

Realigning Suicide Risk Assessment and Transforming Behavioral Healthcare in the Army Soldier Recovery Unit

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Introduction

•Primary Driver: The Initial Mandate

This effort began with the overarching mandate to align all Soldier Recovery Unit (SRU) policies with directives from the Defense Health Agency (DHA), MEDCOM, and Army Regulation 40-58.

•Evidence-Based Justification: Discovering the Flaw

This mandate prompted an internal review by Medical Readiness Command, Pacific (MRC, P), which found that 100% of risk-level downgrades were clinically justified. This finding proved that the SRU's legacy Army Recovery Care Program (ARCP) - Risk assessment tool had a critical tendency to over-index patient risk.

•Organizational Pressures: The Compounding Factors

The clinical need for a new system was amplified by concurrent organizational pressures, including the SRU REDUX and SRU REFORM initiatives and a severe 100% realignment in specialized Behavioral Health Case Manager assets.

•The Goal: The Path Forward

The project's goal was to resolve these challenges by realigning the SRU's suicide risk assessment process with the DHA's evidence-based framework (AI 6025.06), creating a sustainable, accurate, and integrated care model that could adapt to the new staffing realities.

Objectives

Learning Objective	Detailed Information
1. Describe the realignment of SRU and DHA- Suicide Risk Care Pathway (SRCP) risk levels.	SRU internal risk categories were mapped to the evidence-based DHA-SRCP framework: SRU High Risk aligns with DHA-SRCP High Acute; SRU Moderate with Intermediate Acute; and SRU Guarded/Low with Low Acute. This change standardizes risk definition across the enterprise.
2. Analyze the Course of Action (COA) for transforming SRU behavioral health processes.	Implement a COA to transfer BH assessment duties from HI SRU social workers to Nurse Case Managers (NCMs) and licensed BH Providers within Military Treatment Facilities in response to a 100% personnel realignment.
3. Discuss the impact of the risk assessment realignment.	The realignment produced a significant shift in risk categorization: the Moderate-Risk population fell from 48% to 18%, while the Low-Risk population grew from 10% to 65%. This enhanced accuracy allows for more appropriate disposition recommendations.
4. Identify necessary SRU policy changes for regulatory alignment.	SRU policy requires updates to formalize the transfer of BH responsibilities to NCMs and Providers, adopt the DHA/MEDCOM-mandated risk reassessment schedule, and replace all legacy risk terminology with official DHA-SRCP definitions to ensure compliance.

Method — Participants

•**Participants:** The review included a cohort of 62 service members (N=62) within MRC, P Hawaii's (HI) SRU.

•The subgroup breakdown was:

- Primary BH: n = 20 (32%)
- Secondary BH: n = 31 (50%)
- No BH affiliation: n = 11 (18%)

Method — Materials & Measures

•**Legacy Tool (Replaced):** The Army Recovery Care System Behavioral Health Risk Mitigation Questionnaire (ARCS BHRMQ) tool.

•**New Framework (Implemented):** The Commander's Risk Assessment – Questionnaire (CRA-Q) and the Columbia-Suicide Severity Rating Scale (C-SSRS) were adopted to align with the DHA's BH Stratified Risk Assessment model.

Method — Procedure

1. Analysis: A crosswalk analysis of SRU policies against DHA, MEDCOM, and Army Regulation 40-58 was performed to identify discrepancies in protocols and role definitions.

2. Re-stratification: A Behavioral Health Subgroup was formed to review all active cases, re-stratifying each service member using the new DHA-SRCP risk levels.

3. COA Development: In response to the mandated 100% realignment in HI's SRU BH personnel, an integrated care model was developed. This COA transferred initial BH screening duties to SRU Nurse Case Managers (NCMs), with confirmations and oversight from licensed BH Providers within the Military Treatment Facility (MTF) when indicated per policy.

1.Ethics & Privacy Posture: This project was reviewed and designated as a process improvement evaluation and determined to not be research by a Tripler Army Medical Center (TAMC) determination official.

Results-Descriptive Statistics

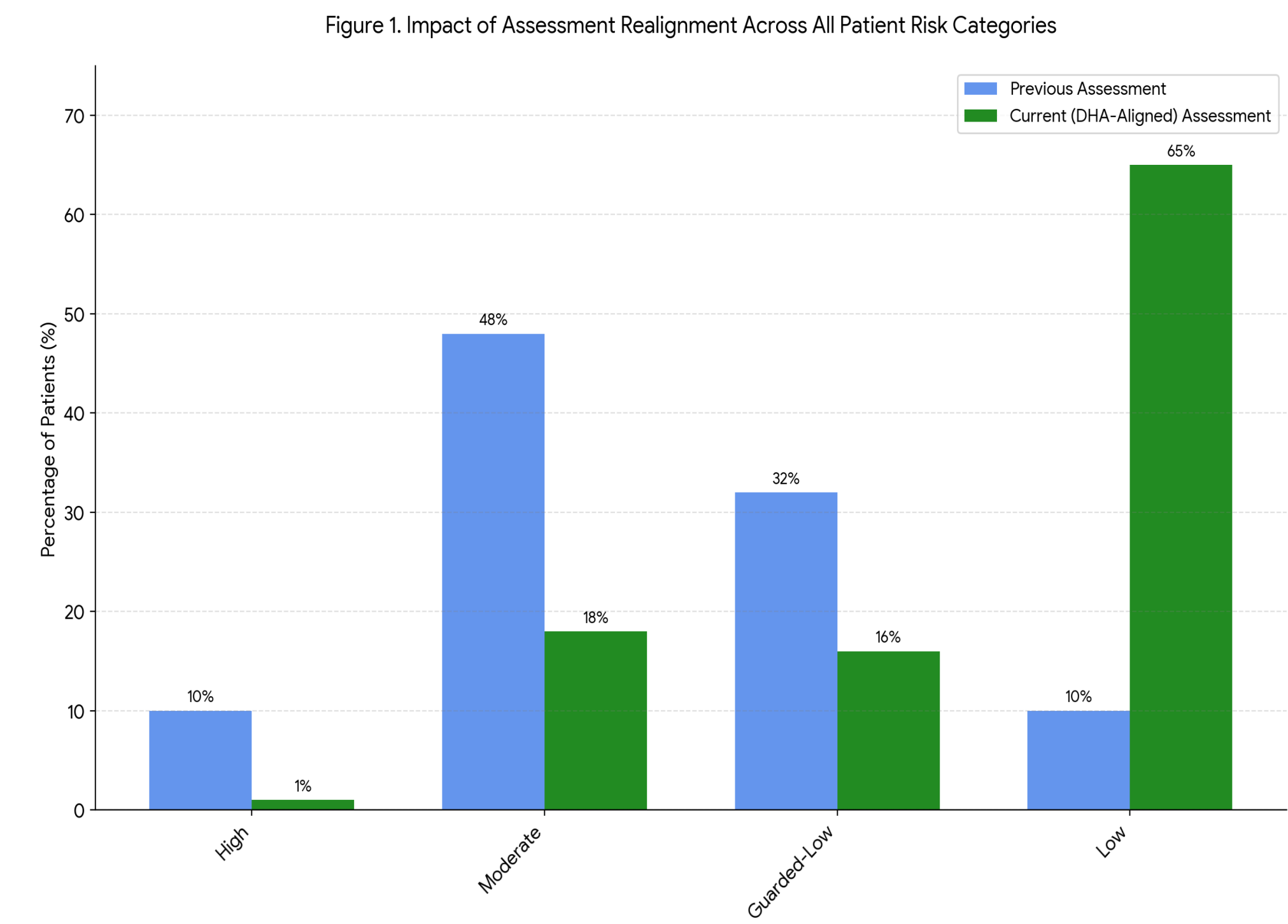


Figure 1. Impact of Assessment Realignment Across All Patient Risk Categories. The chart displays the percentage of the total cohort (N = 62) within each risk stratification level before and after the implementation of the DHA-aligned assessment framework. A significant re-stratification occurred, with a notable decrease in the "Moderate/Intermediate" category and a substantial increase in the "Low/Low" category.

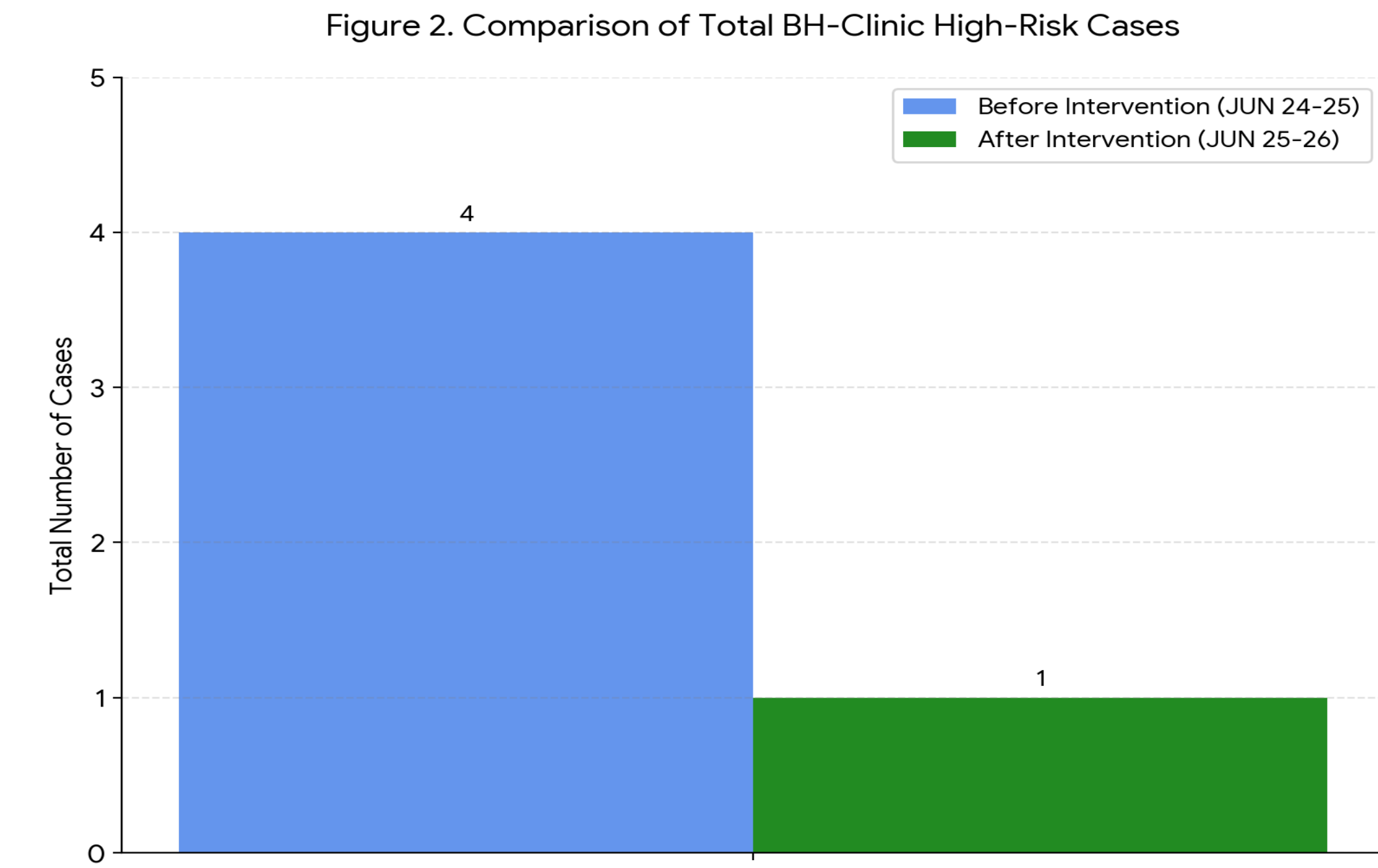


Figure 2. Comparison of Total BH-Clinic High-Risk Cases. The bars display the absolute count of SRU service members classified as high-risk immediately before (n = 4) and after (n = 1) the implementation of the new assessment framework. The observed decrease may be partially influenced by a concurrent reduction in total SRU complex case enrollments.

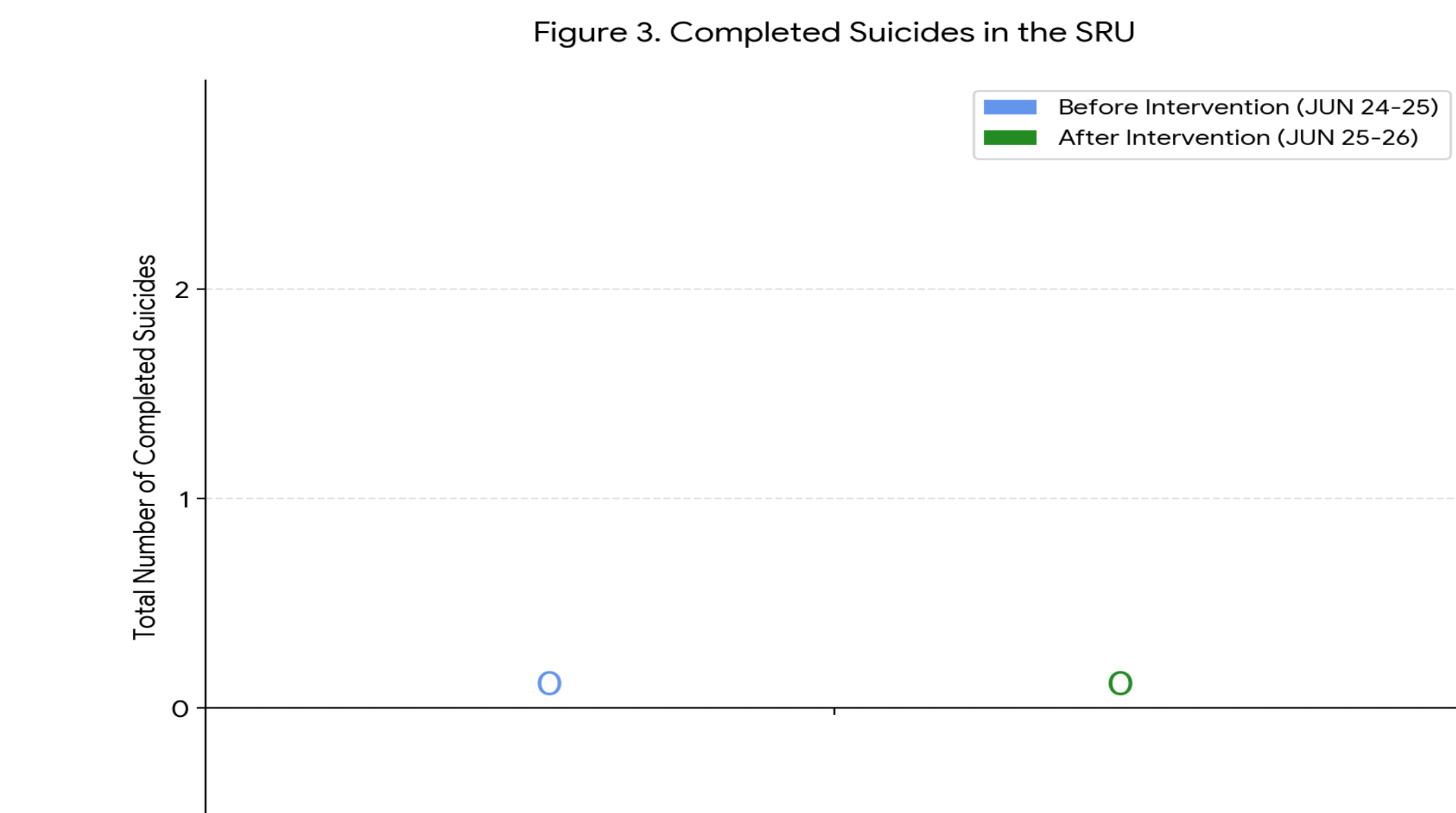


Figure 3. Completed Suicides in the SRU before and after Intervention. The chart displays the absolute number of completed suicides within the Soldier Recovery Unit. The rate remained at zero (n = 0) both before and after the implementation of the DHA-aligned risk assessment framework, indicating that the new process maintained the highest level of patient safety regarding this critical outcome.

Discussion

•Risk Stratification Accuracy

Adopting the DHA-aligned framework corrected the legacy tool's tendency to over-index risk. This yielded a clinically justified re-stratification, reducing "High-Risk" cases (Figure 2) and enabling a more accurate allocation of limited clinical resources.

•Operational Adaptation

The new integrated care model successfully mitigated the mandated 100% realignment in specialized BH personnel by transferring primary screening duties to trained NCMs, with oversight from licensed BH providers within the MTFs (per policy).

•Enhanced Patient Safety

Crucially, this operational shift and more accurate risk stratification were achieved without compromising patient safety. The rate of completed suicides remained at zero both before and after the intervention, demonstrating the safety and efficacy of the new process (Figure 3).

•Reliability

While initial efficacy is strong, long-term success depends on continuous training and clinical audits to ensure NCMs maintain high inter-rater reliability with the new assessment tools.

Limitations

•Generalizability Limits:

The small cohort size (N = 62) from a single Medical Readiness Command (MRC, P) limits the immediate extrapolation of these outcomes to all ARCPs.

•Sustainment Risk:

The model's heavy reliance on the rapid up-skilling of generalist NCMs to execute specialized screening presents a potential vulnerability in maintaining inter-rater reliability over time.

•Potential Confounding Variable:

The observed decrease in total high-risk cases (Figure 2) may be partially influenced by a concurrent reduction in overall complex case enrollments, not solely the intervention.

•Short Observation Period:

While the rate of completed suicides remained at zero (Figure 3), the observation period was brief. Long-term monitoring is required to confirm the lasting safety of the new process

Implications & Future Directions

•Expanded Validation:

Replicate this crosswalk analysis across other Medical Readiness Commands to validate the findings from this small cohort (N = 62) against a broader, Department of War (DoW) -wide population.

•NCM Competency & Auditing:

Establish robust, continuous training for NCMs on C-SSRS administration and implement routine clinical audits by licensed BH Providers to ensure high inter-rater reliability over the long term.

•Longitudinal Outcome Tracking:

Monitor the long-term disposition outcomes of the re-stratified cohort (e.g., Return to Duty, Home of Record (HOR transfers). This is critical to confirm that the downward shift in risk levels does not negatively impact patient safety, including the rate of

completed suicides, over an extended period.

Conclusions

Aligning the SRU's suicide risk assessment process with the DHA-SRCP framework produced a more accurate, evidence-based risk stratification of service members. This transformation established a sustainable, integrated care model that successfully mitigates a 100% realignment in BH personnel. To institutionalize these improvements, SRU policy must be formally updated to codify the new roles, assessment frequencies, and standardized terminology, ensuring long-term alignment with overarching DHA and Army directives.

References

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Note: Due to space constraints, only core references are presented. A complete reference list is available upon request.