Spc. Matthew Mackintosh, a public affairs specialist with Headquarters and Headquarters Battalion, U.S. Army Pacific, displays a tattoo on his wrist on 2 October 2023 at Fort Shafter, Hawaii. The semicolon represents a place where a sentence could end but continues on; it is a symbol used for suicide awareness and prevention. Just like its grammatical use, it represents a moment when a life could have ended, but the choice was made to continue on. (Photo by Spc. Matthew Mackintosh, U.S. Army)

Reconsidering Our Approach to Suicide Prevention

Maj. Gen. James P. Isenhower III, U.S. Army
Maj. Allison Webb, MD, U.S. Army Reserve

If we keep doing what we're doing, we'll keep getting what we're getting.

—Maj. Richard Pedersen, July 1994

Over the past two decades, the Army's approach to suicide prevention might best be characterized by the following steps: identify suicide risk, mitigate suicide risk, and escort the soldier to behavioral health. At Fort Bliss, Texas, this approach is failing. Despite our programs, processes, and emphasis, we have failed to reduce the mean number of suicides per year since 2012.[1]

In our discussions with medical clinicians, they explain to us their belief that much of this failure is due to our continued and relentless application of a set of flawed assumptions. First, our profession's typical way of addressing challenges will work, from the military decision-making process (MDMP) to our habitual reliance on procedure and compliance. Second, individual risk evaluation and mitigation of said risk will reduce suicides at the population level. Third, our current prevention paradigm, the Ask–Care–Escort–Suicide Intervention (ACE-SI) model with the resulting over-reliance on the behavioral health system of care, will change the problem of suicide on a broad scale.

We were struck when, instead of radically changing our processes and approach in the 2023 release of Army Regulation 600-92, *Army Suicide Prevention Program*, the regulation doubled down on its major tenets of suicide prevention.[2] In this article, we seek to challenge the prevailing data and mindsets that underscore our profession's approach to suicide prevention and provide suggestions for what we might do differently. By no means can we claim success. But for more than a decade, we at Fort Bliss have failed to lower our mean suicide rate, and if we keep doing what we're doing, we'll keep getting what we're getting.

Flawed Assumption #1

Our problem-solving tools, such as the MDMP, will help us address suicide.

We're not going to "MDMP" our way out of this.

—Maj. Allison Webb[3]

In the spring of 2023, Fort Bliss saw a brief spike in suicides. In each case, the chain of command was doing what our Army had asked of them: conducting risk assessments; reviewing weekend plans; maintaining routine, personal contact; and ensuring appropriate medical treatment. The installation commander told his higher headquarters, "We can't see what we're doing wrong," when he requested an immediate external assessment team to provide an objective evaluation of suicide prevention efforts and outcomes. In less than two weeks, an ad hoc, multidisciplinary team traveled to Fort Bliss to conduct a broad assessment over several days.

The staff assistance visit was revealing.[4] From the division psychiatrist's vantage point, the most impactful outcome was the immeasurable benefit of getting multidisciplinary partners from across the division and installation together in one room to discuss the effectiveness of collaboration and interventions. This intervention alone increased participation in subsequent working groups and engendered critical and more productive conversations on how we

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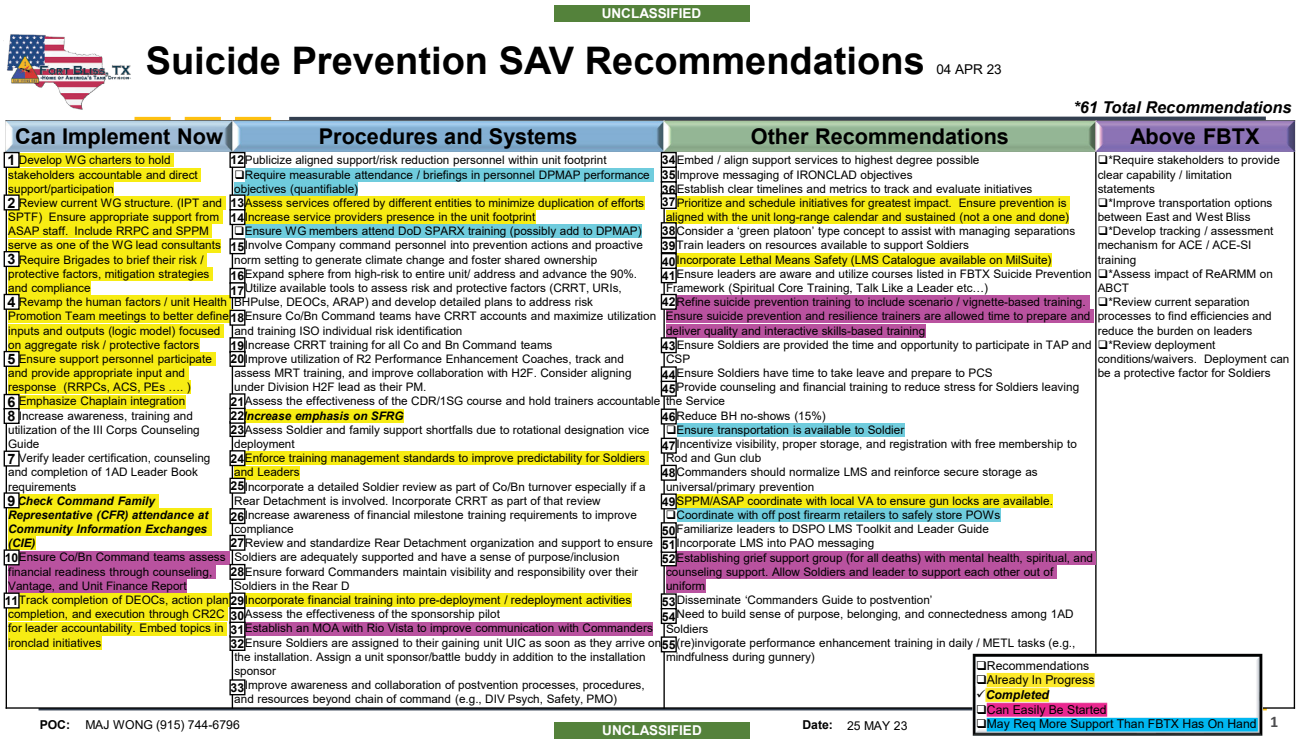
Maj. Allison Webb, MD, U.S. Army Reserve, recently served as the 1st Armored Division (1AD) psychiatrist at Fort Bliss, Texas. In her role, she was responsible for the behavioral health readiness of 1AD and carefully considered the psychological interventions that will help us win future wars. She is now a staff psychiatrist in the VA Durham Health Care System and serves in the Army Reserve at the Uniformed Services University in Bethesda, Maryland. She is double board certified in internal medicine and psychiatry and graduated from the combined Internal Medicine-Psychiatry program at Walter Reed National Military Medical Center. She completed her undergraduate medical training at Duke University School of Medicine and holds a master's degree in teaching from American University.



(Figure courtesy of the authors)

Figure 1. Suicide Prevention Staff Assisted Visit Recommendations

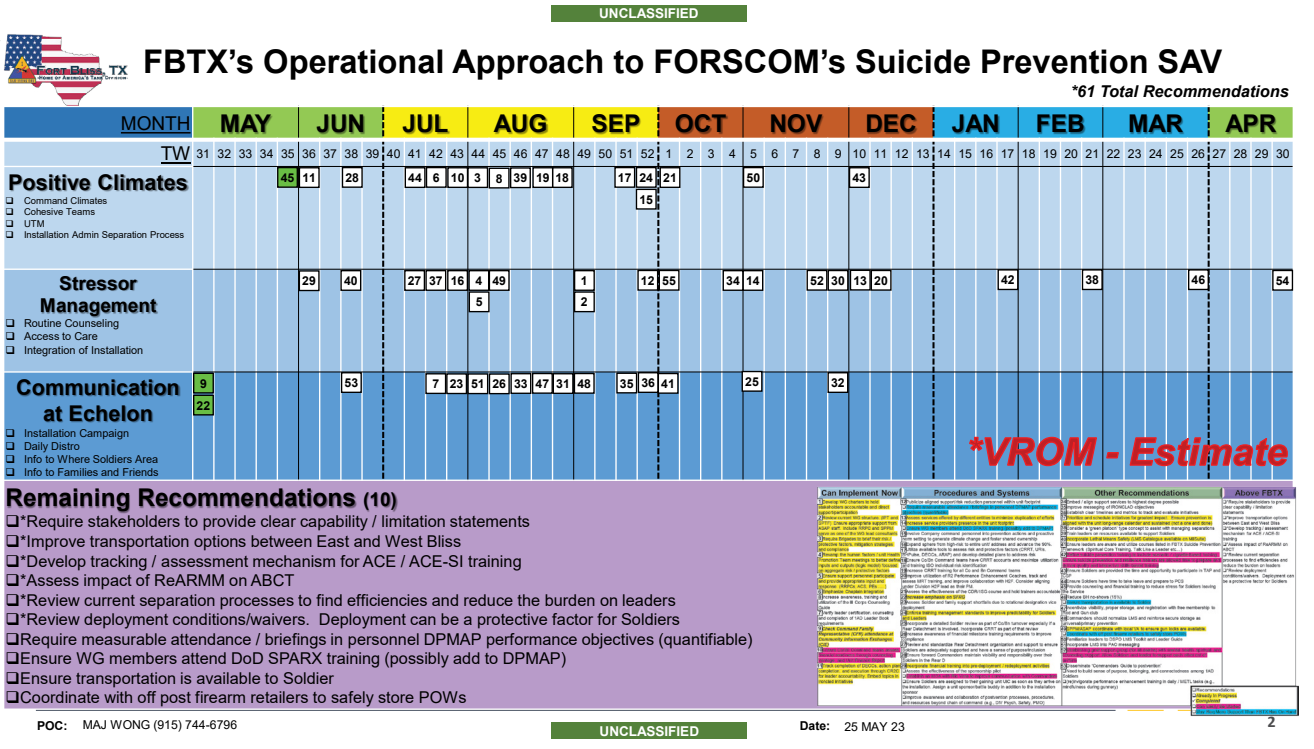
can work together. This is meaningful because suicide prevention is a relational effort at its core.

However, division and installation staff were overwhelmed by the sheer volume of feedback and recommendations (see figure 1). The staff assistance visit provided seventy-four recommendations, ranging from increased shuttle bus frequency to Defense Organizational Climate Survey out-brief compliance. Underscoring the challenge of suicide prevention, none of the seventy-four recommendations addressed causation, but instead correlation, those environmental factors that may or may not contribute to suicide. Which of these recommendations were more important? Which of these recommendations might best address prevention?

As an Army staff is apt to do, we crafted a comprehensive campaign plan to address all seventy-four recommendations over the next year (see figure 2). Using a typical Army problem-solving framework (MDMP), we created a structure and process followed by compliance measures. By day, by week, by month, we had a plan to address all seventy-four recommendations. In the middle of the briefing, as our best division planners were explaining the campaign plan to the division's leadership, the division psychiatrist pushed the "on" button on the microphone in front of her station and said, "Gentlemen, I'm sorry to interrupt, but … we're not going to 'MDMP' our way out of this."

Our military profession values a bias for action. The MDMP helps us chart a viable path in the face of a complex problem. In this case, our problem-solving paradigm just created more tasks, more for leaders to accomplish, more for their leaders to inspect to ensure compliance. When we attempt to do "all the things" at once, we create an environment of white noise in which no one effort can have a visible impact on suicide prevention. We realized how much we had already demanded of overwhelmed company commanders and first sergeants. Yet here we were putting more on the chain of command. "Swinging at every pitch" left our company-level leadership nearly numb to the onslaught of programs, chain-teaching, initiatives, and good ideas.

We are not suggesting that fewer iterations or even one intervention is a panacea for suicide prevention.



(Figure courtesy of the authors)

Figure 2. Fort Bliss's Operational Approach to Army Forces Command's Suicide Prevention Staff Assisted Visit

We've come to suspect that multiple small interventions by leaders who show that they care will bring more value. Teams and individuals within a system are our most powerful but rate-limiting path to suicide prevention. When we task-saturate our leaders, we take from them the valuable and necessary time to convey to soldiers their value to the leader, the unit, and the Army.

The military is well-equipped and trained to deal with mission sets in which a targeted intervention will result in an anticipated outcome. The MDMP is a time-tested methodology to address problems and make quick decisions. While it has been effective in many military contexts, its application to the nuanced issue of suicide prevention is problematic. At Fort Bliss, we had a clear appetite for a rapid solution, though we believe that our understandable desire for a fast solution is part of the problem. That, and our profession's familiarity and reliance on process, procedure, and compliance, might be robbing leaders of the time they need to convey care and concern for a soldier in the face of challenge.

Flawed Assumption #2

Identifying suicide risk will reduce completed suicides.

An individual risk assessment is only as good as it provides a sense of care and connection to the individual.

—Maj. Allison Webb[5]

Data do not support the concept that suicide risk exists on a linear continuum from suicidal ideation to suicide attempt to completed suicide.[6] Further, there is no predictive validity to any of the suicide risk assessment tools, which are reliant on individual suicidal risk factors.[7] The broad medical community has little to no evidence that individual risk factors are predictive.[8] Yet, on our installation, as in the Army at large, we continue to rely on them.

At Fort Bliss, our data and experience continues to emphasize that risk screenings are rarely predictive of future suicide events. In a deep dive investigation of the twenty suicides completed between September 2020 and 2021, only half of all completed suicides had any

behavioral health care prior to the event.[9] From fiscal year 2018 to present, only four soldiers who completed suicide were posthumously identified with previous suicidal ideation by serious incident reporting. Thus far in calendar year 2024, exactly 0 percent of individuals who completed suicide at Fort Bliss were identified by their command as high risk prior to the suicide event.[10] Of all in-processing screening completed between January 2022 and March 2024 on 14,976 soldiers, eight soldiers later committed suicide. Only one had answered affirmatively to having suicidal ideations during installation in-processing.[11] In other words, we are more frequently surprised by "out-of-the-blue" suicide events and find that (thankfully) most of the soldiers identified as high risk in our formation survive.

Despite these data, most of the Army's suicide prevention efforts involve engaging in significant efforts to identify "at-risk" soldiers and mitigate said risk. At our installation, this begins with the needs assessment described above that is performed at installation in-processing to identify "high-risk" soldiers. We require commanders to use the Commander's Risk Reduction Toolkit to evaluate the individual risk of their soldiers. Every month, we require brigades to conduct "health of the force" meetings (or other meetings with eponyms for risk assessment and reduction efforts) to monitor high-risk soldiers. After inpatient behavioral health hospitalization, soldiers are monitored on clinical acute risk clinic trackers and receive weekly safety checks with an embedded behavioral health clinician. What's more, when a suicide is completed, the emphasis in fatality review boards tends to the soldier's known or unknown risk factors, suggesting that the chain of command should have, or could have, intervened to reduce risk prior to the event. While this might be the case in some instances, it is not the case for every suicide.

We are not suggesting that these exercises independently are futile. There certainly are benefits to providing care to an at-risk soldier. Every life matters; we do find people we can get to care and support. However, at a system level, we have not identified the potential negative outcomes from our collective policies and procedures that focus so heavily—almost solely—on the risk of the individual. What is the cost to the rest of the formation when a commander focuses much of their time on a few individuals? How can we expect command teams to build cohesive teams and positive climates when they are required to devote hours to risk-related meetings per month, even before considering other interventions to support high-risk soldiers?

What we will never know is exactly how many suicides we have avoided or lives we have saved because we mitigated risk for the soldiers identified as high risk. However, given the paucity of data supporting our risk reduction strategies, and that individual risk reduction has been the major strategy for suicide prevention in the Army over the past twenty years with ever-increasing suicide rates, we should at least pause to consider if this approach is working.

Our tendency toward compliance makes good sense in much of what we do in the military. But when the medical community concludes that there is zero predictive validity to individual risk factors, we might benefit from revisiting our focus on the administrative requirements of risk assessments, instead focusing on leaders' and fellow soldiers' effective ability to convey care and connection with an at-risk soldier and provide the positive climate where soldiers feel proud, valued, and part of a team.

Flawed Assumption #3

Getting someone to mental health care will reduce suicide risk.

I did my part ...

—Statement from a leader during a fatality review board[12]

Major concepts and assumptions in the field of suicide prevention can be challenged by existing evidence. We would like to directly address our concerns with the "escort" component of ACE. Escorting to a higher level of care assumes that this act will reduce suicide rates, and that the system is poised to respond with evidence-based interventions and strategies.

The mental health system is not a panacea for suicide prevention because suicide is not always a mental health problem. In *Rethinking Suicide*, Craig Bryan explained that the 2003 study by Jonathan Cavanaugh et al. *retrospectively* diagnosed individuals who committed suicide on psychological autopsy postdeath.[13] In short, even when there is little to no evidence to support the presence of a mental health diagnosis in life, we still ascribe a postmortem mental health diagnosis on the

Jason Johnston poses for an Army Substance Abuse Program photo on 12 July 2019 at the Training Support Center Visual Information Office, Panzer Kaserne, Stuttgart, Germany. The image was used during Suicide Awareness Month. (Photo by Michele Wiencek, U.S. Army)

engrained assumption that "healthy people" would not kill themselves. This logic is flawed. Multiple lines of evidence support that the presence of mental illness is only weakly correlated with suicide.[14]

Our current military mental health care system neither has the tools nor the capacity to respond adequately to suicidal patients at a broad scale. We know of only a few treatments that have strong evidence for directly reducing suicidal risk: cognitive behavior therapy for suicide prevention and dialectical behavior therapy are among these.[15] Other therapies that are most employed for traditional behavioral health diagnoses can reduce the symptoms of those diagnoses (i.e., depression) but do not necessarily decrease the rates of suicide-related behaviors. Routine therapy does not guarantee improved outcomes regarding suicidal patients; we must employ treatments that focus on what the suicidal patient should do in times of crisis.[16]

Our Army's behavioral health system is understaffed, under-resourced, and undertrained in the above therapy modalities to be able to address suicide as a mental health problem. Our most recent Department of Behavioral Health standard operating procedures directs that "high-risk" soldiers receive weekly safety checks. The quality of these checks essentially amounts to a behavioral health technician screening a soldier if they have suicidal thoughts or a "high-risk group" check-in.[17] Soldiers are not typically getting high quality, evidenced-based therapy until after intake, which at many installations can take eight to twelve weeks to schedule.

We are not suggesting that mental health care is not important, critical, or impactful. Therapy and appropriate mental health care treatment can transform and save lives. Rather, we just want to reassess the use and efficacy of the system for suicide *prevention* and reevaluate our ability to provide evidence-based care in the current system.

Also, we are not suggesting that the sole solution is to hire more behavioral health professionals, especially in the face of a national shortage. (Admittedly, we would

love to see fully staffed Behavioral Health Departments across the Army.) In fact, we believe that a soldier's chain of command has much to offer. Our Army's ACE-SI framework, particularly the "E," might be part of our problem. We are concerned that the "escort" mandate presents an unintentional excusal framework, suggesting that we—the chain of command—cannot address most stressors and have done our part by escorting a soldier to a medical professional. We should be quick to note that a soldier's chain of command has no business trying to provide the care that only a medical professional can provide for an actively suicidal soldier. However, we commonly see the chain of command escorting soldiers to behavioral health for nearly any stress, not just those identified as suicidal in the ACE-SI framework. Limiting referrals to only those soldiers who truly need the level of expertise of a professional will help reduce the burden on the system of care.

Effective management of daily stressors is part-and-parcel of routine leadership. Anecdotally, we've seen many cases where a soldier's immediate chain of command outsourced to a battalion chaplain or a behavioral health professional a coaching and/or counseling requirement fully within their ability to address, from a break up with a significant other to financial instability to poor time management.

Battalion chaplains are not the primary counselor in the battalion. The squad leader is. If the squad leader is uncomfortable coaching a subordinate through a routine stressor, the platoon sergeant should be next. If the platoon sergeant is uncomfortable addressing the stressor, then the first sergeant or company commander should try before making a deliberate decision to seek professional assistance.

While we would benefit from reinforcing our counseling obligations at lower echelons, we must also provide the coaching and mentoring on how to do that, even more important in the face of false narratives that suggest daily stressors are the sole domain of medical professionals. We owe junior leaders more training on effective counseling during professional military education and, more often, as part of units' routine training requirements. We've become quick to jump to the "E" in ACE-SI, but we should emphasize the critical role of the "C," which necessarily comes before the "E." "I did my part" isn't always escorting a soldier to professional care. It can often be a leader helping a soldier manage routine stressors, showing how much they *care* for a soldier's well-being.

What Can We Do Instead?

To be frank, we're not certain. But we do know that after myriad efforts, we at Fort Bliss haven't lowered the suicide rate in more than a decade of persistent effort. So, we've changed our approach after our conclusion that we've been operating under flawed assumptions.

After multiple campaigns with nearly a dozen lines of operation and more than two hundred distinct objectives, we've decided to stop addressing everything, everywhere, all at once. Instead, we're moving away from focusing on individual factors and toward environmental, systemic factors that impact our whole formations. We're working to mirror public health

Combat boots line the stage of Beaty Theater, Fort Gregg-Adams, Virginia, on 20 September 2023 during Suicide Prevention and Awareness Month in remembrance of service members lost to suicide. (Photo by Ericka Gillespie, U.S. Army)

approaches and theories that have been historically successful in reducing car accidents and smoking across our population. As a result, we've asked our division and installation to focus on three things: establishing and sustaining positive climates, helping soldiers manage daily stressors at the unit level, and communicating to the company-level chain of command only that which helps them with the first two.

Positive climates require training, persistence, and, perhaps most importantly, institutional patience. This is a long-term perspective, a deliberate decision to not focus on a reduction in short term suicide rate. We owe soldiers a sense of esprit, belonging, and value. We also owe the chain of command the training on how to achieve these characteristics. That will demand training here on the installation (not the schoolhouse, where time and repetition are limited) on how to build pride, a sense of cohesion, and training schedule predictability.

Coaching soldiers through routine stressors requires training on how to ask tough and invasive questions, how to respond to those questions, and how to know when it's time to seek help from higher in the chain of command or from trained medical professionals.[18] We're integrating peer-group counseling techniques.[19] We're encouraging shade-tree counseling, in addition to the administrative and regulatory requirements that come across as pro forma. And, we're reinforcing that the first line of care is the point of contact, in the immediate chain of command, vice the battalion chaplain or the behavioral health professional.

Just as difficult is the staff's obligation to sort through the volume of communiques and good ideas and provide the company commander and first sergeant with only what they need to build and preserve a positive climate and help soldiers manage daily stressors. We must remain wary of the flurry of energetic interventions precipitated by triggering events. This particular task lies with higher commanders and their staffs. We must focus our messaging to the company level to ensure it is value added and doesn't become "white noise" to leaders who already have too much to accomplish in the duty day.

Will this work? We're not sure. We certainly invite input. But at this point, we've decided to stop doing what we've been doing. We're embracing a more adaptive, environmental, and systemic approach that acknowledges the intricate and often contradictory aspects of suicide prevention in our evolving attempt to make meaningful strides in the ongoing battle to keep each soldier in our formation healthy, strong, and fully prepared to fight. ■

Notes

Epigraph. Quote attributed to one of the author's leaders, Maj. Richard Pedersen, in July 1994 at Fort Campbell, Kentucky.

1. Our operations research/systems analysis (ORSA) team analyzed our suicide event trendline from 2012 through 2023. The trend line shows a statistically significant increase ($p < 0.05$) from 2012 to 2023 in suicide rate per one hundred thousand soldiers. Fort Bliss, Texas, averages approximately eleven deaths by suicide per year.

2. Army Regulation (AR) 600-92, *Army Suicide Prevention Program* (Washington, DC: U.S. Government Publishing Office, 2023). AR 600-92 strongly emphasized continued use of visibility tools, reporting and surveillance, ACE-SI (Ask, Care, Escort—Suicide Intervention), and initially mandated the suicide response team for any suicide attempt (the later intervention was later rescinded). We were grateful for the later change, as looking at each suicide attempt would have placed significant administrative burden at a senior command level far removed from the event, disabling the lower echelons to act more nimbly and efficaciously in their interventions. Finally, we are unaware that any division-level psychiatrists or clinicians were engaged in the development of this regulation.

3. Statement attributed to Maj. Allison Webb, 1st Armor Division (1AD) division psychiatrist, May 2023.

4. Staff assistance visits (SAV) are a common tool used by senior commanders to request an outside view of their formations and are recommended in AR 600-92. The SAV out-brief in April 2023 provided recommendations across multiple domains including the postvention process, capability and capacity, risk mitigation, and improving prevention governance. In many ways, their recommendations were consistent with population, systemic approaches that we could implement to create lives worth living. However, we have observed that as leaders, it is common to feel stuck between the paradigm of "there is no silver bullet to reduce suicide rates" and "everything and anything that improves the human experience can make a small impact on suicide rates."

5. Statement attributed to Maj. Allison Webb, 1AD division psychiatrist, in the commanding general's weekly behavioral health update slide, 14 June 2023.

6. Craig Bryan, *Rethinking Suicide: Why Prevention Fails, and How We Can Do Better* (New York: Oxford University Press, 2022), 58–64.

7. Ibid., 64–69.

8. Elizabeth O'Connor et al., *Screening for Suicide Risk in Primary Care: A Systematic Evidence Review for the US Preventive Service Task Force*, Evidence Synthesis No. 103 (Rockville, MD: Agency for Healthcare Research and Quality, 2013), https://www.ncbi.nlm.nih.gov/books/NBK137737/.

9. In November 2021, the senior commander requested a "suicide deep dive" on all suicide events between September 2020 and September 2021 when Fort Bliss experienced twenty suicides. Factor analysis discovered only half (10/20) of the soldiers had received any form of behavioral health care prior to their suicide.

10. Our ORSA team analyzes and tracks all suicidal ideations, attempts, and completions. Data is fed to these trackers through serious incident reports and fatality review board briefs. This data is presented on a serious incident report dashboard, which allows continuous monitoring of suicide related trends across Fort Bliss. We find that even with all of our risk screening efforts, we "miss" many of the individuals who will later complete suicide.

11. Every soldier at Fort Bliss receives a "needs assessment" screening at in-processing. Questions focus on stressors, food insecurity, musculoskeletal injuries, spirituality, suicidality, sleep, substance use, and the Army Body Composition Program.

12. Statement from a leader in a fatality review board, November 2023.

13. Jonathan Cavanaugh et al. "Psychological Autopsy Studies of Suicide: A Systematic Review," *Psychological Medicine* 33, no. 3 (2003): 395–405, https://doi.org/10.1017/s0033291702006943.

14. Joseph Franklin et al., "Risk Factors for Suicidal Thoughts and Behaviors: A Meta-Analysis of 50 Years of Research," *Psychological Bulletin* 143, no. 2 (2017): 187–232, https://doi.org/10.1037/bul0000084.

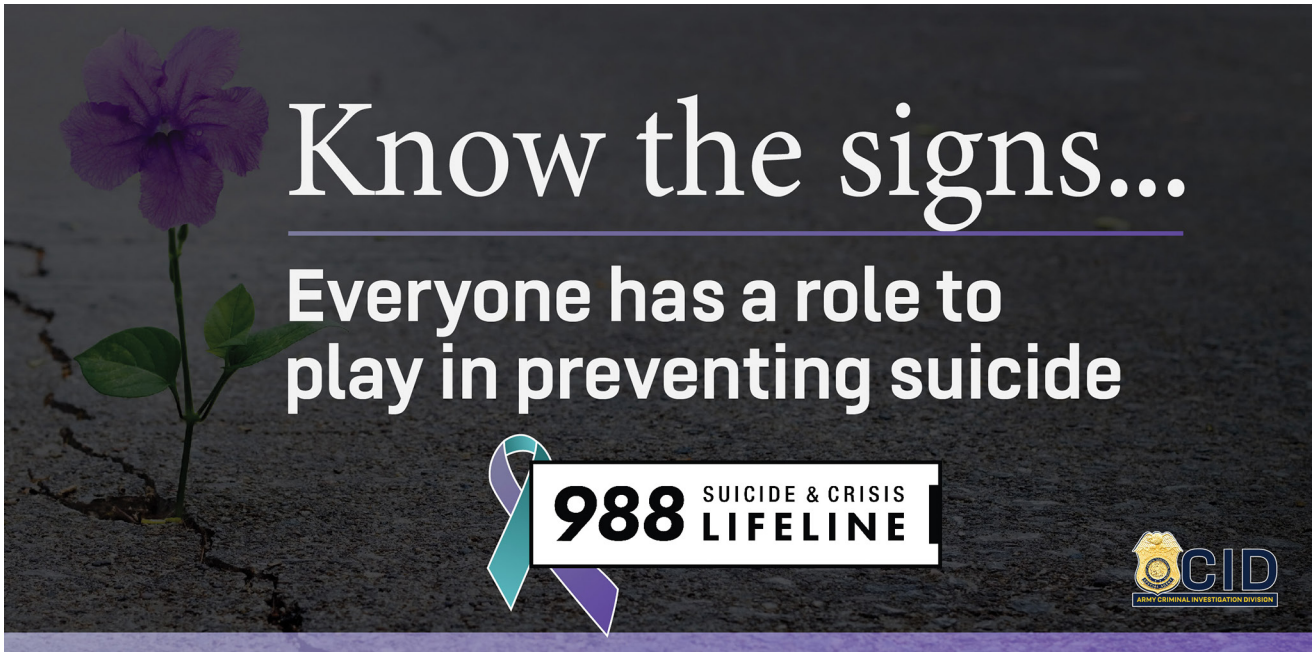
15. Bryan, *Rethinking Suicide*, 129–35. Treatments typically known by practitioners as "suicide focused treatments" are those with the highest evidence for reducing suicidal thoughts and behaviors. These treatments typically address how a patient should deal with the distress and suicidal thoughts, and what actions they need to employ to reduce suicidality. These treatments include dialectical behavior therapy (DBT), cognitive behavior therapy for suicide prevention (CBT-SP), collaborative assessment and management of suicidality (CAMS), and crisis response planning (CRP).

16. Ibid., 136–42.

17. William Beaumont Army Medical Center (WBAMC) Department of Behavioral Health (DBH), DBH SOP 20-03, "At Risk Management Policy" (Fort Bliss, TX: WBAMC DBH, 23 March 2022). DBH SOP 20-03 outlines that "high risk patients will have weekly scheduled clinic appointments if feasible. Weekly in person contact is preferred." Due to access to care, these appointments often become "safety checks" performed by psychiatric technicians or group therapy appointments. Defense Health Agency (DHA) Procedural Instruction 6025.06, *Standardized Templates for Primary Care Clinical Encounter Documentation* (Falls Church, VA: 16 May 2018). Notably, DHA 6025.06 does not stipulate that patients be seen weekly. Providing weekly evidence-based care and treatment is a considerable challenge in the current staffing climate, despite the fact that most evidence-based therapies must be dosed at least once weekly for effectiveness.

18. Fort Bliss engaged Walter Reed Army Institute of Research to deliver a training called "BH GEAR" (Behavioral Health Guidelines for mEdic Assessment and Response), which is specifically focused on training medics on how to recognize and stabilize psychiatric emergencies in the deployed environment. First-line leaders were also invited to attend this training. We have also revamped our company commander and first sergeants' course to include training on risk levels and educate commanders on resources available that do not entail necessitating taking the soldier to clinical behavioral health (military family life consultants, chaplains, etc.).

19. The nonprofit Give an Hour, https://giveanhour.org/, has offered two iterations of peer-support training for Fort Bliss. This training is specifically focused on building skills in emotionally supporting peers. Our pilots had much better success when offered closer to brigade combat team footprints and embedded in the training program for our Green Platoon.



(Image by Frances Seybold, Department of the Army Criminal Investigation Division)

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