suicides between 2003 and 2005, and (5) Fort Campbell, Kentucky, with 14 soldier suicides between 2006 and 2007. There was an EPICON at Fort Carson, Colorado, in 2008, which focused on homicides, but included other violent crimes and suicides. At the time of this

writing, there is another EPICON to examine suicides and accidental deaths in the warrior transition units.

An EPICON may become necessary when the requirements for epidemiological expertise or even simple personnel exceed the resources of a theater or regional medical command. EPICON teams hold the benefit of bringing in new resources capable of focusing solely on the issue at hand, free of the distractions and demands inherent to supporting a community or organization. Additionally, the higher level of tasking



**Figure 25-4.** Suicide factors to consider. Although it is important to identify and help individual soldiers, the biggest impact will come from programs that shift the overall population risk back to the left. Effective medical treatment can prevent individuals from increasing in risk or decrease their risk, but it cannot shift overall population risk very much. BH: behavioral health

authority associated with EPICONS may open doors to data sources and collaboration that are difficult to achieve when such investigations are conducted with a local approach. It is important to note that EPICONS are not staff assistance visits or inspections, nor are they research endeavors. EPICONS provide a mechanism to investigate a disease cluster on an urgent/emergent basis. They can be conducted as a public health initiative without a research protocol. The perception that there is a problem (eg, increased numbers of suicide behaviors, homicides, etc) can lead to request for an EPICON.

### **Initiation of an Epidemiological Consultation and Operational Support**

The request for an EPICON usually originates from local leadership (eg, hospital, brigade, or installation commander). Implementing an EPICON requires extensive coordination and approval, particularly from the local leadership of the installation that is involved, as well as OTSG, MEDCOM, and other stakeholders. Both AR 40-5, *Preventive Medicine*,<sup>41</sup> and DA PAM 40-11, *Preventive Medicine*,<sup>42</sup> task the commander, PHC(P), with the responsibility to provide EPICON support worldwide. PHC(P) responds to such taskings from MEDCOM and OTSG through the Proponency Office for Behavioral Health and the Proponency Office for Preventive Medicine. PHC(P) is readily able to assemble a team of experts (often pulling resources from throughout the Army) to deploy on short notice. All tasking should come through OTSG/MEDCOM for purposes of validation, command visibility, and resourcing approval. The process of validation is one that should take place between the theater or regional medical command and MEDCOM/OTSG.

It may be necessary to draw on resources from the Armed Forces Health Surveillance Center and PHC(P) to analyze data in this process. Command interest, political pressure, and media attention may all influence the validation of an EPICON. The PHC(P) operational support section is capable of facilitating country clearances, travel orders, funding citations, travel reservations, hotel accommodations, and even work environment requirements such as computer connections, meeting room reservations, and rental cars. In preparing for an EPICON, it is a great help to prearrange for a meeting room that can accommodate the entire EPICON team during evenings and on weekends. This working space should have computer connections and the ability to accommodate screen projection of computer documents.

A team leader will be selected, usually a senior officer. EPICONS have had teams of varying sizes

from 4 to 14 people, composed of individuals from OTSG, PHC(P), the regional medical centers, installation, and subject matter experts from throughout the Army. The challenge is balancing the need to include all of the stakeholders, but not overwhelm the local environment. Appropriate agency representatives may include behavioral health, chaplains, installation management activity, and the G-1. The local behavioral health leadership should be included as much as possible, as they will need to contribute to the analysis and implementation of recommendations.

The following representatives should be considered as members of any behavioral health EPICON team:

- team leader: senior preventive medicine officer or behavioral health specialist;
- local senior behavioral health clinician (social work, psychology, psychiatry);
- epidemiologist with appropriate database development support;
- chaplain;
- Army Substance Abuse Program representative;
- safety officer representative with knowledge of Army risk reduction data;
- health risk communication specialist;
- G-1 representative; and
- unique representation depending on the target population (such as senior noncommissioned officers, unit behavioral health specialist, division surgeon, local civilian resources, and unit/installation public affairs officer).

Once a team has been established, it is essential to formulate a schedule from which all of the team members can work. This timeline will establish the necessary planning meetings, the dates of deployment, and deadlines for work to be done in preparation for the EPICON, as well as documentation requirements. All members must understand the importance of meeting the timelines established by the EPICON leader. Scheduling the time for the team to visit is always a challenge. Most assessments have taken 1 to 2 weeks, and may require repeated visits. An inbrief and outbrief must be arranged with the local installation command, and often the hospital command. Other important agencies with whom to communicate include behavioral health, chaplains, CID, and Army Community Services, including Family Advocacy, Risk Reduction Program, and the Army Substance Abuse Program. Clinical records, including medical, behavioral health, family advocacy, and substance abuse, should be reviewed on the index cases. Much of this work can be done in advance of the actual

EPICON visit by the installation and local MTF in the interest of efficiency and to maximize use of time on the ground once the team arrives. It would be helpful for all established EPICON team members to review previous copies of installation-level EPICONS conducted in the past. Such EPICONS are available through the PHC(P) Directorate of Epidemiology and Disease Surveillance.

The content of the inbrief to be presented to the installation and MTF commands should be completed in advance of the EPICON deployment. The inbrief should clearly reflect the team's understanding of the command's intent for the EPICON. This will often include an initial hypotheses held by those who are at the installation. (Note that initial hypotheses are often wrong, but it is critical to recognize both the concerns and the questions asked by leadership as a starting point.) The inbrief should include a description of the team composition, a schedule (to include the outbrief date), a plan of action, and realistic requirements for support. It is important to establish a senior unit or installation leader to serve as a point of contact in advance of the EPICON's deployment. Discussions prior to the visit with the point of contact and relevant staff will help to reduce any misunderstandings or communication shortfalls in advance of the prebrief to senior leadership, which is most often a general officer.

### **Epidemiological Consultation Activities on the Ground and Data Sources**

As previous team members have performed this mission, they have learned many lessons, both in the science and practical application of this consultative service. Whenever possible, the EPICON team should arrive at its destination on the same day. It is important to have a team meeting immediately after arrival to review the overall plan, schedule, and ground rules. No overt activity or interviews should be conducted before the command has received its prebrief and has given the team permission to proceed. Engaging the command staff early and frequently throughout the EPICON process can be very beneficial.

Outbreaks of completed suicides are hard to study because they are very rare and present challenges for epidemiological analysis. As of 2008, the rate in the US Army was 20/100,000/year. This compares to the demographically matched population of 20/100,000/year. Even more rare in the Army are homicides paired with suicides. However, similar psychological dynamics may lead to both suicides and suicide-homicides. These dynamics are usually in the context of broken intimate relationships, with accompanying fears of hu-

miliation, rejection, and loss. In general the motives for suicide and methods of suicide are reflective of the historical Army findings. The top apparent motivations for suicide in soldiers were found to be relationship failures, followed by legal and occupational difficulties and financial problems. Severe mental illness leading to suicide is rare in the military population but may occur. Among soldiers, impulsivity and substance abuse are more often than not contributing factors. Chronic pain, medical disability, and individual perceptions of general health all merit further analysis as risk factors for suicide in the military. Deaths by firearm, hanging, and jumping are the most common methods. All of the findings above mirror historical trends and substantiate the importance of looking across the spectrum of medical and social data on an installation during an EPICON.

The following data sources have proven helpful in evaluating individual suicides in the military:

- medical and behavioral health records,
- ASERs,
- CID files,
- AR 15-6 (commander's inquiry reports),
- RCA reports,
- Post-Deployment Health Assessment/Post-Deployment Health Re-Assessment records,
- deployment data (date arriving and departing, location, days in theater),
- enlistment medical waiver data,
- Army Substance Abuse Program records,
- Family Advocacy Program data,
- line-of-duty reports, and
- Armed Forces Institute of Pathology data.

The most useful individual suicide data sources have proven to be DoDSERS, RCA reports, and CID reports. It is important to get the installation commander's support to gain access to all of these data sources. Although the above data are useful for looking at the index cases on an installation (see following section on epidemiological methods), it is also useful to evaluate population data from the community. Population-based data from an installation or theater can reveal important information on trends related to leadership, morale, operations tempo, mental health support, alcohol-related events, domestic violence, and so forth. All of these are important indicators of the behavioral health of a community and may offer insight in the generation of hypotheses or reveal associations in the course of epidemiological analysis that lead to recommendations.

The following are useful sources of population data on Army installations:

- installation population size and demographics (denominator data),
- installation deployment cycle and impact on population calculations,
- behavioral health utilization and workload,
- behavioral health staffing,
- Army risk reduction data,
- Military OneSource reports,
- Army Substance Abuse Program data, and
- installation-level Family Assistance Program data.

Additionally, it may be helpful to conduct interviews and focus groups to explore concerns of the soldiers (junior enlisted and junior noncommissioned officers), military leadership, MTF staff, community-based agencies and installation support staff, and military family members or family readiness groups. Such sessions, when conducted by experienced health risk communications specialists, can reveal important information on prevailing perceptions, stigma associations, knowledge status, and morale within subpopulations on an installation. When collected early, this information can help guide the course of the EPICON. It also can be useful in targeting intervention strategies at the community level.

Likewise, surveys can be of great assistance when applied to an appropriate number of individuals. In most of the EPICONS that have been completed, staff from WRAIR or PHC(P) performed anonymous soldier surveys. The surveys ask about a wide range of issues, including access to care and command climate. The most recent survey administered by PHC(P) looked for associations with self-reported suicidal ideation. Surveys contribute to the inclusion of quantifiable data into the report. The hardest challenge in working with the command is finding time for their soldiers to take the surveys, especially in a high operations tempo environment. PHC(P) has the ability to generate electronic form surveys, which can greatly reduce data-entry workload and errors in analysis.

During the EPICON visit, it is essential to establish a close working relationship with both the MTF and the installation PAOs. All information released publicly must go through these individuals. Similarly, after the EPICON document summary is drafted, it must go through the local PAOs for review prior to the submission to command or OTSG/MEDCOM.

While working an EPICON, it is necessary to generate daily situation reports, which must be forwarded to PHC(P) Operations and up to OTSG. EPICONS are high visibility missions with tremendous sensitivity to the command. The team should document each day's activities (interviews, meetings, surveys, pre-

sentations) to reference in writing the EPICON final document.

### **Methods in the Epidemiological Consultation**

Suicide outbreaks are unique from other types of disease outbreaks because the perception of the outbreak itself may lead to further cases, especially in an adolescent population. This characteristic must be taken into consideration in EPICON activities. Behavioral health assessments may use concepts from infectious diseases epidemiology, such as "exposure" to index cases, "contagion," and "isolation." Epidemiologic methodology in an EPICON should be guided by the services of an experienced epidemiologist on the team. Although the outline presented below is not the focus of this chapter, it is important to briefly discuss epidemiologic methods for understanding behavioral health EPICONS.

During an EPICON, basic epidemiological strategies should be followed, to include:

- defining the questions or current hypotheses (one of these may determine if there is an actual outbreak),
- conducting hypothesis-generating interviews to broaden knowledge of the subject and what should be evaluated more thoroughly,
- establishing a case definition for this public health study,
- conducting an investigation using epidemiological methods,
- completing initial analysis,
- providing initial findings and recommendations to leadership, and
- completing final analysis and write-up.

In general, epidemiologic methods of study include: (a) case series (clinical, forensic, etc); (b) case-control studies (eg, suicide cases vs controls); (c) cross-sectional studies (eg, compare cases with rest of battalion); (d) soldier surveys (usually done by WRAIR or PHC(P)); and (e) focus-group interviews.

The basic questions are:

- Is there a real outbreak of suicidal behavior?
- Is the rate significantly higher than expected (eg, when compared to like installations or the overall Army)?
- What factors contributed to the outbreak and how can they be compared against one another?
- What recommendations can be made to address the problem?

When defining inclusion criteria for cases, the team must determine an outbreak time frame, the individuals included, and their location. An index case definition must also describe who is not included as a case. An example from the Fort Campbell, Kentucky, index case definition is described below:

Index cases were defined as all confirmed and pending suicides occurring between January 1, 2006 and October 31, 2007 based on Army G-1 and Armed Forces Institute of Pathology (AFIP) data. There were a total of 14 index cases in this time period. Cases were restricted to active duty soldiers who were assigned to Fort Campbell, Kentucky, at time of death. Family member, civilian, and retiree suicides were not included in this analysis because of limitations to medical and legal data available on non-active-duty deaths.

One useful tool inherent to any EPICON is an “epi-curve.” Traditionally, a team shows the time course of an epidemic by drawing a graph of the number of cases by their date of onset. This graph, called an epidemic curve, or “epi-curve,” gives a simple visual display of the outbreak’s magnitude and time trend.

Suicides and suicide rates on an installation are always sensitive issues. It is critical to keep the command informed of the status of the assessment. The command must be briefed on the results before any information is released outside of the command. It is important to clarify the level of detail (ie, full report or briefing slides) desired by the command.

Writing the report is a laborious and time-consuming process, especially if the team members have been gone for several weeks for the mission. Upon their return, other duties often interfere with report writing. Different sections of the report may be assigned to different people. It is helpful to develop and adhere to a time line, which is set by the senior officer. Another practical suggestion is that plane rides home should be dedicated to report writing; team members should ensure that computer batteries are charged. PHC(P) uses a standardized EPICON report format that may easily be transformed into a publishable document.

Media attention may or may not be present. There was intensive media attention on the Fort Bragg EPICON. The redacted report was eventually put on the Army medicine Web site ([www.armymedicine.army.mil](http://www.armymedicine.army.mil)). In other cases, media interest is less prominent.

However, all team members should be reminded not to discuss their work with the media without appropriate clearances.

## Results and Lessons Learned

Each EPICON has led to recommendations based on internal assessments of the particular installation that was evaluated. Although each installation’s situation is unique, the overall recommendations will be summarized here, as the reports have had some parallel themes. However, it must be noted that these assessments have been performed on installations where there were apparent suicide clusters, and thus may not be indicative of Army installations as a whole.

The common findings are:

- there is a perceived shortage of behavioral health assets, despite efforts of local commanders to hire more resources,
- there is a stigma involved in seeking help,
- forward-deployed assets are more effective,
- marital therapy should be more available,
- more integration of resources is desirable,
- command is very interested in solving these problems, and
- the effort is essential to maintaining the strength of the fighting force.

Both the local and the overall command have been very interested in these results. In all cases commanders and the medical departments have taken the recommendations seriously. Some examples follow:

- The Fort Leonard Wood, Missouri, report led to the expansion of the “Medical Moment of Truth” at the reception battalion, and to a reexamination of the “unit watch” protocol.
- The Fort Bragg, North Carolina, EPICON spurred development of the Deployment Cycle Support program.
- The Fort Riley, Kansas, EPICON led to an increase in marital therapy resources.
- The Fort Hood, Texas, EPICON reinvigorated the installation-wide risk reduction committees.
- The Fort Campbell, Kentucky, EPICON recommended an improvement in the quality of the “risk reduction” data.

## SUMMARY

Suicide prevention is a continuing challenge. The rate continues to increase, despite development and

use of educational and training materials. The behavioral health epidemiological consultation process is



a useful method of assessing clusters of suicides and suicidal behaviors. The results help to guide both installation and Army-wide efforts to focus on gaps in outreach, education, and treatment.

There are caveats, however. It is notoriously difficult to measure the effectiveness of any suicide prevention program. Because the focus is often on completed suicides, it is not known how many have been prevented via proactive measures by the command and staff. Additionally, the suicide rates are not necessarily a good marker of the mental health of the force. There are other instruments available to assess effectiveness of suicide prevention programs and the quality of services delivered. These include, for example, the DoDSEER, unit surveys, and gatekeeper training.

Suicide affects the psychological and physical health of soldiers, units, family members, and friends. The approach to prevention, intervention, and postvention must be an integrated, multifactorial endeavor involving all levels of the command and family resources. The information presented here illustrates the current initiatives, many of which were developed from lessons

learned in the past. Building products and strategies based on those lessons should enhance the ability to save lives in the future.

The rate of suicides has doubled in the Army in the last 6 years. Every suicide is a tremendous tragedy, for the soldier, for the family, and for the Army. Risk factors for suicide include a break-up in a relationship and trouble at work. Medical issues, especially chronic pain or disability, may precipitate a suicide attempt. Alcohol abuse can disinhibit someone in many ways and result in self-injury. In recent years, there has been a rise of suicides in senior noncommissioned officers, senior officers, female soldiers, and soldiers in the warrior transition units. Medical soldiers are not immune.

There are numerous educational resources for soldiers and families detailing suicide awareness and intervention for someone in trouble. To take care of fellow soldiers (“Ask, Care, and Escort”), ask about their issues, take care of them, and do not leave them alone. Get them to a chaplain, a medic, combat stress control, or their command. “Shoulder to shoulder: No Soldier stands alone.”

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