



Maj. Amy Thrasher, 18th Military Police (MP) Brigade behavioral health officer, leads yoga for physical training with soldiers from the 194th MP Company April 2021 at Camp Aachen, Germany. Yoga practice has documented benefits to physical and emotional health. It was one of the brigade resiliency team's most requested events. (Photo by Spc. Benjamin Purcey, 18th MP Brigade Public Affairs Office)

Collaboration between Leadership and Behavioral Health

How One U.S. Army Brigade Created a Novel Approach to Suicide Prevention

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Multiple stressors tax Army units routinely. For units stationed overseas, those stressors include frequent short-notice deployments and numerous multinational training exercises, and they have been exacerbated by the COVID-19 pandemic. And many of these stressors are not unique to overseas units. Organizations based in the continental United States also face multiple challenges in operational tempo, resource management, and supply-demand issues.

These factors demanded an innovative approach, particularly regarding behavioral health, to

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adhere to the “Army People Strategy.” Through command-embedded behavioral health collaboration, the 18th Military Police (MP) Brigade developed and implemented a novel strategy that prioritized soldier well-being, enhanced suicide prevention programming, and achieved a positive command climate. These successes provide early evidence of an approach that could be scaled or replicated. This approach included the data-driven deployment of an internally sourced resiliency team. Similar approaches are warranted, given more recent societal trends and their deleterious impact on unit readiness.

Behavioral Health of Soldiers Today: A Leader's Perspective

Suicidal thoughts, behaviors, and events are not unique to the uniformed services. Many in our society, especially teens and young adults, struggle with mental health issues that sometimes lead them to believe the only way out is through self-harm. In October 2021, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association jointly declared a national state of emergency regarding youth mental health.¹ According to the National Alliance on Mental Illness, “Suicide is the second-leading cause of death among people age 15 to 24 in the U.S. Nearly 20% of high school students report serious thoughts of suicide and 9% have tried to take their lives.”² First-time service members fall within this demographic, making it critical for the Armed Services to have awareness of this problem and develop integrated prevention plans. Suicide-related events tragically rip military units apart and can have a ripple effect that extends to future service members and their propensity to serve.

Suicide prevention in the U.S. Army has traditionally involved three major components, captured in the Ask, Care, and Escort Suicide Intervention (ACE-SI) training program.³ ACE-SI includes one-and-one-half hours of standardized training that provides soldiers with the awareness, knowledge, and skills necessary to intervene with those at risk for suicide. The purpose of ACE-SI is to help soldiers and junior leaders become more aware of steps they can take to prevent suicides and to build confidence in their ability to act in such situations. ACE-SI encourages soldiers to directly

and honestly question any battle buddy who exhibits suicidal behavior. The battle buddy asks a fellow soldier whether they are suicidal (e.g., “Are you thinking about hurting or killing yourself?”), then provides basic care for the soldier (e.g., “I am here for you. I care about you. I’m going to help you.”), and finally escorts the soldier to the source of professional help (e.g., to a leader, medical clinic, chaplain, etc.). This training helps soldiers reduce their fear and discomfort around suicide.

Background: Brigade Embedded Behavioral Health

In 2012, following years of extensive validation, the Department of the Army directed replication of the EBH model of health-care delivery across all deployable units.⁴ The EBH transition provided a single point of entry in the behavioral health system for soldiers and leaders. Doctrinally, embedded behavioral health refers to the system of health-care delivery in which units are

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Additionally, it helps govern appropriate actions to prevent suicides when confronted with actively suicidal battle buddies.

The ACE-SI program, while extremely valuable in training soldiers and leaders, is geared toward intervention rather than prevention. As the brigade commander and behavioral health officer for 18th MP Brigade, we recognized the limitations of ACE-SI and sought to go beyond policy. It is important here to articulate the limited training in suicide prevention and behavioral health support that leaders have before assuming command. Commanders, like all soldiers, are required to attend the ACE-SI training annually, but they receive no additional education beyond this standard. This is not to say that the Army does not prepare leaders to assume command at the brigade level. New brigade commanders receive over four weeks of precommand training that includes topics regarding the morale and welfare of soldiers and aspects of suicide prevention. But effective suicide prevention requires expertise beyond general training. For that, leadership and the behavioral health team of the 18th MP Brigade collaborated with multiple special staff sections to develop an effective suicide prevention program (see section titled “Developing a Novel Approach”). Because leaders rarely receive training and education in the role of embedded behavioral health (EBH), many do not know what the EBH team has to offer until their first office call with the brigade Behavioral Health Office (BHO). Therefore, the discussion of command-EBH integration must start with an explanation of EBH teams and functions.

assigned to specific clinics and certain providers. This allows for continuity between leadership and behavioral health staff. The model also includes the creation of an internal embedded brigade behavioral health team. Structurally, the behavioral health team falls under the brigade surgeon cell and is composed of two behavioral health officers (one psychologist, one social worker) and two behavioral health technicians (military occupational specialty 68X). Most Army psychologists and social workers receive two weeks of training on the role of embedded behavioral health during their initial entry training. Once embedded, the brigade EBH team—especially the BHO—becomes the de facto behavioral health subject-matter expert and primary point of contact for the brigade commander.

The BHO has three functions: treatment, prevention/outreach, and consultation (see figure 1, page 88). Treatment includes conducting evaluations, providing therapy, documentation, attending meetings, and essentially all activities related to clinical care. It is often assumed that the treatment function is the entirety of the BHO’s job. In practice, however, clinical care should be no more than 50 percent of the BHO’s duties. It is important that commanders and leaders understand this and utilize their EBH teams for more than just treatment. BHOs divide the remainder of their time between the other functions.

The prevention/outreach function refers to all health-promotion activities implemented outside of the clinic. These activities include psychoeducation, skills training, and general wellness activities. The



18 Military Police Brigade Behavioral Health Capabilities



Prevention & Outreach

- Battlefield Circulation
- Brief Classes (Stress Management, Sleep Hygiene, Yoga, etc.)
- Optimum Performance Training (Bio-feedback, Mindfulness, Meditation)
- Host Morale Events

Treatment

- Individual & Group Therapy
- Command-Directed & Fitness for Duty Evaluations
- Psychological Testing
- Telehealth/VTC
- Referrals

Consultation

- Advise Commands on BH/medical matters
- Maintain Records of Suicide-Related Incidents
- Unit Needs Assessments
- Team Building & Leadership Activities

(Figure by Maj. Amy Thrasher)

Figure 1. Brigade Embedded Behavioral Health Team Capabilities, 2020

concept is that if soldiers receive some training and knowledge in managing emotional sequelae early and efforts are made to promote wellness, they are less likely to develop behavioral health disorders in the future. These efforts, in turn, contribute to resilience and force readiness.

Consultation refers to the direct interactions between the BHO and leaders throughout the organization. It takes the form of formal meetings (e.g., high-risk trooper meetings, command and staff meetings, planning conferences, and community health promotion councils). It also takes the form of one-on-one touchpoints with various leaders, primarily the brigade commander. Together, the brigade commander and BHO work toward improving the health of the force.

Leveraging BHO Functions to Support the Army People Strategy

The Army has rightly emphasized the importance of its people and the necessity to build cohesive teams. This is the genesis of the “Army People Strategy” (APS). The APS outlines four critical enablers to achieving the Army’s strategic outcomes. They are Talent Management, Quality of Life, Army Culture, and Resources and Authorities.⁵ The brigade BHO is uniquely qualified and prepared to support the Quality of Life and Army Culture enablers within the brigade structure.

Quality of Life refers to “the full range of Army care, support, and enrichment programs, with an initial focus upon: Housing and barracks; Healthcare; Childcare; Spouse Employment; and Permanent Change of Station (PCS) moves.”⁶ BHOs leverage their role as consultants to assist the brigade commander in developing and implementing programs aimed at these efforts. Assistance ranges from simple consultation on a specific soldier (e.g., the commander has concerns about a high-risk soldier and asks the BHO for their input on safety plan and disposition) to formal programming (e.g., a suicide stand-down conducted conjointly with the brigade chaplain). Such outreach efforts are based on the needs of the audience and determined in consultation between the brigade leadership and BHO. A one-size-fits-all model of psychoeducation does not work. Here, the BHO and command team discuss trends across the brigade. The BHO then recommends interventions based on those trends. These are specific ways in which commands can leverage BHO support to enhance the lives of soldiers and support critical enabler #2 of the APS.

Likewise, the BHO supports APS critical enabler #3, Army Culture. Army Culture refers to the “foundational values, beliefs, and behaviors that drives an organization’s social environment, and it plays a vital role in mission accomplishment.”⁷ At the organizational level,

culture manifests in the brigade's command climate. BHOs have unique talents and insight to help commanders establish and maintain a healthy command climate. If a commander is open to learning more about leadership style or communication, the BHO has the expertise to assist either in one-on-one coaching or in a leader professional development (LPD) group setting. For example, a battalion commander might request the BHO present an LPD on emotional intelligence to all

functions of the brigade EBH team, making the brigade BHO a primary point of contact for improving quality of life and Army culture in the brigade.

Developing a Novel Approach via a Five-Step Problem-Solving Process

Tying the threads of suicide prevention, command-behavioral health collaboration, and the APS together, the authors began a dialogue about innovative

“Rebuilding trust after a violation requires patience, insight, and skills inherent in the work of BHOs [behavioral health officers].”

senior NCOs and officers in the battalion. This example demonstrates how consultation with commanders can lead outreach activities aimed at promoting healthy culture within the unit.

Another aspect of Army culture is building cohesive teams through trust. Trust is the BHO's essential trait. Behavioral health professionals are highly trained in ways to build trust and rapport. In the Army, that capability translates into building trust with leaders, community stakeholders, and soldiers. And the BHO can help leaders apply the same principles to their formations. This is again where consultation plays a key role.

In addition to standard measures of command climate such as the Defense Organizational Climate Survey, the embedded BHO has the capability to conduct unit needs assessments (UNA). The UNA provides detailed feedback on key indicators of climate and trust. Based on these results, the BHO works with leaders to address gaps in trust. The BHO also assists in preventing and addressing barriers to trust. The APS identifies symptoms of broken trust: “sexual assault, sexual harassment, suicide, discrimination, hazing/ bullying, domestic violence, ... poor housing, and reckless activities.”⁸ Rebuilding trust after a violation requires patience, insight, and skills inherent in the work of BHOs. Not only can BHOs help leaders repair or preserve trust, but they can also serve as surrogates for leaders in tenuous situations. If the BHO has the rapport with soldiers, they can assist in delivering the commander's message of trust and care. The Army's focus on “people first” aligns with the goals, purposes, and

ways to support soldiers. We were determined to take a different approach to a problem all units face: suicide prevention. If you are an Army leader, you have been to a commander's conference at some level where suicide trends were discussed. One can recall the numerous times where PowerPoint slides were generated showing suicidal ideations, suicide attempts, and actual suicides by unit, over time, side by side. Each data point was shown in some color of red indicating its negative connotation. It was clear to most that if your unit had a high number of ideations, attempts, or actual suicides, that there was something wrong within that unit. This is sometimes the case. But experience suggests that this approach leads to commanders basing a suicide prevention program on the prevention of statistics, rather than the actual prevention of suicide. This approach can lead to underreporting and stigmatization within the formation and through the chain of command. The lack of attention to detail means potentially missing a soldier's needs. It also ignores critical information regarding suicidal ideations. Any suicide prevention program needs to consider the five Ws of suicide-related incidents.⁹ This information can help guide prevention and outreach strategies. At the 18th MP Brigade, we were determined to turn this method on its head and adjust our approach. To ensure we met the needs of our soldiers, we applied a five-step problem-solving process. The steps are engage, track, identify, deploy, and assess.

Engage. Step one, engage, starts with *engaged leadership* that supports soldiers. Leaders must create an atmosphere of openness in which soldiers know they

Table. VA/DOD Clinical Practice Guidelines Definitions

Suicidal Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself with evidence, whether the implicit or explicit, of suicidal intent.
Suicide Attempt	A nonfatal self-inflicted potentially injurious behavior with any intent to die as a result of the behavior.
Suicide Completion	Death caused by self-inflicted injurious behavior with any intent to die as a result of the behavior.
Suicidal Ideation	Thoughts of engaging in suicide-related behavior. (Various degrees of frequency, intensity, and duration)

(Table from VA/DOD Clinical Practice Guidelines for Assessment and Management of Patients at Risk for Suicide, Definitions, 2013)

analyzing the data we had at our fingertips. One of our early tasks was tracking all suicide-related behaviors across the brigade. Suicide-related behaviors include suicidal ideations, suicidal self-directed violence, suicide attempts, and suicide completions (see the table).¹⁰ Brigade policy mandated that every suicide-related event required a detailed serious incident report describing the who, what, when, where, how, and—if known—why of the incident. This information, which included standard demographic and unit

can express their thoughts and concerns. This starts at the top with the brigade command team but must flow down to lowest echelons of leadership. Within the 18th MP Brigade, engagement meant shifting the culture away from any stigma that suicide-related events might create. It started with leadership messaging to soldiers throughout the formation: If you are hurting, if you need help, if you feel helpless, reach out! Reach out to your battle buddy, reach out to your team leader, squad leader, your family, the chaplain, behavioral health, or anyone.

Leaders spoke of their own histories seeking assistance following significant life events. The intent was to destigmatize behavioral health issues and let soldiers know that it was okay to have these thoughts and to ask for help. The EBH team was also important in reducing stigma by spending time shoulder-to-shoulder with soldiers across the brigade. The goal was for soldiers to recognize the members of their EBH team so that they knew who to seek out if they needed support. Furthermore, the objective was to provide help to soldiers and then get them back in the fight. All these engagement activities provided buy-in from leaders and soldiers throughout the brigade.

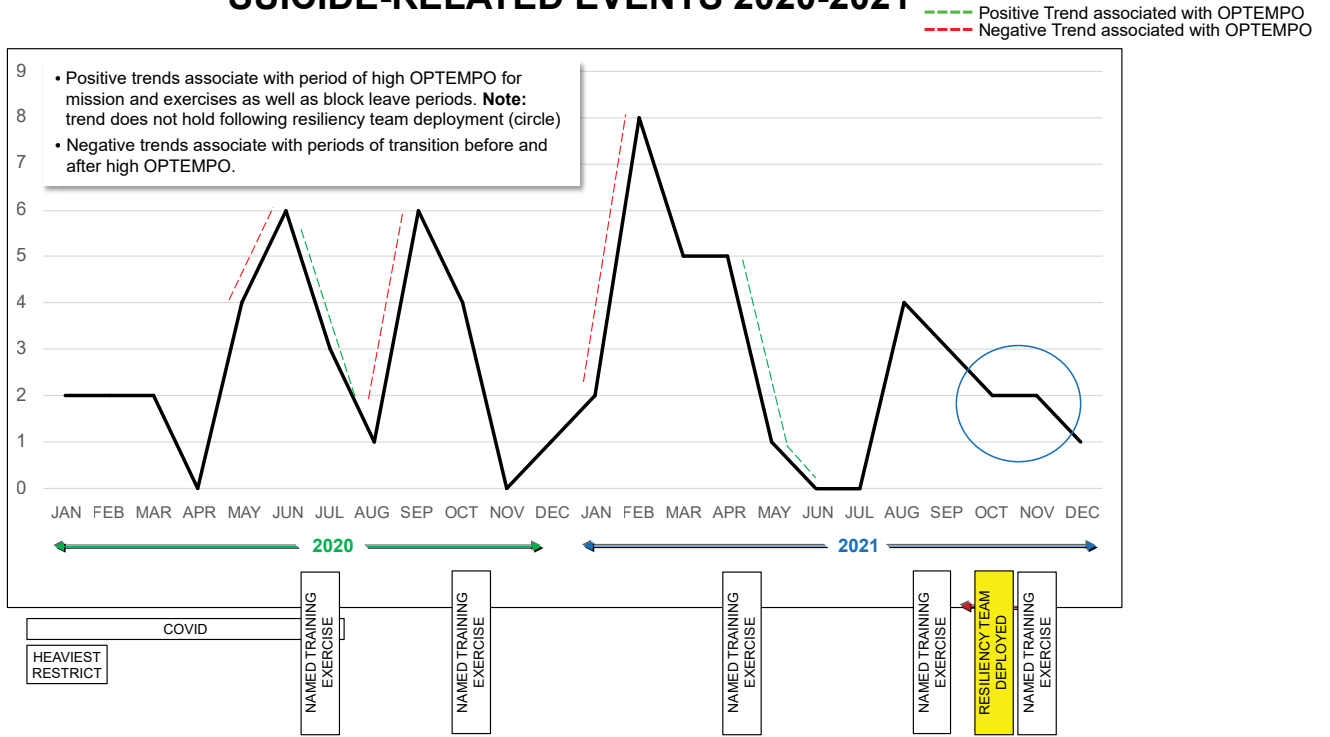
Track. The second step, tracking, refers to data generation and analysis. Any approach to problem solving must be data driven to be useful. In the military, we constantly track information and assess what information means and how it can be harnessed to boost efficiency, effectiveness, and readiness. In terms of addressing suicide-related events, this meant

information, date of arrival to the unit, date of incident, whether it was the soldier's first duty station, when the incident occurred in terms of weekdays/weekends/holidays, and possible precipitating factors (defined as difficulties in finances, relationships, occupation, health, legal, family concerns, or unknown) was logged and maintained as an internal document.

Using this yearslong log, we developed a series of tracking charts (see figures 2 and 3, page 91). These visual aids helped us identify informal trends in suicide-related behaviors and subsequently respond to those trends. From these charts, we determined two foci: time and precipitating factors. Regarding time, we observed increased suicidal ideations immediately before (defined as the two weeks prior to the start of) major training or field exercises. This trend held across three years of data. Regarding precipitating factors, analysis of the data identified several common precursors to suicide-related events: marital distress, family problems, and occupational issues. From that, we hypothesized that the increased stress and burden on individuals and families in the days preceding major training exercises was likely one of the underlying sources of increased suicidal ideations and other suicide-related events. With this hypothesis in mind, we proceeded to the next step: identify.

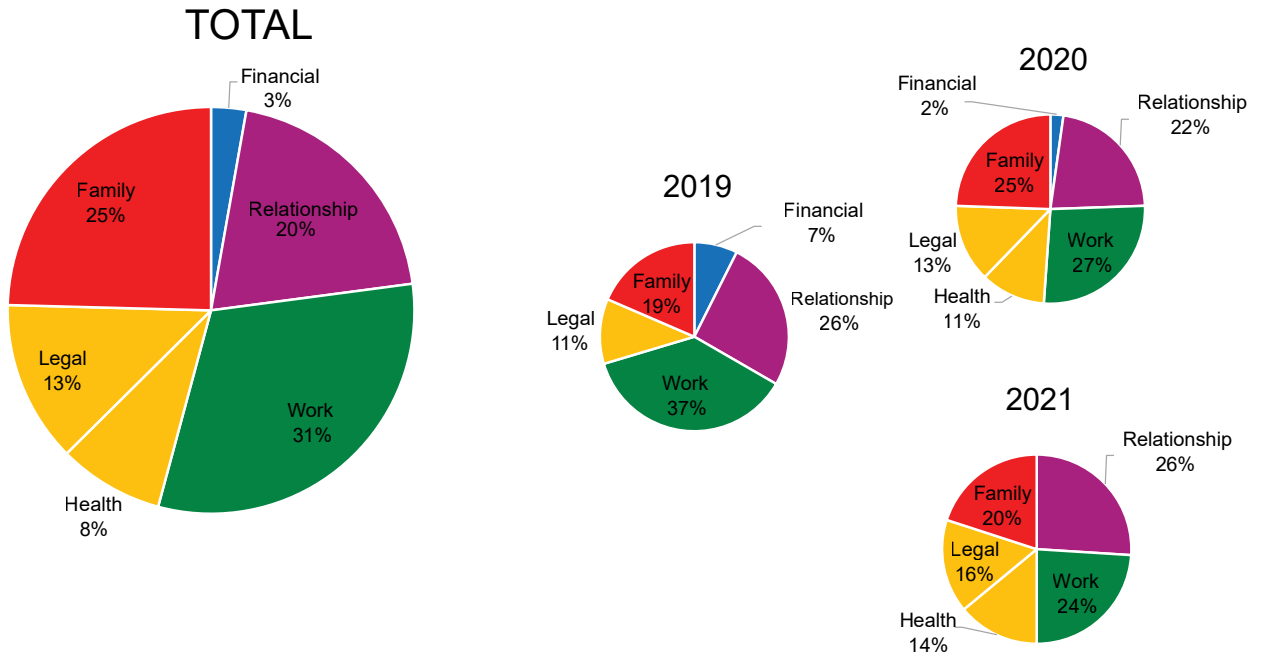
Identify. Leaders must identify assets and resources available and capable of meeting the demands of the presenting concern. Identification requires collaboration between commanders and unit, garrison, and community stakeholders. It is noteworthy that one's

SUICIDE-RELATED EVENTS 2020-2021



(Figure by Maj. Amy Thrasher; this figure shows a decrease in incidents following deployment of resiliency team in 2021)

Figure 2. Sample Suicide-Related Behavior Tracking Chart (Incidents over Time)



(Figure by Maj. Amy Thrasher; this figure shows a breakdown of precipitating factors to suicide-related behaviors, 2019–2021)

Figure 3. Sample Suicide-Related Events Tracking Chart



(Figure by Maj. Amy Thrasher)

Figure 4. Composition of the 18th Military Police Brigade Resiliency Team

ability to identify these resources is positively correlated to the level of engagement conducted in step one. The more engaged the leader, the more likely that leader will be able to recognize what assets are available and how those assets can support the mission. As Sergeant Major of the Army Michael Grinston recently noted, “Maybe [Soldiers] seek behavioral health, maybe you can talk to a chaplain ... I think when we use all the resources that we have, I think we’re all going to be in a better mental state. We can’t just use only one resource.”¹¹ Likewise for us in the 18th MP Brigade, it was clear that resiliency did not reside with behavioral health alone. Many of the trends gleaned from data analysis indicated that soldier behavioral health issues stemmed from a variety of precipitants, as previously noted. This analysis necessitated a holistic approach, where specific concerns were addressed with the appropriate expert. The solution was the creation of a brigade resiliency team, dedicated to suicide prevention and soldier wellness. Based on the data and feedback from soldiers and leaders, we identified five key resources: the behavioral health team, the unit ministry team, the soldier and family readiness assistant, the military equal opportunity advisor, and the Sexual Harassment/Assault Response and Prevention program representative (see figure 4). The purpose of the newly formed resiliency team was to conduct resiliency-focused battlefield circulation in which these subject-matter

experts deployed to units in the days immediately preceding major missions. With the key resources identified, it was time to deploy them.

Deploy. Deployment, step 4, is the application of resources to the area of concern. This is the inflection point, where leaders can promote growth. For the brigade resiliency team, this was their battlefield circulation. Circulation consisted of formal programming and informal outreach, tailored to the specific needs of the unit, delivered in a timely manner (e.g., hosting a resiliency day in the two-to-four weeks prior to a long field cycle). For example, as one company prepared for a KFOR (Kosovo) rotation, the team traveled to that unit and provided unit-specific training on health and wellness before they left. The goal was to provide additional support and education to soldiers in support of the mission.

In the weeks preceding scheduled circulation, company commanders, platoon leaders, and non-commissioned officers consulted with the resiliency team and selected the specific topics and activities they viewed as most beneficial to their soldiers (see figures 5 and 6, page 93). While visiting these units, resiliency team members also conducted informal circulation, during which they elicited feedback from soldiers. This was the team’s chance at further engagement. All this information—formal data collection, feedback from commanders, and feedback from

18th MP BDE Resiliency Team Capabilities	
SHARP <ul style="list-style-type: none"> • Conduct focus groups/small group discussions • Situational based training on real situations that are affecting our unit • Specialized training for Leaders on prevention of SA/SH, and retaliation • SHARP annual training • Resiliency-based practical exercises 	UMT <ul style="list-style-type: none"> • Lead small group Strong LIFE discussions • Interactive suicide briefs (scenario-based skit/role plays) • Suicide Prevention training (e.g., ACE, "ASIST") • Pastoral Counseling (Couples and Individual) • Strong Bonds Training: Couple/Single Soldiers • Moral Leadership Training (PLT Level on BN) • Command Advisement on morale & religious matter
EO <ul style="list-style-type: none"> • Brief Classes (Treatment of Persons, Prevention of discrimination, Microaggressions, etc.) • Observance events • Conduct focus groups/small group discussions • Leader involvement/policing the ranks • EO annual training • Resiliency-based practical exercises 	BH <ul style="list-style-type: none"> • Command consultation • Lead small group discussions: <ul style="list-style-type: none"> • Skills training (Stress Relief, Yoga, Mindfulness, Meditation, Sleep Hygiene, Anxiety/Depression) • Psychoeducation (Influence of Personality, Holistic Health, Emotional Intelligence) • Optimum performance training • Host morale events (e.g., waffles/grilled cheese)

(Figure by Maj. Amy Thrasher)

Figure 5. Resiliency Team Battlefield Circulation Menu of Options

soldiers—helped determine the best employment of resources to ensure we were, in fact, putting our people first.

Assess. Having deployed assets to address the problem, the next step is assessment. Just as we need to track data to identify resources, we also need to track data on effectiveness of the deployed program.

How has implementation led to change?

For the resiliency team, assessment included after action reviews following every outreach event; written memoranda for record from each section; and debriefs with company, battalion, and brigade command teams outlining areas of success and improvement as well as any recommendations from the team. Additionally, we used the ongoing suicide-related incidents tracking log to assess changes in the quantity and timing of incidents. We observed a decrease in suicidal ideations after deploying the resiliency team for the first time (figure 2). The assessment step is ongoing. Any feedback derived from the assessment process leads directly back through the five-step process, where leaders consider how to engage with soldiers, track and analyze data, and redeploy resources. As the resiliency team

reassessed their process over time and integrated leader input, circulation activities became more refined and led to a better product.

Prior to implementing this approach within the 18th MP Brigade, on paper and per regulation, we had a healthy suicide prevention program. Our number of trained soldiers met the regulatory requirements. We had a behavioral health team in place. We trained our leaders appropriately and had a positive command climate. But it wasn't enough. Meeting the Army standard served as the foundation, but by going

beyond policy, we provided our soldiers much needed access to additional resources and tools, resulting in improved coping skills and greater ability to tackle challenges. This, in turn, enhanced readiness rates both tangibly and intangibly across the formation. And, most importantly, while impossible to prove, it is our belief that this approach saved lives.

Commander's Request/Focus: Preparing Soldiers for upcoming deployment, team building

Schedule of events:

Time	Topic/Activity	Presenter
0630-0730	Yoga/PT	BHO
0730-0900	Personal hygiene/breakfast Resiliency team will host waffle breakfast for those interested	Resiliency team
0930-1000	SHARP pre-deployment brief	SARC
1000-1130	Conflict Styles Class and team exercise	BHO
1130-1300	Lunch	
1300-1400	"A Valuable Deployment" class/brief	Chaplain/SARC
1400-1430	Teamwork activity	MEO
1430-1530	Understanding micro-aggressions/ improving communication	MEO
1530-1600	Q & A with resiliency team	Resiliency team
1600-??	Outbrief/Feedback with Company CMD team	Resiliency team

(Figure by Maj. Amy Thrasher)

Figure 6. Sample Resiliency Team Program of Events

Conclusion

The outreach program outlined above follows the Department of Defense Instruction (DODI) 6400.09, *DoD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm*, translating guidance to the organizational level.¹² DODI 6400.09 states that leaders take actions to “foster command climates of dignity, respect, inclusion, and connectedness” while implementing data-informed, integrated prevention programs.¹³ The point of emphasis is that leaders and subject-matter experts collaborated to develop a program that met the needs of soldiers while providing quality feedback for the command team. At

the 18th MP Brigade, “people first” was a mantra long before it was an Army initiative. This program supports the APS critical enabler #2, Quality of Life, by providing tailored support at the right time and place. It also supports critical enabler #3, Army Culture, in that the leadership fostered a climate of openness and acceptance through destigmatization of help-seeking behavior. These initiatives helped build stronger, more resilient teams, and it was done through coordination between brigade leaders and embedded behavioral health. We hope this article serves as an example of how leaders and EBH teams can collaborate for the good of the formation. ■

Notes

1. “AAP-AACAP-CHA Declaration of a National Emergency in Child and Adolescent Mental Health,” American Academy of Pediatrics, last updated 19 October 2021, accessed 12 January 2023, <https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/>.

2. Sandy Cohen, “Suicide Rate Highest among Teens and Young Adults,” UCLA Health, 15 March 2022, accessed 12 January 2023, <https://connect.uclahealth.org/2022/03/15/suicide-rate-highest-among-teens-and-young-adults/>.

3. “Suicide Prevention Training,” Army Suicide Prevention Program, last updated 28 June 2021, accessed 12 January 2023, <https://www.armyg1.army.mil/hr/suicide/training.asp>.

4. All Army Activities (ALARACT) Message 186/2012, “Army Implementation of Behavioral Health System of Care (BHSOC) Embedded Behavioral Health (EBH),” 13 July 2012.

5. Michael A. Grinston, James C. McConville, and Ryan D. McCarthy, “The Army People Strategy: Diversity, Equity, and Inclusion Annex” (Washington, DC: U.S. Department of Defense, 1 September 2020), 5, accessed 10 September 2020, https://www.army.mil/e2/downloads/rv7/the_army_people_strategy_2019_10_11_signed_final.pdf.

6. *Ibid.*, 10.

7. *Ibid.*, 11.

8. *Ibid.*, 12.

9. The five Ws refers to the description of who, what, when, why, and where of any given situation or event.

10. The Assessment and Management of Risk for Suicide Working Group, *VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide* (Washington, DC: Department of Veterans Affairs/Department of Defense, 2013), 13.

11. Haley Britzky, “Sgt. Maj. of the Army to Leaders: Stop Using Behavioral Health as a Universal Band-Aid for Problems,” Task & Purpose, 17 October 2022, accessed 12 January 2023, <https://taskandpurpose.com/news/army-behavioral-health-wellness-checks-grinston/>.

12. Department of Defense Instruction 6400.09, *DoD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm* (Washington, DC: Office of the Undersecretary of Defense for Personnel and Readiness, 11 September 2020), accessed 12 January 2023, <https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/640009p.pdf>.

13. *Ibid.*, 12.



Department of Defense Instruction 6400.09, *DoD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm*

This instruction established and integrates policies and responsibilities to mitigate self-directed harm and prohibited abusive or harmful acts using a career-cycle perspective to promote enduring force readiness.

To view DOD Instruction 6400.09, visit <https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/640009p.pdf>.