TRAINING SUPPORT PACKAGE (TSP)

TSP Number / Title	T340 / SUICIDE PREVENTION
Effective Date	01 Oct 2004
Supersedes TSP(s) / Lesson(s)	T340, Suicide Prevention, Version 1, Oct 03.
TSP Users	600-BNCOC, Basic Noncommissioned Officer Course
Proponent	The proponent for this document is the Sergeants Major Academy.
Improvement Comments	Users are invited to send comments and suggested improvements on DA Form 2028, *Recommended Changes to Publications and Blank Forms.* Completed forms, or equivalent response, will be mailed or attached to electronic e-mail and transmitted to: COMDT USASMA ATTN ATSS DC BLDG 11291 BIGGS FIELD FT BLISS TX 79918-8002 Telephone (Comm) (915) 568-8875 Telephone (DSN) 978-8875 E-mail: atss-dcd@bliss.army.mil
Security Clearance / Access	Unclassified
Foreign Disclosure Restrictions	FD5. This product/publication has been reviewed by the product developers in coordination with the USASMA foreign disclosure authority. This product is releasable to students from all requesting foreign countries without restrictions.

PREFACE

Purpose

This Training Support Package provides the instructor with a standardized lesson plan for presenting instruction for:

Task Number	Task Title
081-831-9018	Implement Suicide Prevention Measures
081-831-9028	Implement a Suicide Prevention Program

This TSP Contains

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SUICIDE PREVENTION
T340 / Version 2
01 Oct 2004

SECTION I. ADMINISTRATIVE DATA

All Courses Including This Lesson

Course Number	Version	Course Title
600-BNCOC	2	Basic Noncommissioned Officer Course

Task(s) Taught (*) or Supported

Task Number	Task Title
081-831-9018	Implement Suicide Prevention Measures
081-831-9028	Implement a Suicide Prevention Program

Reinforced Task(s)

Task Number	Task Title

Academic Hours

The academic hours required to teach this lesson are as follows:

	Resident Hours/Methods	
	3 hrs	/Conference / Discussion
Test	0 hrs	
Test Review	0 hrs	
Total Hours:	3 hrs	

Test Lesson Number

	Hours	Lesson No.
Testing (to include test review)	3 hrs	E303

Prerequisite Lesson(s)

Lesson Number	Lesson Title
None	

Clearance Access

Security Level: Unclassified
Requirements: There are no clearance or access requirements for the lesson.

Foreign Disclosure Restrictions

FD5. This product/publication has been reviewed by the product developers in coordination with the USASMA foreign disclosure authority. This product is releasable to students from all requesting foreign countries without restrictions.

References

Number	Title	Date	Additional Information
SUI-1	ARMY SUICIDE PREVENTION - A GUIDE FOR INSTALLATION UNITS	01 Jul 2002	Draft Version
SUI-2	SUICIDE PREVENTION LEADER TRAINING	01 Jul 2002	Draft Version

Student Study Assignments

Before class--

- Read Army Suicide Prevention - A Guide for Installations and Units (Draft), Chapters 1 thru 5, (SH-2).
- Read Suicide Prevention Leader Training, (SH-3).

During class--

- Participate in classroom discussion.
- Observe TVT on Suicide Prevention.

After class--

- Turn in recoverable materials.
- Participate in an after action review for lesson.

Instructor Requirements

1:16, SSG, BNCOC graduate, served as a squad leader, ITC, and SGITC qualified

Additional Support Personnel Requirements

Name	Stu Ratio	Qty	Man Hours
None			

Equipment Required for Instruction

ID Name	Stu Ratio	Instr Ratio	Spt	Qty	Exp
441-06 LCD Projection System	1:16	1:1	No	1	No
559359 SCREEN PROJECTION	1:16	1:1	No	1	No
5820-00-T81-6161 VCR	1:16	1:1	No	1	No
702101T134520 DELL CPU, MONITOR, MOUSE, KEYBOARD	1:16	1:1	No	1	No
7110-00-T81-1805 DRY ERASE BOARD	1:16	1:1	No	1	No
7510-01-424-4867 EASEL, (STAND ALONE) WITH PAPER	1:16	1:1	No	1	No
SNV1240262544393 36 - INCH COLOR MONITOR W/REMOTE CONTROL AND LUXOR STAND	1:16	1:1	No	1	No
*TVT 8-93 SUICIDE PREVENTION	1:16	1:1	No	1	No

* Before Id indicates a TADSS

Materials Required

Instructor Materials:
- VGTs: 28.
- TSP.
- TVT 8-93: Suicide Prevention, 19 Minutes.
- Army Suicide Prevention - A Guide for Installations and Units, (Draft).
- Suicide Prevention Leader Training, (Draft).

Student Materials:
- Pen or pencil and writing paper.
- Army Suicide Prevention - A Guide for Installations and Units (Draft) SH-2.
- Suicide Prevention Leader Training, (Draft) SH-3.
- All reference material issued for this lesson.

Classroom, Training Area, and Range Requirements

GEN INSTRUCT BLDG (CLASSROOM SIZE 40X40 PER 16 STU)

Ammunition Requirements

ID	Name	Exp	Stu Ratio	Instr Ratio	Spt Qty
None					

Instructional Guidance

NOTE: Before presenting this lesson, instructors must thoroughly prepare by studying this lesson and identified reference material.

Before class--

- Read all TSP material be ready to conduct class.
- Issue Army Suicide Prevention - A Guide for Installations and Units (Draft), SH-2 three days before class.
- Issue Suicide Prevention Leader Training (Draft), SH-3.
- Schedule TVT to start immediately after the instructional lead-in.

During class--

- Conduct this lesson using the Small Group Instruction method.
- Use the questions provided to generate discussion among the students.
- The facilitator may need to create additional questions to ensure student participation continues throughout the lesson material.
- Cover all learning objectives.

After class--

- Collect recoverable materials, SH-2 and SH-3.
- Report any lesson discrepancies to the Senior Small Group Instructor.
- Conduct an after action review for the lesson.

Proponent Lesson Plan Approvals

Name	Rank	Position	Date
/s/ Wilson, Karen M.	GS09	Training Specialist	**9 AUG 04**
/s/ King, Phillip W.	GS11	Course Manager, B/ANCOC	9 AUG 04
/s/Bennett-Green, Agnes D.	SGM	Chief, B/ANCOC	9 AUG 04
/s/ Lemon, Marion	SGM	Chief, CDDD	9 AUG 04

SECTION II. INTRODUCTION

Method of Instruction: Conference / Discussion
Technique of Delivery: Small Group Instruction (SGI)
Instructor to Student Ratio is: 1:16
Time of Instruction: 30 mins
Media: TVT 8-93, Suicide Prevention, (19 Minutes)

Motivator

As squad leaders suicide prevention is one of your responsibilities.

The Army's strength rests with our soldiers, civilians, retirees, and their families, each being a vital member of our institution. Suicide is detrimental to the readiness of the Army and is a personal tragedy for all those affected. Therefore, suicide has no place in our professional force. Suicide among our soldiers and their family members is a serious growing problem. Suicide prevention must be the business of every leader, supervisor, soldier, and civilian employee in the United States Army. To facilitate this effort, there is a need for a coordinated program for suicide prevention at every Army unit.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Describe the Army's Suicide Prevention Program.
Conditions:	As a small unit leader in a company or battalion level unit.
Standards:	Described the Army's Suicide Prevention Program by: • defining the barriers of the Army's Suicide Prevention Model. • explaining unit leadership responsibilities for identifying high-risk individuals for suicide. • identifying caring and proactive leaders' responsibilities in suicide prevention. • identifying leadership responsibilities for encouraging help seeking behaviors within their subordinates. • explaining the leader's role in teaching positive life coping skills development to their soldiers and civilian personnel. • identifying intervention and applied suicide intervention skills training (ASIST) to assist commanders. IAW Army Suicide Prevention - A Guide for Installations (Draft), and Suicide Prevention Leader Training (Draft).

Safety Requirements	None
Risk Assessment Level	Low
Environmental Considerations	**NOTE:** It is the responsibility of all soldiers and DA civilians to protect the environment from damage. None
Evaluation	During this course of instruction, you will take a 50-question examination. The examination will include questions on the ELOs and TLO from this lesson. You must correctly answer 35 questions or more to receive a GO. A GO is a graduation requirement.

Instructional Lead-In

NOTE: Keep in mind that the introduction of a very sensitive topic requires an equally sensitive approach. You must assume that some of the class will include soldiers touched by suicide and some that thought of or even attempted suicide. Use caution when you are discussing this topic.

NOTE: Schedule the TVT to start after the introduction lead-in. After the film is over, allow time for a short 6-minute discussion. The TVT is 19 minutes.

Suicide prevention is everyone's business. You must understand the potential for suicides and increase awareness for recognizing individuals who are at risk or exhibit self-destructive behavior. It is your responsibility to help your soldiers and civilians understand how to identify at-risk individuals, recognize warning signs, and know how to take direct action. Then, you must act to provide immediate assistance and prevention to suicidal individuals. Persons contemplating suicide are often incapable of reaching out to help themselves. Providing help to your squad members is one of your responsibilities along with your unit leadership chain of command.

We will begin by watching a TVT on suicide prevention. The TVT will serve as our basis from which we will start our class discussion.

NOTE: Show TVT 8-93, "Suicide Prevention" (19 Minutes).

The TVT reviews the issues and situations that address the Army's policy on suicide prevention. Describe the action or situation that might have prevented the events in the TVT.

NOTE: Start a discussion with students and how it relates to their own experiences. Remember; use care while discussing this topic.

SECTION III. PRESENTATION

NOTE: Inform the students of the Enabling Learning Objective requirements.

A. ENABLING LEARNING OBJECTIVE

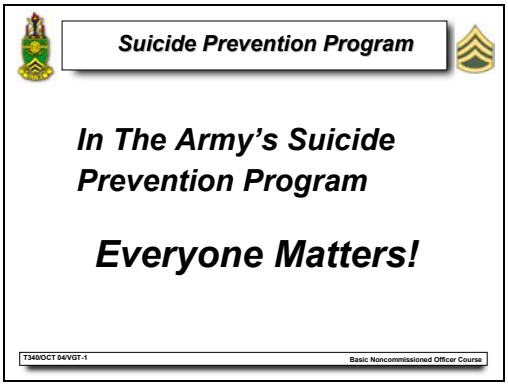
ACTION:	Define the principles and barriers of the Army's Suicide Prevention Program and Model.
CONDITIONS:	As a small unit leader in a company or battalion level unit.
STANDARDS:	Defined the principles and barriers of the Army's Suicide Prevention and Model by reviewing-- • the goal. • CSA statement. • mental disorders. • potential suicide triggers. • warning and danger signs. • resources and reasons for living. IAW the Army Suicide Prevention - A Guide for Installations and Units (Draft).

1. Learning Step / Activity 1. Suicide Prevention Program

Method of Instruction: Conference / Discussion
Technique of Delivery: Small Group Instruction (SGI)
Instructor to Student Ratio: 1:16
Time of Instruction: 40 mins
Media: VGT-1 thru VGT-15

NOTE: The training developer copied this material from the Army Suicide Prevention Program draft regulation. The text may contain passive voice, misspellings, grammatical errors, etc., and may not be in compliance with the Army Writing Style Program

SHOW VGT-1, SUICIDE PREVENTION PROGRAM



Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-6), para 1-1

REMOVE VGT-1

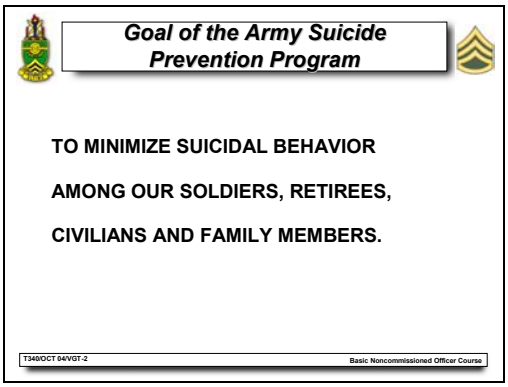
NOTE: As time permits before the break, solicit experiences from the students that encountered any of the situations identified on the TVT.

Break: TIME: 00:50 to 01:00

QUESTION: What is the goal of the Army Suicide Prevention Program?

ANSWER: See VGT-2.

SHOW VGT-2, GOAL OF THE ARMY SUICIDE PREVENTION PROGRAM



Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-6), para 1-2

NOTE: Ask one student to read VGT-2 and have students turn to para 1-2, and generate a brief discussion on the goal of the Army Suicide Prevention Program.

NOTE: The training developer copied this material from the Army Suicide Prevention Program draft regulation. The text may contain passive voice, misspellings, grammatical errors, etc., and may not be in compliance with the Army Writing Style Program.

The goal of any Army Suicide Prevention Program is to minimize suicidal behavior among our soldiers, retirees, civilians and family members. Suicidal behavior includes self-inflicted fatalities, non-fatal self-injurious events, and suicidal thoughts.

Suicide prevention is an evolving science. It is our responsibility as leaders to utilize the best-known available methodology in caring for our soldiers, retirees, civilians and family members. The success of our efforts will be measured by the confidence and conscience of knowing that:

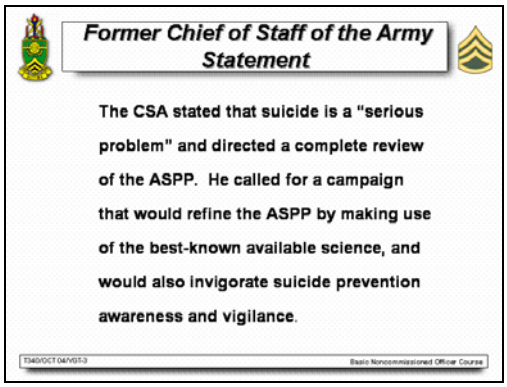
- ✓ we have created and fostered an environment where all soldiers, civilians and family members at risk for suicide will quickly be identified and receive successful intervention and appropriate care;
- ✓ where help-seeking behavior is encouraged and accepted as a sign of individual strength, courage and maturity, and;
- ✓ where positive life-coping skills are taught and reinforced by all leaders.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-6), para 1-2

NOTE: Clarify any questions students may have on the goal of the ASPP.

REMOVE VGT-2

SHOW VGT-3, FORMER CHIEF OF STAFF OF THE ARMY STATEMENT



Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-6), para 1-3

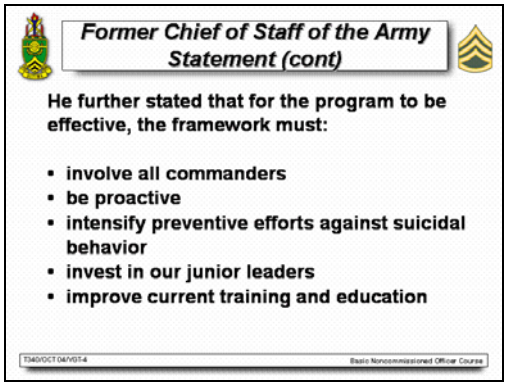
NOTE: Solicit one student to read VGT-3 and ask another student to explain the former CSA statement. Clarify any questions the student may have.

In 2000, following a 27% increase in the number of reported suicides within the Army during 1997-1999, the former CSA, General Eric K. Shinseki, stated that suicide is a “serious problem” and directed a complete review of the ASPP.

NOTE: Clarify any questions the students may have up to this point on the former CSA statement.

REMOVE VGT-3

SHOW VGT-4, FORMER CHIEF OF STAFF OF THE ARMY STATEMENT, (CONT)



Ref: Army Suicide Prevention - A Guide for Installations and Units, (SH-2-6), para 1-3

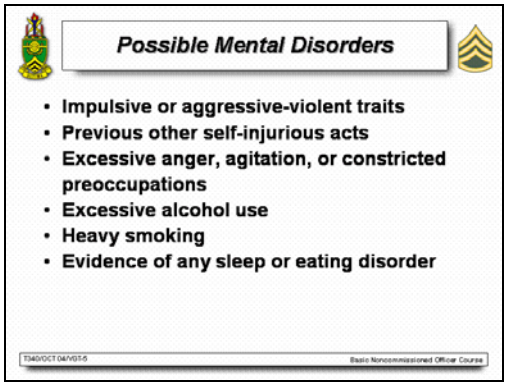
The former CSA has given clear guidance in making the suicide prevention program a high priority. This was to ensure you and all leaders protect our valuable resources of America, our soldiers, and civilians.

NOTE: Ask the students to explain the former CSA statement in their own words and clarify any misunderstanding they may have.

REMOVE VGT-4

All leaders should realize that soldiers and civilians enter into the Army with varying levels of life-coping skills. Leaders should not assume that all soldiers and civilians entering the Army can adequately handle the inherent stress of military service or even life in general, especially if they are already predisposed to psychiatric disorders. It is unrealistic for a leader to understand the genetic composition of their soldiers and civilians, or know their complete developmental history. Leaders, however, can make proper assessments of their life-coping skills by observation and personal dialogue focused on learning and understanding their soldier's background. We will look at the common causes of suicide. Also we will look at how to you, as leaders, can learn to recognize the common danger and warning signs so you can properly anticipate suicidal, or other dysfunctional behavior, and make preemptive referrals to professional mental health care providers before a crisis ensues.

SHOW VGT-5, POSSIBLE MENTAL DISORDERS



Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-7), para 2-2

Mental disorders are health conditions characterized by alterations in thinking, mood, or behavior which relate to distress and/or impaired functioning and spawn a host of human problems that may include disability, pain, or death. Mental disorders occur throughout society affecting all population demographics including age, gender, ethnic groups, educational background, and even socioeconomic groups. In the United States, approximately twenty-two percent of those between the ages of 18-64 years had a diagnosis of some form of mental disorder.

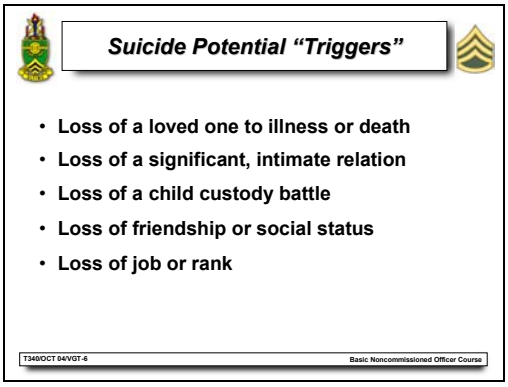
Mental illness is more common than cancer, diabetes, or heart disease, filling almost 21 percent of all hospital beds at any given time. In fact, the number one reason for hospitalizations nationwide is a biological psychiatric condition. Mental disorders also affect our youth. At least one in five children and adolescents between 9-17 years have a diagnosable mental disorder in a given year, about five percent of are extremely impaired. Mental disorders vary in severity and disabling effects. However, current treatments are highly effective and offer a diverse array of settings. The treatment success rate for schizophrenia is sixty percent, sixty-five percent for major depression and eighty percent for bipolar disorder. This compares to between 41-52 percent success rates for the treatment of heart disease.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-8), para 2-2

NOTE: Clarify any questions the students may have about possible mental disorders.

REMOVE VGT-5

SHOW VGT-6, SUICIDE POTENTIAL "TRIGGERS"



Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-11), para 2-5

NOTE: Call one student to read the bullets on the VGT and then clarify any misunderstanding they may have.

Small unit leaders have the most crucial role in establishing and determining the conditions of the soldier and civilian's work environment. These leaders should strive to have a positive influence on them by being a proper role model for them to emulate. For some soldiers and civilians, their role and camaraderie within their unit and the relationship with their first line supervisor might be the only positive, life-sustaining resource available to them in times of adversity. Therefore, everyone should take this responsibility seriously.

Although it is the responsibility of the professional mental health care provider to diagnose a mental disorder, there are certain behaviors that indicate an underlying mental disorder. Leaders should be cognizant of these warning behaviors that might indicate the presence of a mental disorder which place soldiers at risk for suicide or other dysfunctional behavior.

Leaders who spot such behavior and/or suspect that one of their soldiers or civilians is suffering from a mental disorder should notify their chain of command so that the commander can decide upon making a referral to a mental health care provider. It is important to note that persons with mental disorders are often unable to

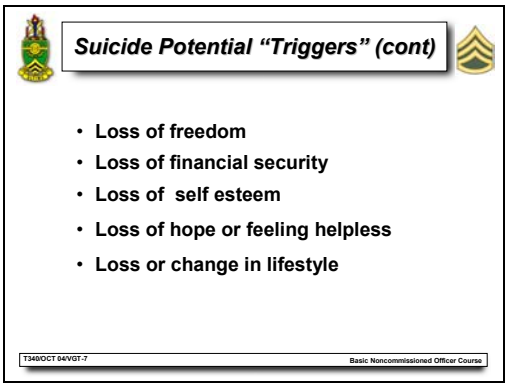
appreciate the seriousness of their problem, as the disorder frequently distorts their judgment. Therefore, they must rely upon others for assistance.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-10, 11), para 2-4 and para 2-5

REMOVE VGT-6

NOTE: Call on a student to read VGT-7 and generate a brief discussion on each bullet.

SHOW VGT-7, SUICIDE POTENTIAL"TRIGGERS" (CONT)



Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-11), para 2-5

Obviously, the common theme for all these potential triggers is some form of a loss to the individual. As leaders you must realize that each individual will handle a particular life stressor differently. Therefore, all leaders should anticipate potential "life crises" and ensure that the individual has the proper resources to handle the adversity. This might include appointing a "life-line" buddy to watch over the individual until the crisis has passed or referral to the unit chaplain or other professional counselors.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-11), para 2-5

REMOVE VGT-7

NOTE: Clarify any questions students may have up to this point about the goal, the former CSA statement, possible mental disorders, or suicide potential triggers of the Army Suicide Prevention Program.

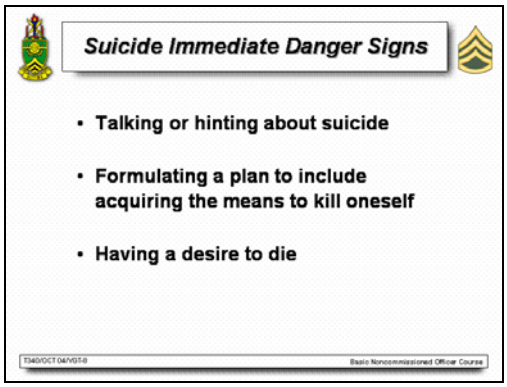
To the well-adjusted person, suicide is an irrational act. This attitude, however, might interfere with a person's ability to promptly intervene if they assume that

everyone shares their opinion. Some consider suicide a method of ending or escaping from pain or other problems.

Let's look at the immediate danger signs of potential suicide that you should look for.

NOTE: Direct the students to (SH-2-13), para 2-7. Use the information in the paragraph to lead to a short discussion on the immediate danger signs for the next two VGTs.

SHOW VGT-8, SUICIDE IMMEDIATE DANGER SIGNS

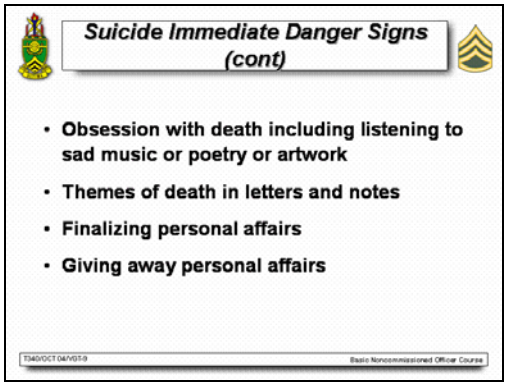


Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-13), para 2-7

NOTE: Clarify any questions students may have up to this point on suicide immediate danger signs. Show VGT-9 and resume discussion.

REMOVE VGT-8

SHOW VGT-9, SUICIDE IMMEDIATE DANGER SIGNS, (CONT)



Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-13), para 2-7

Anyone, especially first line supervisors, who recognizes these warning signs must take immediate action. The first step should be to talk to the individual, allow them to express their feelings and ask them outright and bluntly, “Are you considering suicide?” or “Are you thinking about killing yourself?” If their response is “yes” intervene immediately with life-saving steps, such as ensuring the safety of the individual, notifying the chain of command or chaplain, calling for emergency services or escorting the individual to a mental health officer.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-13), para 2-7

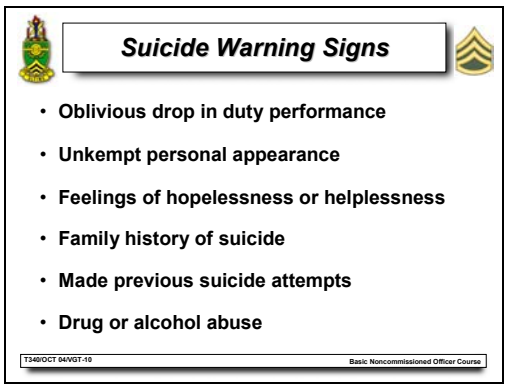
NOTE: Clarify any questions the students may have up to this point.

REMOVE VGT-9

Now let’s look at the suicide prevention warning signs. The list on the VGT contains some warning signs that might precede suicide behavior. Although not as serious as the danger signs previously listed, do not disregard them; react with immediate personal intervention. As leaders you must also be aware of the warning signs.

NOTE: Ask one student to read each bullet and then generate a brief discussion on VGT-10 and VGT-11. Ensure the student understands that although warning signs don’t generate the same level of immediacy as danger signs, they should nevertheless not be ignored.

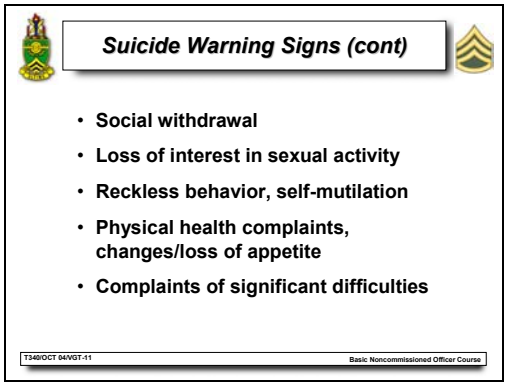
SHOW VGT-10, SUICIDE WARNING SIGNS



Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-13, 14), para 2-8

REMOVE VGT-10

SHOW VGT-11, SUICIDE WARNING SIGNS (CONT)



Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-13, 14), para 2-8

It is the responsibility of all leaders, soldiers, and civilians to watch for these danger and warning signs and realize that they might not be capable of helping themselves and, therefore, require immediate action.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), SH-2-13, 14), para 2-8

NOTE: Ensure the students understand the difference between the suicide danger and suicide warning signs. Clarify any questions the students may have.

REMOVE VGT-11

As leaders it is certainly important to understand what causes suicidal behavior, but it is also very important to understand the resources that offer protection against dysfunctional, self-injurious behavior.

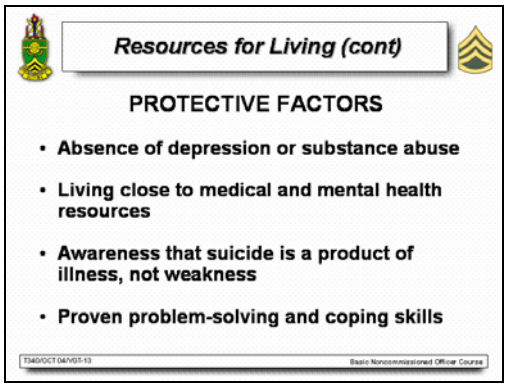
SHOW VGT-12, RESOURCES FOR LIVING

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-14, 15), para 2-9

NOTE: Have one student read the bullets on the VGT and generate a brief discussion on the resources for living protective factors.

REMOVE VGT-12

SHOW VGT-13, RESOURCES FOR LIVING (CONT)



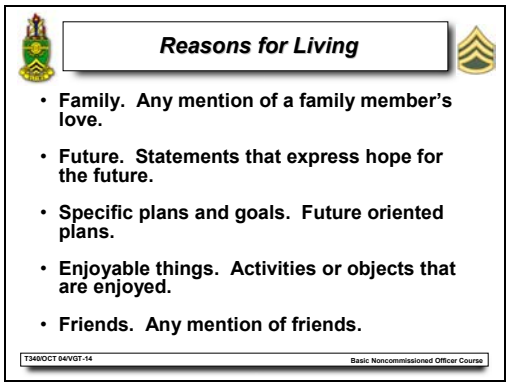
Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-14, 15), para 2-9

NOTE: Ask one student to read the VGT and generate a brief discussion on the resources for living and clarify any questions the students may have.

REMOVE VGT-13

Now let's look at the reason for living. Just as important as recognizing reasons for suicidal behaviors, we must recognize the reasons for living.

SHOW VGT 14, REASONS FOR LIVING

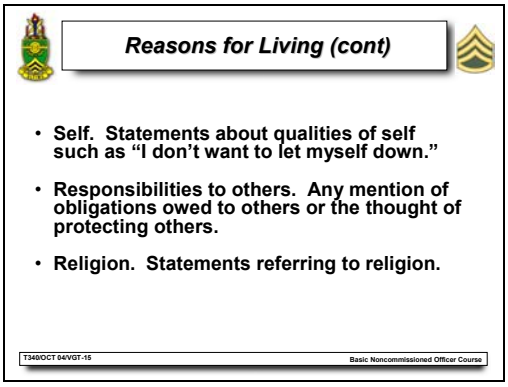


Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-14, 15), para 2-9

NOTE: Ask the students to turn to para 2-9 and from VGT-14 and 15, generate a brief discussion on the reasons for living.

REMOVE VGT-14

SHOW VGT-15, REASONS FOR LIVING (CONT)



Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-14, 15), para 2-9

Leaders should understand what serves as a source of strength or life-sustaining resource for the soldier and civilian and use them when counseling them through a particular crisis. Also, understanding a soldier or civilian's life resources will alert the leadership to potential problems when one of those resources are removed or is in danger.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-14, 15), para 2-9

REMOVE VGT-15

NOTE: Clarify any questions the students may have regarding the reasons for living.

B. ENABLING LEARNING OBJECTIVE

ACTION:	Explain unit leadership responsibilities for identifying high-risk individuals for suicide.
CONDITIONS:	As a small unit leader in a company or battalion level unit.
STANDARDS:	Explained unit leadership responsibilities for identifying high-risk individuals for suicide IAW Army Suicide Prevention - A Guide for Installations and Units (Draft).

1. Learning Step / Activity 1. Identifying High Risk Individuals for Suicide

Method of Instruction: Conference / Discussion
Technique of Delivery: Small Group Instruction (SGI)
Instructor to Student Ratio: 1:16
Time of Instruction: 10 mins
Media: VGT-16 thru VGT-19

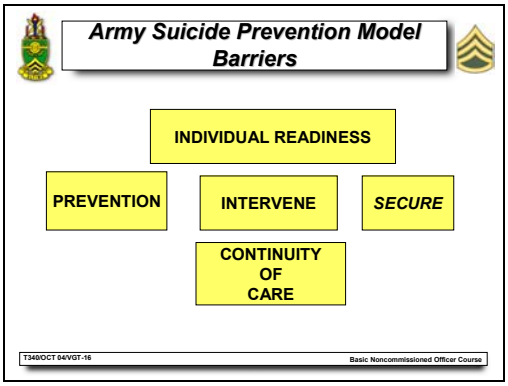
QUESTION: What is the true focus regarding the Army Suicide Prevention Model (ASPM)?

ANSWER: It focuses on maintaining the individual readiness of the soldier and civilian.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), para 3-1

NOTE: Ask students to turn to para 3-1, (SH-2-16) and review the Army Suicide Prevention Model. Generate a brief discussion on the barriers of the suicide model.

SHOW VGT-16, ARMY SUICIDE PREVENTION MODEL BARRIERS



Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-16), para 3-1

Now let us review the barriers of the Army Suicide Prevention Model. The Army Suicide Prevention Model focuses on maintaining the individual readiness of the soldier and civilian. Occasionally, through normal life experiences, a person enters a path that, if followed and without interruption or intervention, could allow a normal life stressor or mental disorder to become a life crisis, which might lead to thoughts of suicide and eventually suicidal behavior and possible injury or death. Parallel to the suicidal path is a “safety net” that represents the Army’s continuity of care. As the actual suicidal risk escalates, so does our response by becoming more directive and involving more professional health care providers. To prevent a person from progressing down the suicidal path are three “barriers”: prevention, intervention, and security. These barriers target specific programs and initiatives for varying degrees of risk to block any further progress along the suicidal path. Provided below is a quick

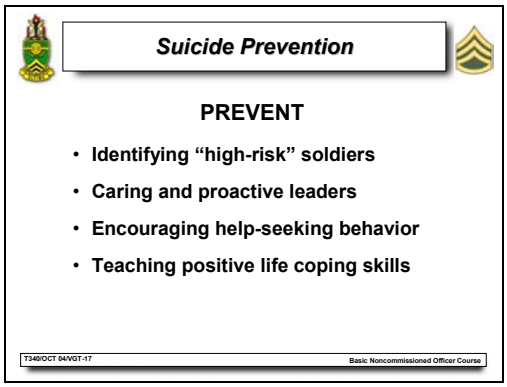
outline of each of these “barriers” with more detailed strategies following in Chapters 4, 5, and 6.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-16), para 3-1

REMOVE VGT-16

NOTE: Clarify any question the students may have with the barriers of the Army Suicide Prevention Model.

SHOW VGT-17, SUICIDE PREVENTION



Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-19) para 4-1 thru 4-4

NOTE: Ask students to turn to para 3-1 thru 3-1d (SH-2-16, 17), and generate a brief discussion from the para 3-1a.

Prevention is our main effort to minimize suicidal behavior that you as squad leaders must know. It focuses on preventing normal life “stressors” from turning into a life crisis. “Prevention Programming” focuses on equipping the soldier and civilian with the coping skills to handle overwhelming life circumstances that can sometimes begin a dangerous journey down a path to possible suicidal behaviors. This barrier allows the individual to operate “in the green” or at a high state of individual readiness. Prevention includes establishing early screening to establish baseline mental health and offer specific remedial programs before the occurrence of possible dysfunctional behavior. Prevention is absolutely dependent on caring and proactive small unit leaders who make the effort to know their subordinates, including estimating their ability to handle stress and offer a positive, cohesive environment which nurtures and develops positive life coping skills.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-16, 17), para 3-1

REMOVE VGT-17

NOTE: Clarify any questions the students may have.

Let's look at the things that identify people as high risk.

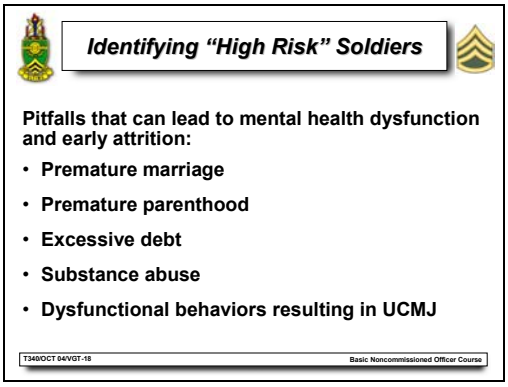
QUESTION: In the prevention barrier, what action should a squad leader take to alert himself to potential suicidal behaviors?

ANSWER: He should identify high-risk individuals.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-19), para 4-1

Identifying "High Risk" individuals begins with pre-screening upon arrival for initial entry training (IET) within the Army to identify those individuals considered high risk for suicidal behavior. Today's recruits enter the Army with varying resiliency levels to handle stress, anger, and intimate personal relationships. As we previously discussed, some soldiers enter the Army with dysfunctional health risk behaviors. Recognizing that the baseline mental health of our inductees may be less than best requires proactive identification and targeted education/intervention and ongoing mentoring by unit leadership. This intervention will assist the first term soldier and civilian in avoiding some of the normal pitfalls that can lead to mental health dysfunction and subsequent early attrition.

SHOW VGT-18, IDENTIFYING "HIGH-RISK" SOLDIERS

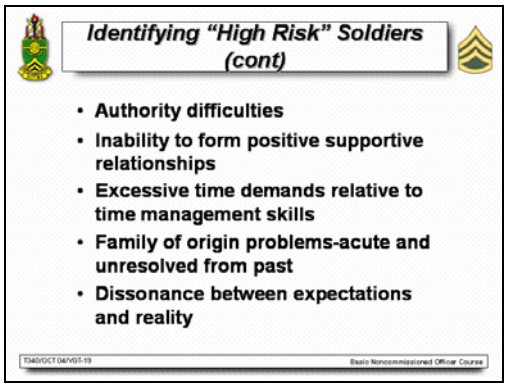


Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-19), para 4-1

NOTE: Ask students to turn to para 4-1 and generate a brief discussion on identifying high-risk soldiers.

REMOVE VGT-18

SHOW VGT-19, IDENTIFYING "HIGH RISK" SOLDIERS (CONT)



Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-19), para 4-1

As leaders recognize that the baseline mental health of our inductees may be less than optimum requires proactive identification and targeted education/intervention and ongoing mentoring by unit leadership. You also should remember these pitfalls when you see them, because this is one of your responsibilities as a leader.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-19), para 4-1

REMOVE VGT-19

NOTE: Ask the students to review the information on the VGT. Clarify any misunderstandings about identifying high-risk soldiers.

C. ENABLING LEARNING OBJECTIVE

ACTION:	Identify caring and proactive leader's responsibilities in suicide prevention.
CONDITIONS:	As a small unit leader in a company or battalion level unit.
STANDARDS:	Identified caring and proactive leader's responsibilities in suicide prevention IAW Army Suicide Prevention - A Guide for Installations and Units (Draft).

1. Learning Step / Activity 1. Caring and Proactive Leader's Responsibilities

Method of Instruction: Conference / Discussion
Technique of Delivery: Small Group Instruction (SGI)
Instructor to Student Ratio: 1:16
Time of Instruction: 5 mins
Media: VGT-20

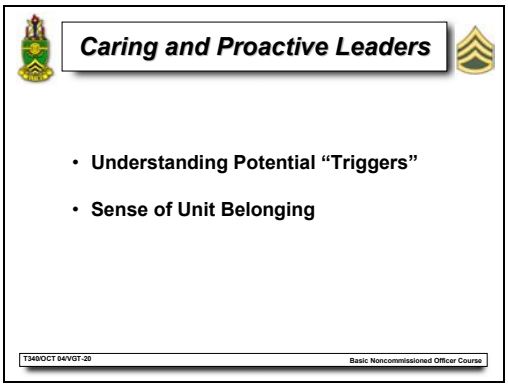
NOTE: Using the information in (SH-2-19, 20), para 4-2 generate a discussion on the caring and proactive leaders' responsibilities toward subordinates.

QUESTION: What actions demonstrate leader involvement in suicide prevention?

ANSWER: See VGT-20.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-19, 20), para 4-2

SHOW VGT-20, CARING AND PROACTIVE LEADERS



Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-19, 20), para 4-2

As leaders you must be caring and proactive. Now let's look at what and how caring and proactive leaders act towards their subordinates. Although our first line of defense will be our soldiers and civilians, truly our most valuable player in suicide prevention will be you as the small unit leader or first line supervisor. You must recognize that the most important resources entrusted to your care are your soldiers and civilians. Suicide prevention requires active and concerned leaders like yourself who express a sincere interest in the overall welfare of your subordinates. This includes taking the time to learn as much as you can about the personal dynamics of your subordinates. You must be able to recognize serious personal problems before they manifest themselves as dangerous dysfunctional behavior(s) and recognize the

basic symptoms of a serious mood disorder such as depression and substance abuse. The intent is not to train you to make a clinical diagnosis, but rather to train you to recognize "high risk soldiers and alert the chain of command of a particular concern so that the commander can make an informed, "pre-emptive" decision to make a referral to a professional Mental Health Officer (MHO). In addition, you and all leaders should be familiar with those stressors and potential suicidal "triggers" and know when one of your soldiers or civilians are experiencing a crisis and might be at risk.

All leaders should strive to create and foster an environment of acceptance and cohesion for all members of their unit or section. No one should ostracize or make any member of a unit feel unwelcome, regardless of their action. Everyone should feel that they are a valuable part of the team and that others depend on them. This is especially true when someone is facing a problem or potential life crisis, whether personal or professional.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-19, 20), para 4-2

REMOVE VGT-20

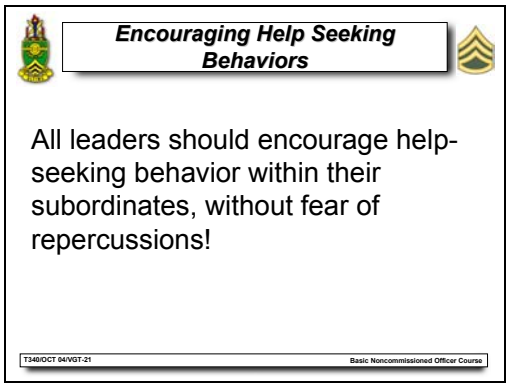
D. ENABLING LEARNING OBJECTIVE

ACTION:	Identify leadership responsibilities for encouraging help-seeking behaviors within their subordinates.
CONDITIONS:	As a small unit leader in a company or battalion level unit.
STANDARDS:	Identified leadership responsibilities for encouraging help-seeking behaviors within their subordinates IAW the Army Suicide Prevention - A Guide for Installations and Units (Draft).

1. Learning Step / Activity 1. Encouraging Help Seeking Behaviors

Method of Instruction: Conference / Discussion
Technique of Delivery: Small Group Instruction (SGI)
Instructor to Student Ratio: 1:16
Time of Instruction: 5 mins
Media: VGT-21

SHOW VGT-21, ENCOURAGING HELP SEEKING BEHAVIORS



Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-20, 21), para 4-3

Now let us review "encouraging help-seeking behaviors". As leaders you must not hinder any soldier seeking out help in any manner, whether it is medical or legal. Subordinates should feel free to seek help without any fear of repercussions.

Clearly, for suicide prevention to be effective, you have to reduce the stigma of seeking mental health counseling. We ca reduce the stigma by first ensuring against the inadvertent discrimination of your soldiers and civilians who receive mental health counseling and secondly by supporting confidentiality between the individual and Mental Health Officer (MHO). Both of these objectives will require comprehensive and command-supported efforts to review policies and procedures.

Confidentiality in the face of suicide risk must strike a balance between safeguarding the individual and/or the public and protecting their privacy rights. For your information, as squad leaders in order to enhance the ASPP and overall effectiveness of the mental health care services, commanders will respect and honor prescribed patient-doctor's privacy rights as prescribed in DoD Regulations, and applicable statutes, including Privacy Act, 5 U.S.C. 552a. Therefore, confidential mental health-care communications will remain private, except as provided by DoD Regulations.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-20, 21), para 4-3

NOTE: Clarify any questions students may have on encouraging help-seeking behaviors.

REMOVE VGT-21

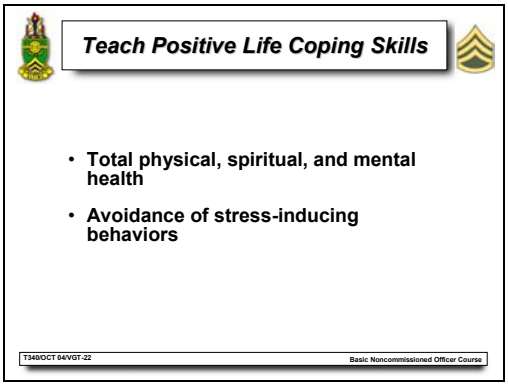
E. ENABLING LEARNING OBJECTIVE

ACTION:	Explain the leader's role in teaching positive life coping skills development to their soldiers and civilian personnel.
CONDITIONS:	As a small unit leader in a company or battalion level unit.
STANDARDS:	Explained the leader's role in teaching positive life coping skills development to their soldiers and civilian personnel IAW the Army Suicide Prevention - A Guide for Installations and Units (Draft).

1. Learning Step / Activity 1. Teach Life Coping Skills

Method of Instruction: Conference / Discussion
Technique of Delivery: Small Group Instruction (SGI)
Instructor to Student Ratio: 1:16
Time of Instruction: 10 mins
Media: VGT-22

SHOW VGT-22, TEACH POSITIVE LIFE-COPING SKILLS



Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-21), para 4-4

NOTE: Have one student read the VGT and solicit students to explain each of the bullets in their own words.

Now let's review the leaders' role in teaching life coping skills development.

Prevention also includes developing the soldier and civilian's (if civilians are in your unit) mental resiliency, emphasizing avoiding premature stress-inducing decisions (i.e., getting married too young or starting a family). It is important for all leaders to

recognize that mental wellness is a component of the triad of overall individual fitness (physical and spiritual being the other two).

NOTE: Although not the squad leader's responsibility he/she should know about the steps to teach positive life coping skills development.

QUESTION: What is the name of a seminar that teaches positive life coping skills?

ANSWER: Building strong ready family (BSRF) seminar.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-21), para 4-4

Positive life coping skills training may include alcohol abuse avoidance, financial management, stress and anger reduction, conflict management, and parenting and family life skills such as the Building Strong and Ready Families (BSRF) seminar originated within the 25th Infantry Division. BSRF offers married couples an opportunity to strengthen their relationship through various instruction and exercises. The seminar focused on those newly married couples who were interested in improving their communication skills and generally being better equipped to handle the stresses of married life, including child rearing. Programs such as BSRF are a great example of how to develop life-coping skills and will indirectly have a positive impact on reducing suicidal behavior. As a leader you should find ways to incorporate these kinds of training events into your squad.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-21), para 4-4

REMOVE VGT-22

NOTE: Clarify any questions students may have on teaching positive life coping skills development.

Break: TIME: 01:50 to 02:00

F. ENABLING LEARNING OBJECTIVE

ACTION:	Identify intervention and applied suicide intervention skills training (ASIST) to assist commanders.
CONDITIONS:	As a small unit leader in a company or battalion level unit.
STANDARDS:	Identified intervention and applied suicide intervention skills training (ASIST) to assist commanders by reviewing-- • army suicide awareness training model, • installation gatekeepers and combat stress team, and • commander's responsibilities, IAW the Army Suicide Prevention - A Guide for Installations and Units (Draft).

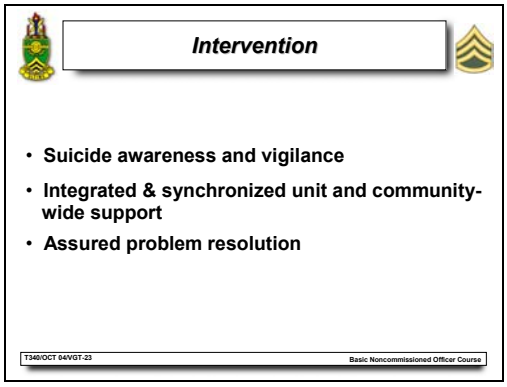
1. Learning Step / Activity 1. Intervention and Applied Suicide Intervention Skills

Method of Instruction: Conference / Discussion
Technique of Delivery: Small Group Instruction (SGI)
Instructor to Student Ratio: 1:16
Time of Instruction: 10 mins
Media: VGT-23 and VGT-24

Now let's review the leaders' role in intervention.

NOTE: Have one student read the VGT and solicit students to explain each of the bullets in their own words.

SHOW VGT-23, INTERVENTION



Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-22), para 5-1

As you can see, intervention has three different elements: Suicide awareness and vigilance, integrated & synchronized unit and community wide-support and assured problem resolution.

QUESTION: What is one of the steps in the intervene process of the ASPP of helping soldiers and civilians?

ANSWER: Suicide awareness and vigilance.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-22), para 5-1

NOTE: Ask the students to turn to para 5-1 and generate brief discussion on suicide awareness and vigilance. Ensure discussion covers refresher training.

Now we will look at suicide awareness and vigilance. This phase deals with individuals who are dealing with a particular crisis that, left untreated, can lead to suicidal behavior. Suicide intervention can involve anyone. The strategy of the ASPP is to train everyone in basic suicide awareness so they can spot someone who is displaying suicidal warning or danger signals and know what actions to take to protect the person at risk. All leaders will ensure that all of their subordinates receive this training at some point in their career and conduct refresher training as needed.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-22), para 5-1

NOTE: Summarize the first hour of the Army's Suicide Prevention Program

REMOVE VGT-23

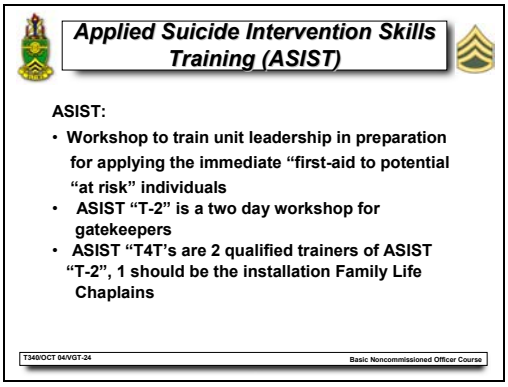
QUESTION: What is the minimum trained ASIST personnel required in each battalion?

ANSWER: One ASIST.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-22), para 5-2

NOTE: Ask student to turn to para 5-2 and generate a brief discussion on the Applied Suicide intervention Skills Training (ASIST).

SHOW VGT-24, APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)



Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-22), para 5-2

Let's look at ASIST. Raising awareness and vigilance will invariably increase the number of "false-positives" or those we identified as at risk for suicide but are not actually considering suicide. These "false-positives" could overwhelm community mental health, resulting in increased workloads and longer referral times for those who are actually at risk. Reducing the number of "false-positives" and to assisting commanders in making an informed determination of suicidal risk will require professional training (such as Living Works Applied Suicide Intervention Training - ASIST). This training must be easily accessible to the unit commanders (i.e., a minimum of one person trained in every battalion). Such training is not just limited to chaplains. During Desert Shield and Storm, V Corps units sponsored many ASIST Workshops for unit leadership and civilians in preparation for an expected increase in the number of potential "at-risk" individuals.

As a supervisor, when your commander or first sergeant asks you to select a soldier to support this requirement, use good judgment when picking your candidate. This is a position that requires maturity and dedication from the candidate.

There is a group called the Living Works whose objective is to register qualified trainers in local communities, who in turn can prepare front-line gatekeepers with the confidence and competence to apply immediate "first-aid" suicide intervention in times of individual and family crises. The ASIST workshops include instruction on

how to estimate suicidal risk and apply an intervention model that reduces the immediate risk of suicide. The purpose of ASIST is not to produce personnel qualified to diagnose mental disorders, or to treat suicidal individuals, but rather to provide the **immediate first aid response for those individuals** until referred to a trained, professional mental health care provider.

ASIST "T-2" is a two-day workshop that commanders should offer to all military and civilian gatekeepers. Each T-2 course consists of approximately thirty individuals and requires two "T4T" level trainers.

To become an ASIST "T4T" qualified trainer requires attendance of the five day trainer's course taught by group Living Works Education.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-22, 23) para 5-2

NOTE: Summarize ASIST concept and clarify any questions the students may have.

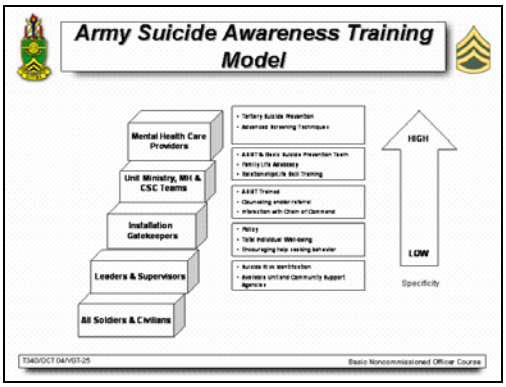
REMOVE VGT-24

2. Learning Step / Activity 2. Army Suicide Awareness Training Model

Method of Instruction:	Conference / Discussion
Technique of Delivery:	Small Group Instruction (SGI)
Instructor to Student Ratio:	1:16
Time of Instruction:	10 mins
Media:	VGT-25

NOTE: Ask students to turn to (SH-2-23 thru 26), para 5-3 thru para 5-5 and generate a brief discussion on the five tiered training strategy.

SHOW VGT-25, ARMY SUICIDE AWARENESS TRAINING MODEL



Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-23), para 5-3

This specialized training consists of five multi-tiered specific groups, each with different responsibilities within ASPP. As you review this VGT you will notice that all the soldiers and civilians are at ground zero.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-24), para 5-3a

REMOVE VGT-25

3. Learning Step / Activity 3. Installation Gatekeepers and Combat Stress Team

Method of Instruction:	Conference / Discussion
Technique of Delivery:	Small Group Instruction (SGI)
Instructor to Student Ratio:	1:16
Time of Instruction:	15 mins
Media:	VGT-26

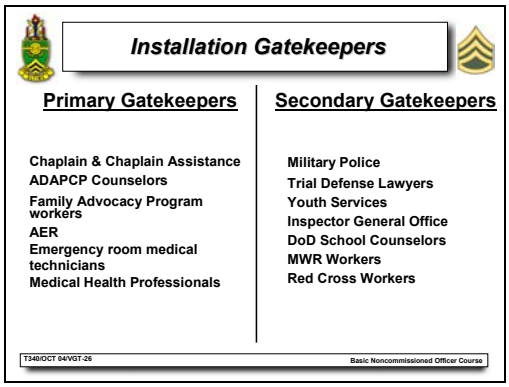
NOTE: Ask students to turn to (SH-2-24), para 5-3c and generate a brief discussion on the installation gatekeepers.

QUESTION: What are the Installation Gatekeepers?

ANSWER: See VGT-26.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-24), para 5-3c

SHOW VGT-26, INSTALLATION GATEKEEPERS



Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-24), para 5-3c

Now let's look at the primary and secondary gatekeepers. Installation gatekeepers are those individuals who in the performance of their assigned duties and responsibilities provide specific counseling to soldiers and civilians in need and receive training in recognizing and helping individuals with suicide-related symptoms or issues. Identify gatekeepers as either a "primary gatekeeper" (those whose primary duties involve primarily assisting those in need and

more susceptible to suicide ideation) or "secondary gatekeepers" (those whose might have a secondary opportunity to come in contact with a person at risk).

NOTE: Summarize the gatekeepers of the suicide prevention and awareness concept and clarify any questions the students may have.

REMOVE VGT-26

NOTE: Review (SH-2-24 thru 26), para 5-3d thru para 5-5 and generate a brief discussion on the combat stress team.

Now let's look at what some units have initiated to reduce stress, dysfunctional behavior, and suicides. The 85th Medical Detachment, Combat Stress Control, following the example first set by the Medical Activity and 1st Cavalry Division in the 1980s, conducts a Combat Stress Fitness Course once or twice a month at Fort Hood for soldiers referred directly from their units or by way of the mental health clinics. For five duty days, the students participate in classes and practical exercises on stress management, anger management, and other life skills, taught by the CSC unit mental health officers and enlisted specialists in a military, not patient care, atmosphere. Finishing the course earns a certificate of completion, which has positive value for advancement. Graduates of the course who entered as candidates for chapter separation from the Army have returned months later as soldiers of the quarter to inspire the new class. The 98th CSC Detachment at Fort Lewis periodically conducts a similar program, both in garrison and during field exercises. At Fort Bragg, the 528th CSC Detachment provides "train the trainer" courses to prepare unit leaders to give their own classes to the troops, including stress control and suicide prevention.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-25), para 5-3e

NOTE: Summarize the combat stress team concept and clarify any questions that students may have.

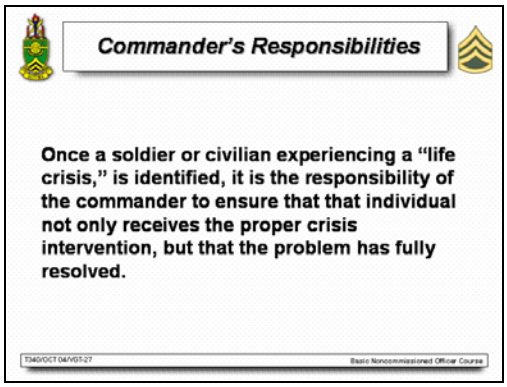
4. Learning Step / Activity 4. Commander's Responsibilities

Method of Instruction:	Conference / Discussion
Technique of Delivery:	Small Group Instruction (SGI)
Instructor to Student Ratio:	1:16
Time of Instruction:	10 mins
Media:	VGT-27

NOTE: Ensure the students understand this is not the responsibility of the squad leader, but good information to know.

NOTE: Have one student read the VGT and solicit students to explain the statement in their own words.

SHOW VGT-27, **COMMANDER'S RESPONSIBILITIES**



Ref: Army Suicide Prevention—A Guide for Installations and Units, (SH-2-27), para 5-6

NOTE: Ask students to turn to para 5-6 and generate a brief discussion on the commander's involvement and responsibilities.

Now let us look at the commander's involvement and his responsibilities to the Army Suicide Prevention Program.

Unit commanders are accountable for their suicide prevention programs. This includes ensuring the proper training of unit personnel and ensuring that all leaders actively engage in the personal welfare of their soldiers.

Once a leader has identified, a soldier or civilian experiencing a "life crisis," it is the responsibility of the commander to ensure that that individual not only receives the proper crisis intervention, but that the problem has fully resolved. The referral doesn't end the commander's intervention responsibility but only initiates the involvement, which continues until care givers can completely assure the commander that the particular crisis or disorder reaches resolution. This includes properly safeguarding the person at risk while they are receiving the required, professional assistance from mental health care providers. As squad leaders, one of your requirements is to assist your commanders in meeting the requirement of training your subordinates.

Behavioral health (BH) professionals that are treating individuals at risk for suicide should keep the commander informed, as well as making recommendations for safeguarding the individual during the treatment (if the treatment is outpatient care). Clear and expedient communications flow is crucial between those who are treating the individual at risk and the individual's commander to ensure disclosure of all appropriate information to enable an accurate diagnosis.

Ref: Army Suicide Prevention—A Guide for Installations and Units, (SH-2-27), para 5-6

REMOVE VGT-27

NOTE: Clarify any questions the students may have regarding the commander's involvement and responsibilities.

SECTION IV. SUMMARY

Method of Instruction: Conference / Discussion
Technique of Delivery: Small Group Instruction (SGI)
Instructor to Student Ratio is: 1:16
Time of Instruction: 5 mins
Media: VGT-28

Check on Learning

QUESTION: What is the true focus regarding the Army Suicide Prevention Model (ASPM)?

ANSWER: It focuses on maintaining the individual readiness of the soldier and civilian.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-16), para 3-1

QUESTION: In the prevention barrier, what action should a squad leader take to alert himself to potential suicide behaviors?

ANSWER: He should identify high-risk individuals.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-19), para 4-1

QUESTION: Who is the most valuable player in the first line of defense of the prevention process?

ANSWER: First line supervisor.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-19), para 4-2

QUESTION: What are the life coping skills training soldiers and civilians use to help reduce premature stress-inducing decisions?

ANSWER: Building strong ready family (BSRF) seminar.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-21), para 4-4

QUESTION: What is one of the steps in the intervene process of the ASPP of helping soldiers and civilians?

ANSWER: Suicide awareness and vigilance.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-22),para 5-1

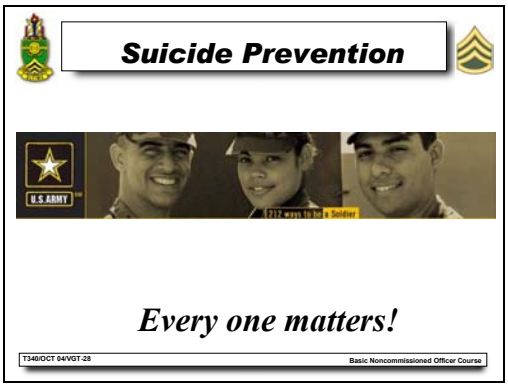
QUESTION: What is the minimum trained ASIST personnel required in each battalion?

ANSWER: One ASIST.

Ref: Army Suicide Prevention - A Guide for Installations and Units (Draft), (SH-2-22), para 5-2

Review / Summarize Lesson

SHOW VGT-28, SUICIDE PREVENTION



Suicide prevention, like all leadership challenges, is not only a commander's program but every leader's responsibility at all levels. The success of the Army Suicide Prevention Program (ASPP) rests upon proactive, caring and courageous soldiers, family members, and Army civilians who recognize the imminent danger and then take immediate action to save a life. We need you as a squad leader to help minimize the risk of suicide within the Army and stop this tragic and unnecessary loss of human life.

Suicide prevention is everybody's business, and in the Army, EVERYONE MATTERS!

REMOVE VGT-28

SECTION V. STUDENT EVALUATION

Testing Requirements

NOTE: Describe how the student must demonstrate accomplishment of the TLO. Refer student to the Student Evaluation Plan.

During this course of instruction, you will take a 50-question examination.

The examination will include questions on the ELOs and TLO from this lesson.

You must correctly answer 35 questions or more to receive a GO. A GO is a graduation requirement.

Feedback Requirements

NOTE: Feedback is essential to effective learning. Schedule and provide feedback on the evaluation and any information to help answer students' questions about the test. Provide remedial training as needed.

None

VIEWGRAPHS FOR LESSON 1: T340 version 2

Enabling Learning Objective A

Learning Step 1

VGT-1, Suicide Prevention Program

Suicide Prevention Program

In The Army's Suicide Prevention Program

Everyone Matters!

T340/OCT 04/VGT-1 Basic Noncommissioned Officer Course

VGT-2, Goal of the Army Suicide Prevention Program

Goal of the Army Suicide Prevention Program

TO MINIMIZE SUICIDAL BEHAVIOR

AMONG OUR SOLDIERS, RETIREES,

CIVILIANS AND FAMILY MEMBERS.

VGT-3, Former Chief of Staff of the Army Statement

Former Chief of Staff of the Army Statement

The CSA stated that suicide is a "serious problem" and directed a complete review of the ASPP. He called for a campaign that would refine the ASPP by making use of the best-known available science, and would also invigorate suicide prevention awareness and vigilance.

VGT-4, Former Chief of Staff of the Army Statement (cont)

Former Chief of Staff of the Army Statement (cont)

He further stated that for the program to be effective, the framework must:

- **involve all commanders**
- **be proactive**
- **intensify preventive efforts against suicidal behavior**
- **invest in our junior leaders**
- **improve current training and education**

VGT-5, Possible Mental Disorders

Possible Mental Disorders

- Impulsive or aggressive-violent traits
- Previous other self-injurious acts
- Excessive anger, agitation, or constricted preoccupations
- Excessive alcohol use
- Heavy smoking
- Evidence of any sleep or eating disorder

VGT-6, Suicide Potential "Triggers"

Suicide Potential "Triggers"

- **Loss of a loved one to illness or death**
- **Loss of a significant, intimate relation**
- **Loss of a child custody battle**
- **Loss of friendship or social status**
- **Loss of job or rank**

VGT-7, Suicide Potential "Triggers" (cont)

Suicide Potential "Triggers" (cont)

- **Loss of freedom**
- **Loss of financial security**
- **Loss of self esteem**
- **Loss of hope or feeling helpless**
- **Loss or change in lifestyle**

VGT-8, Suicide Immediate Danger Signs

Suicide Immediate Danger Signs

- **Talking or hinting about suicide**
- **Formulating a plan to include acquiring the means to kill oneself**
- **Having a desire to die**

VGT-9, Suicide Immediate Danger Signs (cont)

Suicide Immediate Danger Signs (cont)

- **Obsession with death including listening to sad music or poetry or artwork**
- **Themes of death in letters and notes**
- **Finalizing personal affairs**
- **Giving away personal affairs**

VGT-10, Suicide Warning Signs

Suicide Warning Signs

- Oblivious drop in duty performance
- Unkempt personal appearance
- Feelings of hopelessness or helplessness
- Family history of suicide
- Made previous suicide attempts
- Drug or alcohol abuse

T340/OCT 04/VGT-10 Basic Noncommissioned Officer Course

VGT-11, Suicide Warning Signs (cont)

Suicide Warning Signs (cont)

- **Social withdrawal**
- **Loss of interest in sexual activity**
- **Reckless behavior, self-mutilation**
- **Physical health complaints, changes/loss of appetite**
- **Complaints of significant difficulties**

VGT-12, Resources for Living

Resources for Living

PROTECTIVE FACTORS

- **Intact social supports, including marriage**
- **Active religious affiliation or faith**
- **Presence of Dependent young children**
- **Ongoing supportive relationship with a caregiver**

VGT-13, Resources for Living (cont)

Resources for Living (cont)

PROTECTIVE FACTORS

- **Absence of depression or substance abuse**
- **Living close to medical and mental health resources**
- **Awareness that suicide is a product of illness, not weakness**
- **Proven problem-solving and coping skills**

VGT-14, Reasons for Living

Reasons for Living

- **Family. Any mention of a family member's love.**
- **Future. Statements that express hope for the future.**
- **Specific plans and goals. Future oriented plans.**
- **Enjoyable things. Activities or objects that are enjoyed.**
- **Friends. Any mention of friends.**

VGT-15, Reasons for Living (cont)

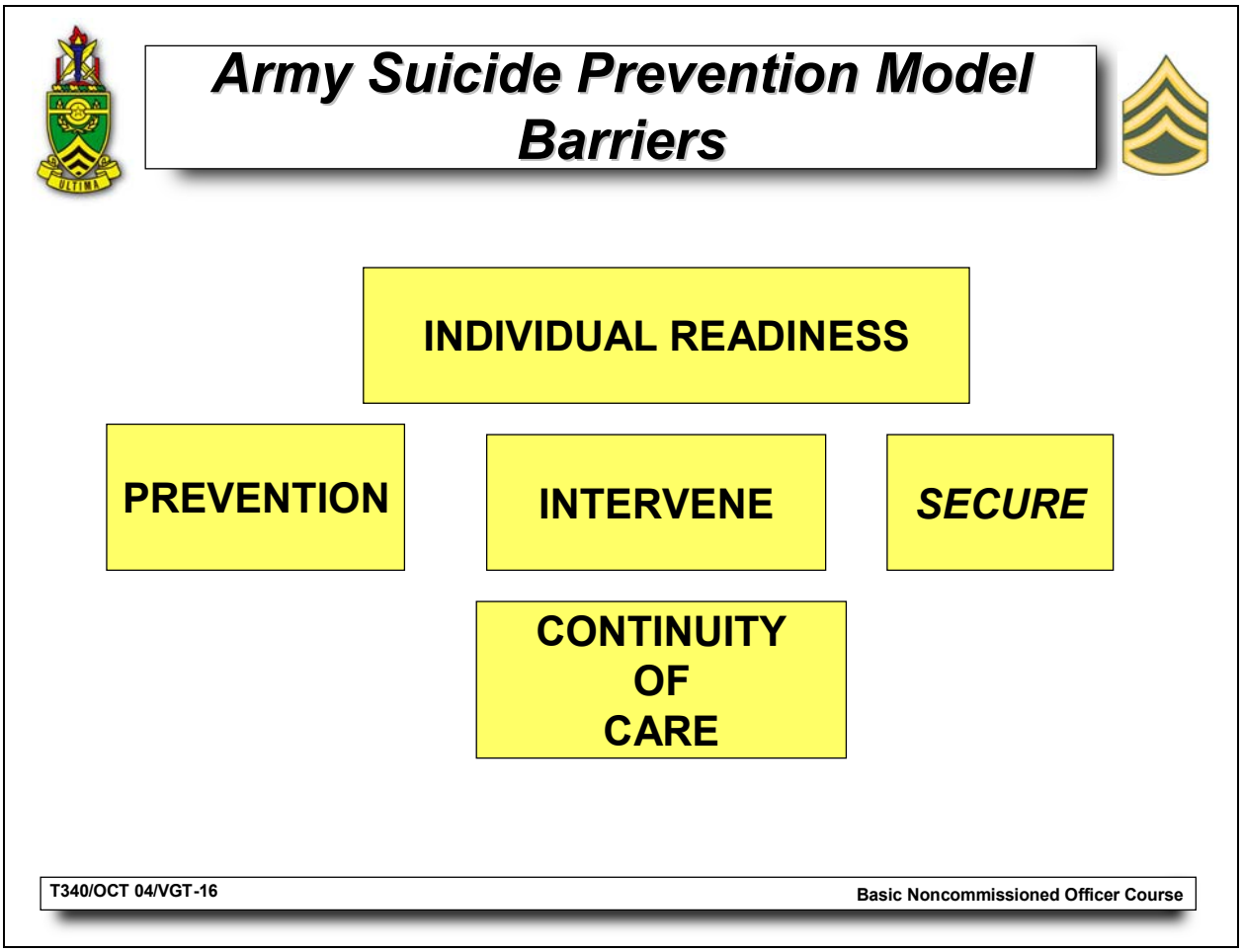
Reasons for Living (cont)

- **Self. Statements about qualities of self such as "I don't want to let myself down."**
- **Responsibilities to others. Any mention of obligations owed to others or the thought of protecting others.**
- **Religion. Statements referring to religion.**

Enabling Learning Objective B

Learning Step 1

VGT-16, Army Suicide Prevention Model Barriers



VGT-17, Suicide Prevention

Suicide Prevention

PREVENT

- Identifying “high-risk” soldiers
- Caring and proactive leaders
- Encouraging help-seeking behavior
- Teaching positive life coping skills

VGT-18, Identifying "High Risk" Soldiers

Identifying "High Risk" Soldiers

Pitfalls that can lead to mental health dysfunction and early attrition:

- **Premature marriage**
- **Premature parenthood**
- **Excessive debt**
- **Substance abuse**
- **Dysfunctional behaviors resulting in UCMJ**

VGT-19, Identifying "High Risk" Soldiers (cont)

Identifying "High Risk" Soldiers (cont)

- **Authority difficulties**
- **Inability to form positive supportive relationships**
- **Excessive time demands relative to time management skills**
- **Family of origin problems-acute and unresolved from past**
- **Dissonance between expectations and reality**

Enabling Learning Objective C

Learning Step 1

VGT-20, Caring and Proactive Leaders

Caring and Proactive Leaders

- **Understanding Potential "Triggers"**
- **Sense of Unit Belonging**

Enabling Learning Objective D

Learning Step 1

VGT-21, Encouraging Help Seeking Behaviors

Encouraging Help Seeking Behaviors

All leaders should encourage help-seeking behavior within their subordinates, without fear of repercussions!

T340/OCT 04/VGT-21 Basic Noncommissioned Officer Course

Enabling Learning Objective E

Learning Step 1

VGT-22, Teach Positive Life Coping Skills

Teach Positive Life Coping Skills

- **Total physical, spiritual, and mental health**
- **Avoidance of stress-inducing behaviors**

T340/OCT 04/VGT-22 Basic Noncommissioned Officer Course

Enabling Learning Objective F

Learning Step 1

VGT-23, Intervention

Intervention

- **Suicide awareness and vigilance**
- **Integrated & synchronized unit and community-wide support**
- **Assured problem resolution**

VGT-24, Applied Suicide Intervention Skills Training (ASIST)

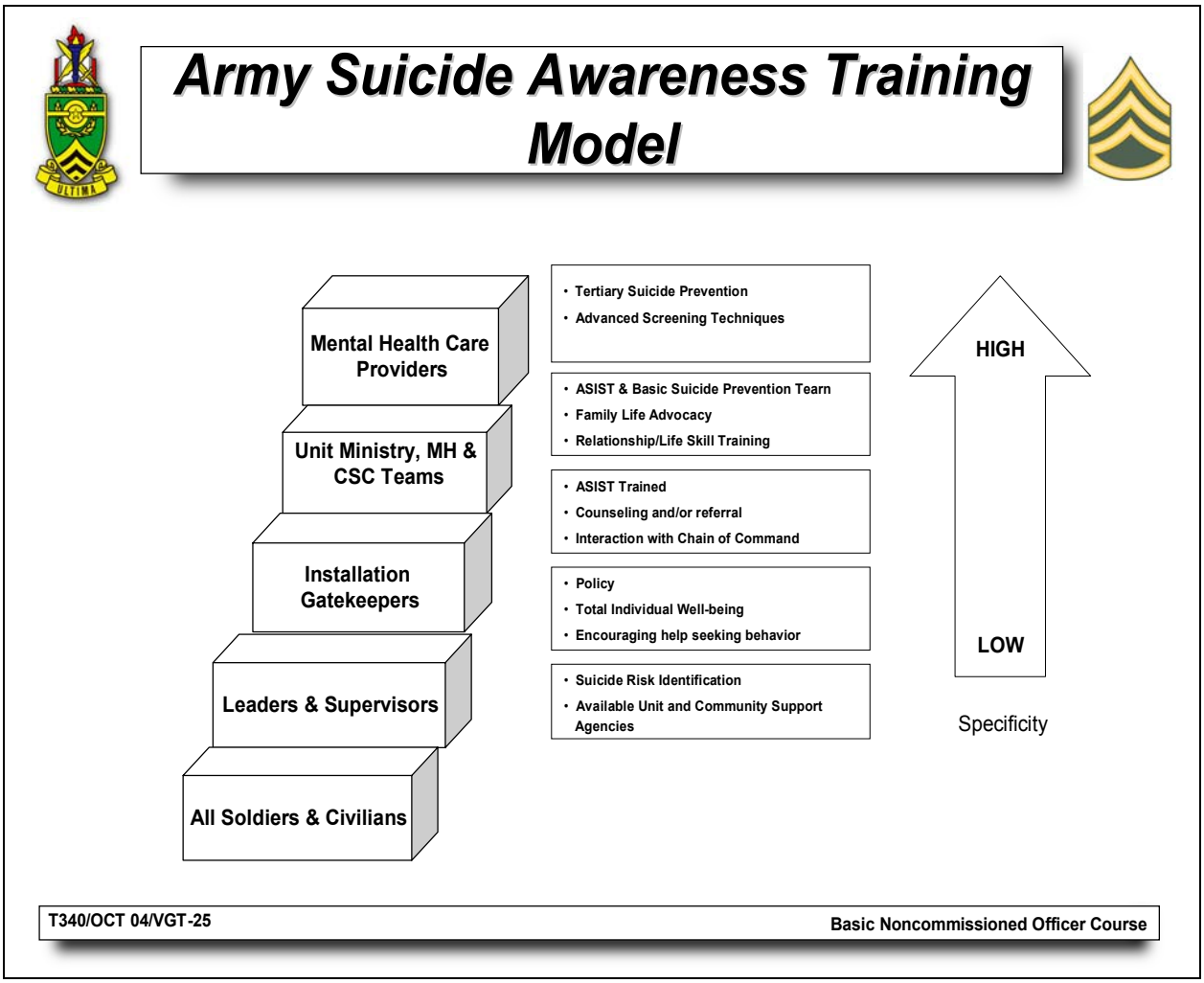
Applied Suicide Intervention Skills Training (ASIST)

ASIST:

- **Workshop to train unit leadership in preparation for applying the immediate "first-aid to potential "at risk" individuals**
- **ASIST "T-2" is a two day workshop for gatekeepers**
- **ASIST "T4T's are 2 qualified trainers of ASIST "T-2", 1 should be the installation Family Life Chaplains**

Learning Step 2

VGT-25, Army Suicide Awareness Training Model



Learning Step 3

VGT-26, Installation Gatekeepers

Installation Gatekeepers

Primary Gatekeepers

- Chaplain & Chaplain Assistance
- ADAPCP Counselors
- Family Advocacy Program workers
- AER
- Emergency room medical technicians
- Medical Health Professionals

Secondary Gatekeepers

- Military Police
- Trial Defense Lawyers
- Youth Services
- Inspector General Office
- DoD School Counselors
- MWR Workers
- Red Cross Workers

T340/OCT 04/VGT-26 Basic Noncommissioned Officer Course

Learning Step 4

VGT-27, Commander's Responsibilities

Commander's Responsibilities

Once a soldier or civilian experiencing a "life crisis," is identified, it is the responsibility of the commander to ensure that that individual not only receives the proper crisis intervention, but that the problem has fully resolved.

Summary

VGT-28, Suicide Prevention

Suicide Prevention

Every one matters!

T340/OCT 04/VGT-28 Basic Noncommissioned Officer Course

Appendix B Test(s) and Test Solution(s) (N/A)

Appendix C Practical Exercises and Solutions (N/A)

HANDOUTS FOR LESSON 1: T340 version 2

This appendix contains the items listed in this table--

Title/Synopsis	Pages
SH-1, Advanced Sheet	SH-1-1 and SH-1-2
SH-2, Draft Army Suicide Prevention - A Guide for Installations	SH-2-1 thru SH-2-50
SH-3, Draft Suicide Prevention Leader Training Slides	SH-3-1 thru SH-3-16

Student Handout 1

Advance Sheet

Lesson Hours This lesson consists of three hours of group discussion.

Overview Suicide prevention must be the business of every leader, supervisor, soldier, and civilian employee in the United States Army.

Learning Objective Terminal Learning Objective (TLO)

Action:	Describe the Army's Suicide Prevention Program
Conditions:	As a squad leader in a classroom or unit environment, given Army Suicide Prevention - A Guide for Installations (Draft), and Suicide Prevention Leader Training (Draft).
Standards:	Described the Army's Suicide Prevention Program by-- • defining the barriers of the Army's Suicide Prevention Model, • explaining unit leadership responsibilities for identifying high risk individuals for suicide, • identifying caring and proactive leader's responsibilities in suicide prevention, • identifying leadership responsibilities for encouraging help seeking behaviors within their subordinates, • explaining the leader's role in teaching positive life coping skills development to their soldiers and civilian personnel, • identifying intervention and applied suicide intervention skills training (ASIST) to assist commanders, IAW Army Suicide Prevention - A Guide for Installations (Draft), and Suicide Prevention Leader Training (Draft).

ELO A Define the principles and barriers of the Army's Suicide Prevention Model.
ELO B Explain unit leadership responsibilities for identifying high-risk individuals for suicide.
ELO C Identify caring and proactive leader's responsibilities in suicide prevention.
ELO D Identify leadership responsibilities for encouraging help seeking behaviors within their subordinates.
ELO E Explain the leader's role in teaching positive life coping skills development to their soldiers and civilian personnel.
ELO F Identify intervention and applied suicide intervention skills training (ASIST) to assist commanders.

Assignments

The student assignments for this lesson are:

- Read Army Suicide Prevention—A Guide for Installations and Units, Chapters 1 thru 5, Draft (SH-2).
- Read Suicide Prevention Leader Training, Draft (SH-3).

Additional Subject Area Resources

None

Bring to Class

You must bring the following materials to class:

- All reference material.
- Pen or pencil.
- Writing paper.

Student Handout 2

ARMY SUICIDE PREVENTION – A GUIDE FOR INSTALLATIONS AND UNITS

This Student Handout Contains

This student handout contains 49 pages of material from the following publication:

Army Suicide Prevention – A Guide for Installations and Units (Draft), July 2002

Cover Sheet	page SH-2-2
Deputy Chief of Staff, G-1, Statement	page SH-2-3
Summary	page SH-2-4
Contents	page SH-2-5
Chapters 1 thru 7	pages SH-2-6 thru SH-2-31
Annex A, Strategies	pages SH-2-32 thru SH-2-37
Annex B, Checklists	pages SH-2-38 and SH-2-39
Annex C, Suicide Risk	pages SH-2-40 and SH-2-41
Annex D, Definitions	pages SH-2-42 thru SH-2-45
Annex E, Abbreviations/Acronyms	pages SH-2-46 and SH-2-47
Annex F, References	page SH-2-48
Annex G, Useful Web Sites	page SH-2-49

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RECOVERABLE PUBLICATION

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Headquarters, Department of the Army, G-1

Army Suicide Prevention – A Guide for Installations and Units

Draft

July 2002 Version

Army Suicide Prevention – A Guide for Installations and Units

1. The Army's strength rests with our soldiers, civilians, retirees, and their families, each being a vital member of our institution. Suicide is detrimental to the readiness of the Army and is a personal tragedy for all those affected. Therefore, suicide has no place in our professional force!

2. We all realize the inherent stress and burdens placed upon our soldiers, civilians and their family members. What defines us as an institution is our compassion and commitment to promoting a healthy lifestyle by emphasizing physical, spiritual and mental fitness. This contributes to the overall well-being of the force and readiness of the Army. Therefore, we must remain cognizant of the potential suicidal triggers and warning signs so that we can raise awareness and increase vigilance for recognizing those whom might be at risk for suicidal behaviors. Furthermore, we must create a command climate of acceptance and support that encourages help-seeking behavior as a sign of individual strength and maturity.

3. Suicide prevention, like all leadership challenges, is a commander's program and every leader's responsibility at all levels. However, the success of the Army Suicide Prevention Program (ASPP) rests upon proactive, caring and courageous soldiers, family members and Army civilians who recognize the imminent danger and then take immediate action to save a life. We need your help to minimize the risk of suicide within the Army to stop this tragic and unnecessary loss of human life. Suicide prevention is everybody's business and in The Army, EVERYONE MATTERS!

JOHN M. LE MOYNE
Lieutenant General, GS
Deputy Chief of Staff, G-1

Headquarters
Department of the Army
Washington, DC
November 2002

Army Suicide Prevention – A Guide for Installations and Units

Summary. This booklet contains the framework to build and organize suicide prevention programs within Army Installations. It represents a refinement of the Army Suicide Prevention Program (ASPP) as currently prescribed in AR 600-63 and DA PAM 600-24. It explains new initiatives and offers recommendations, strategies and objectives for reducing the risk of suicidal behavior within the Army.

Suggested Improvements. The proponent agency of this program is Headquarters, Department of the Army, G-1. Users are encouraged to send comments and suggested improvements directly to DAPE-HRP, 300 Army Pentagon, Room 2B659, Washington D.C. 20310-0300, ATTN: The Army Suicide Prevention Program Manager.

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Annex D – Definitions
Annex E – Abbreviations/ Acronyms
Annex F – References
Annex G – Useful Web Sites

Chapter One – Introduction

"A leader is a dealer in hope"
Napoleon

1-1. Magnitude of the Problem

During the 1990's, the Army lost an equivalent of an entire battalion task force to suicides (803 soldiers). This ranks as the third leading cause of death for soldiers, exceeded only by accidents and illnesses. Even more startling is that during this same period, five-times as many soldiers killed themselves than were killed by hostile fire.

To appreciate the magnitude and impact of suicide, consider that most suicides have a direct, lasting impact on between 6-7 intimate family members (spouse, parents, children), and numerous others including relatives, unit members, friends, neighbors, and others in the local community.

1-2. Army Suicide Prevention Program Goal

The goal of any Army Suicide Prevention Program is to minimize suicidal behavior among our soldiers, retirees, civilians and family members. Suicide behavior includes self-inflicted fatalities, non-fatal self-injurious events and suicidal ideation.

Suicide prevention is an evolving science. It is our responsibility to utilize the best-known available methodology in caring for our soldiers, retirees, civilians and family members. The success of our efforts will be measured by the confidence and conscience of knowing that:

- ✓ we have created and fostered an environment where all soldiers, civilians and family members at risk for suicide will quickly be identified and receive successful intervention and appropriate care;
- ✓ where help-seeking behavior is encouraged and accepted as a sign of individual strength, courage and maturity, and;
- ✓ where positive life-coping skills are taught and reinforced by all leaders.

1-3. CSA Statement

In 2000, following a 27% increase in the number of reported suicides within the Army during 1997-1999, the CSA, General Eric K. Shinseki, stated that suicide is a "serious problem" and directed a complete review of the ASPP. He called for a campaign that would refine the ASPP by making use of the best-known available science, and would also invigorate suicide prevention awareness and vigilance. He further stated that for the program to be effective, the framework must:

- involve all commanders
- be proactive
  - intensify preventive efforts against suicidal behavior
- invest in our junior leaders
  - improve current training and education

Chapter Two - Understanding Suicide Behavior

"We cannot possess what we do not understand."
Goethe

2-1. A Model for Explaining Dysfunctional Behavior

Human behavior is an action influenced by one's genetic composition, shaped by developmental history, and usually as a reaction to a particular stimulus within the environment. The model provided in Figure 1 graphically illustrates how one's genetics, background and current environment can contribute to dysfunctional behavior. Some individuals are born predisposed towards psychiatric illness and/or substance abuse, which makes them more susceptible or vulnerable for certain types of dysfunctional behavior, including suicide. Childhood experiences filled with abuse, trauma, and/or neglect during the crucial, formative stages of personal development will also have a detrimental affect on the development of positive life-coping skills. A "non-supportive environment," whether at work or home, filled with stress, resentment, ridicule, or ostracized from family or friends, might also be conducive to dysfunctional behavior.

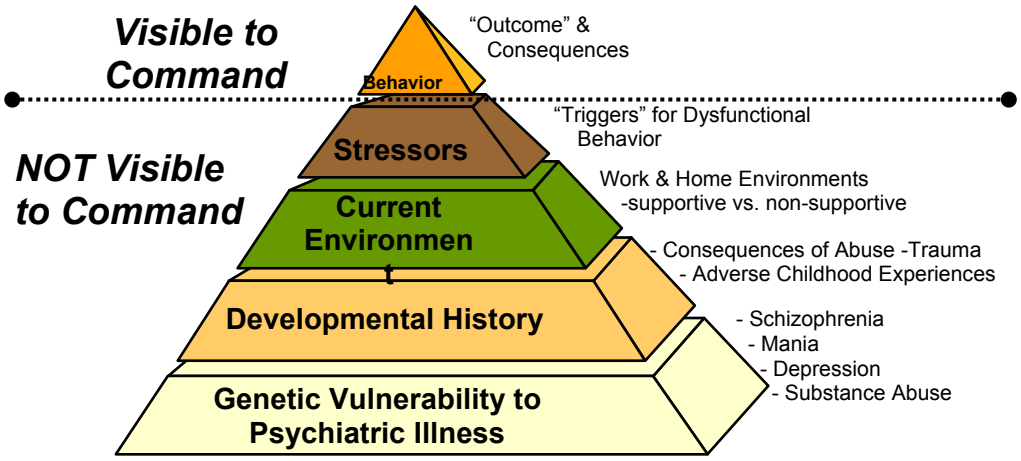


FIGURE 1

Leaders should realize that soldiers and civilians enter into the Army with varying levels of life-coping skills and resiliency as determined by their genetic disposition, developmental and environmental influences. Leaders should not assume that all soldiers and civilians entering the Army can adequately handle the inherent stress of military service or even life in general, especially if they are already predisposed to psychiatric disorder. Although it is unrealistic for a leader to understand the genetic composition of the soldier and civilian, or know their complete developmental history, leaders can make proper assessments of their life-coping skills by observation and personal dialogue focused on learning and understanding the soldier's background. This chapter is designed to explain the causes of suicide and inform leaders of common danger and warning signs so they can properly anticipate suicidal, or other dysfunctional behavior, and make preemptive referrals to professional mental health care providers before a crisis ensues.

2-2. Mental Disorders.

Mental disorders "are health conditions that are characterized by alterations in thinking, mood, or behavior, which are associated with distress and/or impaired functioning and spawn a host of human problems that may include disability, pain, or death."[1] Mental

disorders occur throughout society affecting all population demographics including age, gender, ethnic groups, educational background and even socioeconomic groups. In the United States, approximately twenty-two percent of those between the ages of 18 – 64 years had a diagnosis of some form of mental disorder.[2] Mental illness is more common than cancer, diabetes, or heart disease, filling almost 21 percent of all hospital beds at any given time. In fact, the number one reason for hospitalizations nationwide is a biological psychiatric condition. Mental disorders also affect our youth. At least one in five children and adolescents between 9 – 17 years has a diagnosable mental disorder in a given year, about five percent of which are extremely impaired.

Mental disorders vary in severity and disabling effects. However, current treatments are highly effective and offer a diverse array of settings. The treatment success rate for schizophrenia is sixty percent, sixty-five percent for major depression, and eighty percent for bipolar disorder. This compares to between 41-52 percent success rate for the treatment of heart disease.

In 1996, the Assistant Secretary of Defense for Health Affairs commissioned Dr. David Schaffer, a leading authority on suicide prevention, to analyze the Department of Defense Suicide Prevention Programs. He completed his study that included an in-depth analysis of each service suicide prevention program, in 1997. A key point stressed by Dr. Schaffer was that most suicides are associated with a diagnosable psychiatric disorder such as depression and/or substance abuse. These disorders generally manifest themselves in some form of clinical depression, a disorder that can increase suicidal risk (often in combination with substance abuse), anxiety, impulsiveness, rage, hopelessness and/or desperation.

Although it is the responsibility of the professional mental health care provider to diagnose a mental disorder, there are certain behaviors that indicate an underlying mental disorder. Leaders should be cognizant of these warning behaviors that might indicate the presence of a mental disorder which place soldiers at risk for suicide or other dysfunctional behavior. They are:

- impulsiveness or aggressive-violent traits,
- previous other self-injurious acts,
- excessive anger, agitation, or constricted preoccupations,
- excessive alcohol use,
- heavy smoking, and
- evidence of any sleep or eating disorder.

Leaders who spot such behavior and/or suspect that one of their soldiers or civilians is suffering from a mental disorder should notify their chain of command so that the commander can decide upon making a referral to a mental health care provider. It is important to note that persons with mental disorders are often unable to appreciate the seriousness of their problem, as the disorder frequently distorts their judgement. Therefore, they must rely upon others for assistance.

2-3. Developmental History

Developmentally, the home/family environment where reared will influence one's behavior. Unfortunately, many of today's youth are growing up in "non-traditional" homes, without two consistent parenting figures. This can be detrimental to the

development of "well-adjusted" individuals capable of handling life's general stresses and potentially lead to dysfunctional behavior, including suicide. According to Tondo and Baldessarini,[3] the suicide rate for America's youth is higher in single-parent families, especially when the father is not present. This is particularly alarming considering that over 40% of the youth today are from "non-traditional" homes,[4] which could explain why the suicide rate among America's youth is rising.

Childhood abuse or neglect might also adversely affect the positive development of life-coping skills and lead to dysfunctional behavior. A research article released in 1998 by the American Journal of Preventive Medicine commonly referred to as "The ACE Study," (adverse childhood experiences) stated that there was a "strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death."[5] These adverse childhood experiences include psychological, physical or sexual abuse, and exposure to dysfunctional behaviors including living with a substance abuser, someone with a mental illness, domestic abuse, or criminal activity. As exposures to ACEs increased, so did the risk of several health-related problems including smoking, obesity, depression, use of illegal drugs, promiscuity, and even suicide. According to Legree[6] in a report published in 1997, the consequences of these adverse childhood experiences could cause friction within the Army as those recruits that have been abused can:

- have a significant distrust of authority figures,
- have an over-reliance on self,
- tend to form sexualized relationships prematurely,
- have a increased risk for substance abuse,
- not easily transfer loyalty to institutions such as the Army, and
- have a "me-oriented" attitude, often seeking short-term payoffs.

Other studies indicate that adverse childhood experiences may be prevalent within our recruits. A U.S. Naval Behavioral Health Research Study released in 1995 reported approximately 40% of all Naval recruits self-report having been raised in homes where they were physically and/or sexually abused and/or neglected.[7] In the same study, 45.5 percent of all female recruits reported having a sexual assault before entering the service.

Although today's youth tend to be more technologically astute than previous generations, generally they have less developed relationship skills, especially in anger management. With the prevalence of personal computers and multiple televisions within the household, many of American's youth are spending less time personally interacting with others, which can lead to deficiencies in the development of healthy social skills. As with physical and mental skills and abilities, recruits enter the Army with varying levels of social and life coping skills. A prudent leader will recognize this fact, attempt to assess those assigned to his or her care, and determine who might require remedial assistance and mentoring.

2-4. Influence of the Current Environment

The Army's opportunity for intervention and influencing behavior begins when the soldier or civilian reports to initial entry training (IET) (or equivalent) and lasts beyond their term of service. This intervention can either have a positive or negative influence on their behavior. Small unit leaders should strive to positively impact constructive life coping skills and create an environment filled with support, respect and acceptance,

where individuals feel they are an integral part of a team. This supportive environment can potentially block certain types of dysfunctional behavior by providing soldiers and civilians a support system and adequately equipping them to properly handle life's stressors. The results or reward of a supportive environment (represented in the top left "output" box in Figure 2) will be a better-adjusted individual. Conversely, if the small unit leader creates an environment where negative life coping skills are reinforced or positive life coping skills are ignored, such an environment could then possibly contribute to dysfunctional behavior (represented in the top right "output" box in Figure 2).

Small unit leaders have the most crucial role in establishing and determining the conditions of the soldier and civilian's work environment. These leaders should strive to have a positive influence on them by being a proper role model for them to emulate. For some soldiers and civilians, their role and camaraderie within their unit and the relationship with their first line supervisor might be the only positive, life-sustaining resource available to them in times of adversity. Therefore, everyone should take this responsibility seriously.

Senior leaders are responsible for the development of junior leaders to ensure that they are aware of the importance of being a proper role model and fostering a positive work environment. Commanders and senior Non-commissioned officers and civilian leaders should constantly assess their junior leaders' ability to positively influence behavior. It could be a disastrous mistake to assume that all junior leaders are reinforcing positive life coping skills in the presence of their soldiers and civilians, especially considering that over half of the Army suicides within CY 2001 were in the rank of Sergeant or above (including commissioned officers).

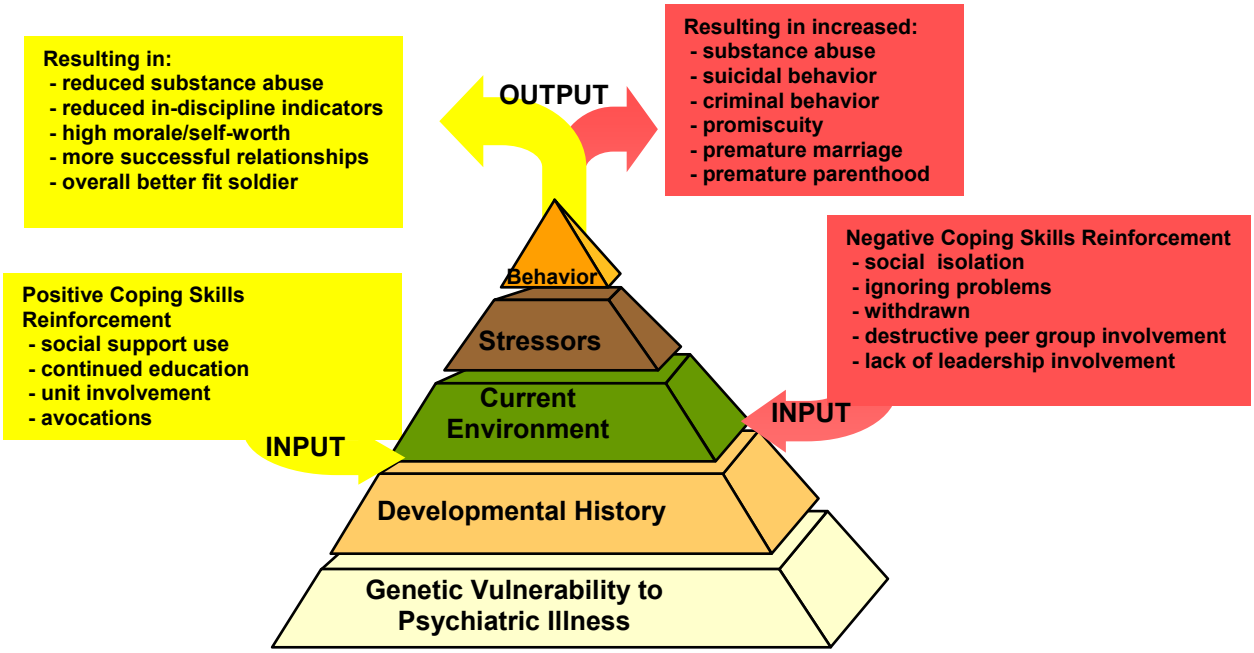


FIGURE 2

Not all suicidal behavior is preventable, but time invested in the positive behavioral development of our soldiers can yield many benefits, especially for younger soldiers.

2-5. Suicide "Triggers"

Although psychiatric illness or substance abuse contributes to a majority of all suicides, the timing of suicide behavior and a significant emotional event, particularly those involving a loss, separation or any change in one's self-esteem and confidence are often linked together.

A review of Army psychological autopsies reveal that approximately seventy-five percent of all soldiers that commit suicide were experiencing "significant problems" within a personal, intimate relationship. In addition, about half had just received or were pending some form of legal action (whether civilian or UCMJ). Approximately forty-two percent were experiencing financial problems and thirty-four percent were known to be suffering from either drug or alcohol abuse problems. Many of the soldiers that completed suicides were experiencing more than one of the problems mentioned above. Leaders must realize that each individual will handle a particular life stressor differently. Some will require assistance, which can range from talking with a friend, to professional counseling. Ignored, or left without any assistance, the stressor can turn into a "life crisis," which could lead to suicide ideation or behavior. Therefore, all leaders should anticipate potential "life crises" and ensure that the individual has the proper resources to handle the adversity. This might include appointing a "life-line" buddy to watch over the individual until the crisis has passed or referral to the unit chaplain or other professional counselors.

Provided below is a list of potential triggers for suicide.

- Loss of a loved one to illness or death.
- Loss of a significant, intimate relationship (divorce, separation, break-up).
- Loss of a child custody battle.
- Loss of friendship or social status (social isolation or ostracism).
- Loss of a job, rank (UCMJ or civilian legal action, separation).
- Loss of freedom (incarceration).
- Loss of financial security (pay loss/reduction, gambling debts, bankruptcy).
- Loss of self-esteem (humiliation, pass over for promotion or schooling).
- Loss of hope or feeling helpless.
- Loss or change in lifestyle (unwanted PCS, major deployment).

Obviously, a common theme for all these potential triggers for suicide is associated with some form of a loss.

2-6. Reasons for Dying

To the "well adjusted" person, suicide is an irrational act. This attitude however might interfere with a person's ability to promptly intervene if they assume that everyone shares their opinion. Some consider suicide a method of ending or escaping from pain or other problems. An understanding of the psychodynamics of suicide is crucial for understanding and potentially predicting suicidal behavior. Dr. Tondo and Baldessarini in an article in Psychiatry Clinical Management,[3] explained suicide psychologically "as an excessive reaction arising from intense preoccupation with humiliation and disappointment that is driven by punitive and aggressive impulses of revenge, spite, or self-sacrifice, wishes to kill and be killed, or yearning for release into a better experience through death."

As previously mentioned, a review of the psychological autopsies revealed that many suicides occurred during or immediately following a problem with an intimate relationship. Some of these suicides could be explained as "death as retaliatory abandonment," a termed coined by Dr. Hendin.[8] In these particular cases, the suicide victim attempts to gain an "illusory control over the situation in which he was rejected." By committing suicide, the victim believes that they will have the final word by committing the final rejection, thus maintaining "an omnipotent mastery through death." An example could be a person who commits suicide following a loss of an intimate relationship where the spouse or significant other initiated the break-up. Here the person attempts to regain control over the situation and dictate the final outcome, which is to reject life.

Another potentially common reason for suicide within the Army is "death as a retroflexed murder" where according to Hendin; the suicide stemmed from anger and was an indirect attempt at revenge against another person. An example could be a soldier returns from an extended deployment and discovers that their spouse is (or was) having an affair. The soldier's feelings turn into a "murderous rage" which leads to suicide. In this example, suicide represents an inability to repress violent behavior, perhaps due to an "overt desire to murder," and allows the "murderous rage" to act out in a violent act against oneself.

Dr. Hendin also explains suicidal reasoning as "death as self-punishment," which he notes is more frequent in males. In these cases, perceived or actual failure causes "self-hatred" which leads to suicide as a form of "self-punishment." Hendin notes that this reaction is more common in men who place extremely "high and rigid" standards for themselves. An example could be a soldier who is pending UCMJ action, or perhaps possible separation from the Army and feels that they have failed and whether through humiliation or embarrassment, feels that they don't deserve to live.

Jobes and Mann[9] examined Suicide Status Forms from various counseling centers and determined that they could categorize suicidal patient's reasons for dying and that these categories vary with responses. They then listed the most frequent categories or reasons for dying which are listed below in descending order beginning with the most frequent.

- Escape – general. General attitudes of giving up or needing a "rest."
- General descriptors of self. References to self such as "I feel awful" or "I'm not worth anything."

- Others/relationships. References to other people such as “I want to stop hurting others” or “retribution.”
- Feeling hopeless. Statements referring to hopelessness such as “Things may never get better” or “I may never reach my goals.”
- Escape-pain. Statements about lessening the pain such as “I want to stop the pain.”
- Feeling alone. Statements that reflect loneliness such as “I don’t want to feel lonely anymore.”

2-7. Suicide Danger Signs
The list below contains immediate danger signs that suicide behavior is imminent.

- Talking or hinting about suicide.
- Formulating a plan to include acquiring the means to kill oneself.
- Having a desire to die.
- Obsession with death including listening to sad music or poetry or artwork.
- Themes of death in letters and notes.
- Finalizing personal affairs.
- Giving away personal possessions.

Anyone who recognizes these warning signs must take immediate action. The first step should be to talk to the individual, allow them to express their feelings and asked them outright and bluntly, “are you considering suicide?” or “are you thinking about killing yourself?” If their response is “yes” then immediate life-saving steps are required, such as ensuring the safety of the individual, notifying the chain of command or chaplain, calling for emergency services or escorting the individual to a mental health officer.

The most important point to consider is to never ignore any of these suicide danger signs or leave the suicidal person alone. After all, you might be the last person with the opportunity to intervene.

2-8. Suicide Warning Signs
The list below contains some warning signs that might precede suicide behavior. Although not as serious as the danger signs previously listed, they should not be disregarded and also require immediate personal intervention. The list includes:

- Obvious drop in duty performance.
- Unkempt personal appearance.
- Feelings of hopelessness or helplessness.
- Family history of suicide.
- Made previous suicide attempts.
- Drug or alcohol abuse.
- Social withdrawal.
- Loss of interest in hobbies.
- Loss of interest in sexual activity.
- Reckless behavior, self-mutilation.
- Physical health complaints, changes/loss of appetite.
- Complaints of significant sleep difficulties.

These signs signal that the person might be experiencing a life-crisis and requires assistance. It is the responsibility of all leaders and the duty of all soldiers and civilians to watch for these danger and warning signs and realize that they might not be capable of helping themselves and therefore, require immediate action.

In addition to the warning signs provided above, there are certain feelings or emotions that might precede suicide. The following is a list of possible feelings or attitudes that the individual at risk for suicide might be feeling. This does not suggest that everyone who has these feelings are at risk, but these feelings persist, then it could signal that the person is having difficulty coping with what ever has initiated the feelings. The most common feelings are:

- hopelessness or helplessness
- angry or vindictive
- guilty or shameful
- desperation
- loneliness
- sad or depressed

Leaders, soldiers and civilians must be confident that the "life crisis" has resolved itself before assuming that the person is no longer suicidal based solely upon the person's behavior. Some individuals might appear to be over their crisis, when in fact, they only appear "normal" because of the relief they feel in having decided on how they are going to resolve their problem through suicide.

2-9. Resources for Living.
Certainly, it is important to understand what causes suicide behavior, but it is also vitally important to understand those resources that offer protection against dysfunctional, self-injurious behavior. Tondo and Baldessarini provide the following list of protective factors against suicide.

- Intact social supports, including marriage.
- Active religious affiliation or faith.
- Presence of dependent young children.
- Ongoing supportive relationship with a caregiver.
- Absence of depression or substance abuse.
- Living close to medical and mental health resources.
- Awareness that suicide is a product of illness, not weakness.
- Proven problem-solving and coping skills.

Just as important as recognizing reasons for suicidal behaviors are reasons for living. Jobes and Mann categorized the top reasons for living in the list provided below (in descending order beginning with the most prominent).

- Family. Any mention of a family member's love.
- Future. Statements that express hope for the future.
- Specific plans and goals. Future oriented plans.
- Enjoyable things. Activities or objects that are enjoyed.
- Friends. Any mention of friends.

- Self. Statements about qualities of self such as " I don't want to let myself down."
- Responsibilities to others. Any mention of obligations owed to others or the thought of protecting others.
- Religion. Statements referring to religion.

Leaders should understand what serves as a source of strength or life-sustaining resource for the soldier and civilian and use them when counseling them through a particular crisis. Also, by understanding a soldier or civilian's life resources will alert the leadership to potential problems when one of those resources have been removed or is in danger.

Chapter Three – The Army Suicide Prevention Model

"Knowing is not enough, we must apply.
Willing is not enough, we must do."
Goethe

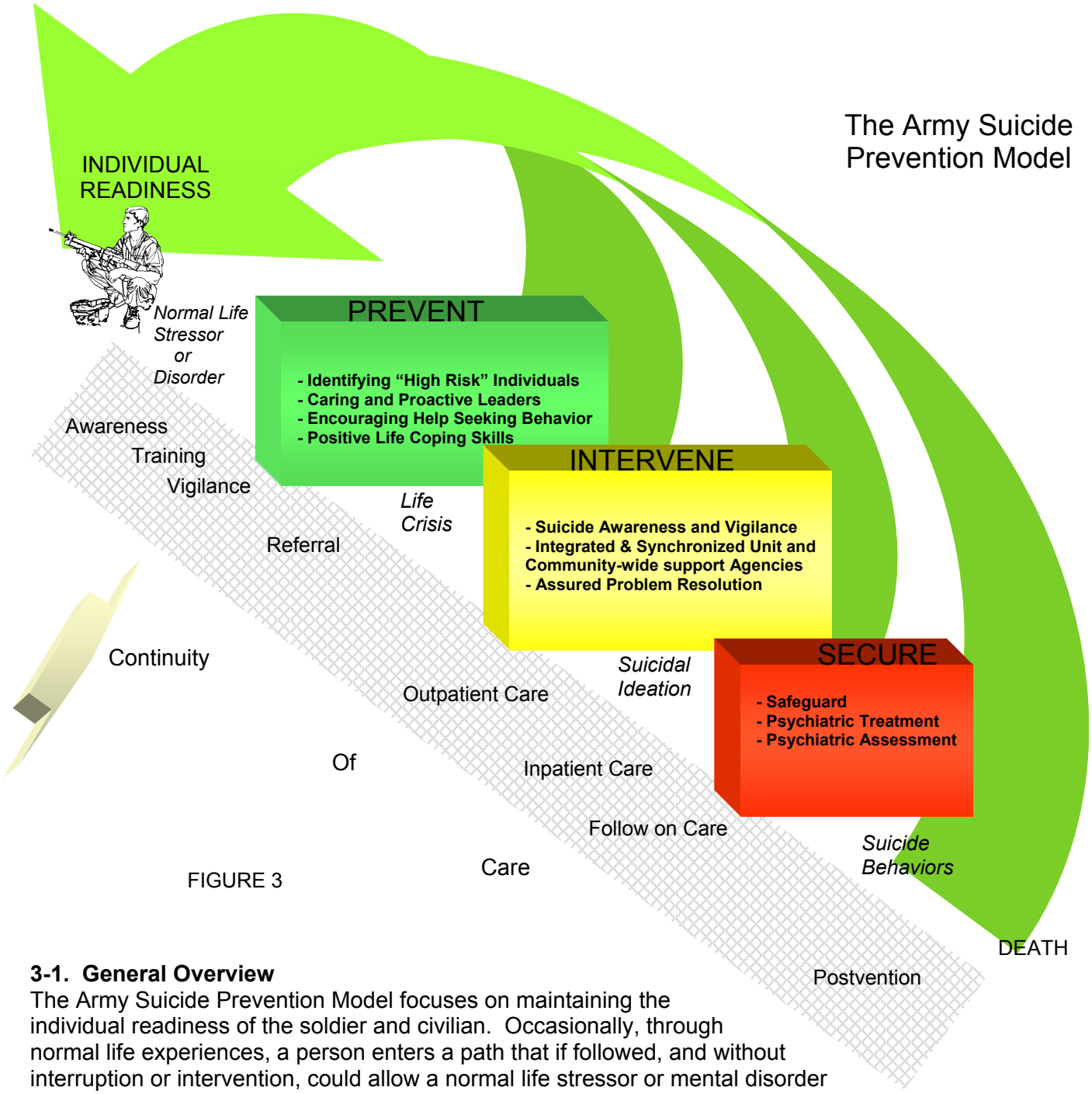


FIGURE 3

3-1. General Overview

The Army Suicide Prevention Model focuses on maintaining the individual readiness of the soldier and civilian. Occasionally, through normal life experiences, a person enters a path that if followed, and without interruption or intervention, could allow a normal life stressor or mental disorder to become a life crisis, which might lead to thoughts of suicide and eventually suicidal behavior and possible injury or death. Parallel to the suicidal path is a "safety net" that represents the Army's continuity of care. As the

actual suicidal risk escalates, so does our response by becoming more directive and involving more professional health care providers. To prevent a person from progressing down the suicidal path are three "barriers" which are: prevention, intervention, and secure. These barriers target specific programs and initiatives for varying degrees of risk to block any further progress along the suicidal path. Provided below is a quick outline of each of these "barriers" with more detailed strategies following in Chapters Four, Five, and Six.

3-1a. Prevent. Prevention is our "main effort" to minimize suicidal behavior. It focuses on preventing normal life "stressors" from turning into a life crisis. "Prevention Programming" focuses on equipping the soldier and civilian with the coping skills to handle overwhelming life circumstances that can sometimes begin a dangerous journey down a path to possible suicidal behaviors. This barrier allows the individual to operate "in the green" or at a high state of individual readiness. Prevention includes establishing early screening to establish baseline mental health and offer specific remedial programs before the occurrence of possible dysfunctional behavior. Prevention is absolutely dependent on caring and proactive small unit leaders who make the effort to know their subordinates, including estimating their ability to handle stress, and offer a positive, cohesive environment which nurtures and develops positive life coping skills.

3-1b. Intervene. Intervention is the barrier that prevents any life crisis or mental disorder to lead to thoughts of suicide. It recognizes that there are times when one should seek professional assistance/counseling to handle a particular crisis or treat a mental illness. In this area, early involvement is a crucial factor in suicide risk reduction. Intervention includes alteration of the conditions, which produced the current crisis, treatment of any underlying psychiatric disorder(s) that contributed to suicidal thoughts, and follow-up care to assure problem resolution. Commanders play an integral part during this phase as it is their responsibility to ensure that the particular problem or crisis has been resolved before assuming that the threat has passed. This barrier is color-coded "yellow" because it warrants caution and the individual readiness is not to an optimal level since the individual might be distracted by the life crisis.

3-1c. Secure. The third and final barrier in this model is perhaps the last possible opportunity to prevent an act of suicide. This occurs when an individual is at risk for suicidal behavior. When someone becomes suicidal, then someone must secure and protect them before they can harm themselves and/or others. This is "tertiary prevention" and requires immediate life-saving action. The focus within this area will be to educate everyone to recognize those suicidal danger and warning signs and if recognized, take immediate, life-saving action. This barrier is color-coded "red" due to the severity of the situation. This individual is considering or has already decided to commit suicide and is in imminent danger of harming him or herself, or possibly others as well.

3-1d. Continuity of Care. The safety net underneath the suicidal path within the model represents the continuity of care that the Army is required and obliged to provide those individuals at risk for suicide. It starts with awareness of the impact and magnitude of suicide within the Army. It continues with training, education, and ensuring constant vigilance of those who might be at risk for suicide. As the risks increases, so does the level of required care, including referrals to professional gatekeepers and if appropriate, in-patient care until assurance of problem resolution. The most intensive care will be required to those who actually commit a suicide act, ranging from medical care and

psychiatric therapy (for non-fatal suicide acts) to bereavement counseling for surviving family members and personal counseling for unit members for completed suicides.

The Army Suicide Prevention Model is to assist those who have any ambivalence towards dying. All leaders should understand that no suicide prevention plan will completely eliminate suicidal behavior. Despite our best efforts, there will always be some, whether through their genetic predisposition and/or their developmental history, who will be more susceptible to suicidal behavior. Some will travel down the path to suicide without ever displaying any recognizable danger signs. Some travel down the path very quickly and don't want any intervention. Suicide is an individual decision and therefore, ultimately, the responsibility of the individual. However, that doesn't relinquish our obligation, but only serves as a challenge to be vigilant and aware so that we can identify all who are at risk and apply the appropriate level of intervention.

Chapter Four – Prevention

A commander should have a profound understanding of human nature…
Sir Basil Liddell Hart

4-1. Identifying "High Risk" Individuals
This phase begins with pre-screening upon arrival for initial entry training (IET) within the Army to identify those individuals considered high risk for suicidal behavior. Today's recruits enter the Army with varying resiliency levels to handle stress, anger and intimate personal relationships. As previously discussed, some are predisposed to dysfunctional health risk behaviors. Recognizing that the baseline mental health of our inductees may be less than optimum requires proactive identification and targeted education/intervention and ongoing mentoring by unit leadership. This intervention will assist the first term soldier and civilian in avoiding some of the normal pitfalls that can lead to mental health dysfunction and subsequent early attrition. These pitfalls include:

PREVENT

- **Identifying "High Risk" Soldiers**
  - Pre-screening for Adverse Childhood Experiences
- **Caring and Proactive Leaders**
  - Understanding Potential "Triggers"
  - Sense of Unit Belonging/Cohesion
- **Encouraging Help-Seeking Behavior**
- **Teach Positive Life Coping Skills**
  - Total Physical, Spiritual, and Mental Health
  - Avoidance of Stress-inducing Behaviors

TABLE 1

- Premature marriage
- Premature parenthood
- Excessive debt
- Substance abuse
- Dysfunctional behaviors resulting in UCMJ
- Authority difficulties
- Inability to form positive supportive relationships
- Excessive time demands relative to time management skills
- Family of origin problems-acute and unresolved from past
- Dissonance between expectations and reality

4-2. Caring and Proactive Leaders
Although our first line of defense will be our soldiers and civilians," truly our most valuable player in suicide prevention will be the small unit leader or first line supervisor. These leaders must recognize that the most important resources entrusted to their care are their soldiers and civilians. Suicide prevention requires active and concerned leaders who express a sincere interest in the overall welfare of their subordinates. This includes taking the time to learn as much as they can about the personal dynamics of their subordinates. They must be able to recognize serious personal problems before they manifest themselves as dangerous dysfunctional behavior(s). Leaders should be trained to recognize the basic symptoms of a serious mood disorders such as depression and substance abuse. The intent is not to train leaders to make a clinical diagnosis, but rather to alert the chain of command of a particular concern, so that the commander can make an informed, "pre-emptive" decision to make a referral to a professional MHO. In addition, all leaders should be familiar with those stressors and

potential suicidal "triggers" and know when one of their soldiers or civilians are experiencing a crisis and might be at risk.

All leaders should strive to create and foster an environment of acceptance and cohesion for all members of their unit or section. No one should ostracize or make any member of a unit feel unwelcomed, regardless of their action. Everyone should feel that they are a valuable part of the team and that others depend on them. This is especially true when someone is facing a problem or potential life crisis, whether personal or professional.

4-3. Encouraging Help Seeking Behavior

All leaders should encourage help seeking behavior within their subordinates, without fear of repercussions. Many senior soldiers and civilians fail to seek professional assistance from a MHO for fear of reprisals, embarrassment, guilt, or shame. According to a 1998 DoD Survey of Health Related Behaviors Among Military Personnel, only 24 percent of soldiers surveyed believed that receiving mental health counseling would not hurt their career. It is therefore easy to understand that although 17.8 percent of soldiers feel that they have needed mental health counseling in the past, only 5.6 percent actually sought and received help.

DoD Survey of Health Related Behavior

	DOD	
Perceived Need for Mental Health Counseling	**17.8%**	**17.6%**
Receipt of Mental Health counseling **from military mental health professional**	**5.6%**	**5.2%**
Perceived Damage to Career		
Definitely Will	17.7%	20.7%
May or May Not	**58.1%**	**59.8%**
Definitely Will Not	**24.2%**	**19.5%**

TABLE 2

Clearly, for our suicide prevention program to be effective, we have to reduce the perceived stigma of seeking mental health counseling. We can reduce the stigma by first ensuring against inadvertent discrimination of soldiers and civilians who receive mental health counseling, and secondly by supporting confidentiality between the individual and MHO. Both of these objectives will require comprehensive and command-supported efforts to review policies and procedures.

Confidentiality in the face of suicide risk must strike a balance between safeguarding the individual and/or the public and protecting their privacy rights. In order to enhance the ASPP and overall effectiveness of the mental health care services, commanders will respect and honor prescribed patient-doctor's privacy rights as prescribed in DoD Regulations, and applicable statutes, including Privacy Act, 5 U.S.C. 552a. Therefore, confidential mental health care communications shall, except as provided by DoD Regulations, not be disclosed. Exceptions to this general rule include, but are not limited to:

- when the patient has given their consent, or
- when the mental health professional believes that a patient's mental or emotional condition makes the patient a danger to himself or herself, or to any other person, or

- when the mental disorder indicates a degree of impairment otherwise suggesting unsuitability for retention in military service, or
- in the case of an adjustment disorder of a military member during the member's initial 180 days of military service, or
- military necessity to ensure the safety and security of military personnel, family members, or government property.

Therefore, mental health professionals will inform the responsible unit commander when one of their soldiers or civilians is at an elevated risk for suicide, or at risk for other dangerous behavior, or if the commander referred the individual. Otherwise, the individual's privacy takes priority and the Army will respect it.

4-4. Teach Positive Life Coping Skills Development

Prevention also includes developing the soldier and civilian's mental resiliency, emphasizing avoiding premature stress-inducing decisions (i.e., as getting married too young, or starting a family). It is important for all leaders to recognize that mental wellness is a component of the triad of overall individual fitness (physical and spiritual being the other two).

Positive life coping skills training may include alcohol abuse avoidance, financial management, stress and anger reduction, conflict management, and parenting and family life skills such as the Building Strong and Ready Families (BSRF) seminar originated within the 25th Infantry Division. BSRF offers married couples an opportunity to strengthen their relationship through various instruction and exercises. The seminar was targeted for those newly married couples who were interested in improving their communication skills and generally being better equipped to handle the stresses of married life, including child rearing. Programs such as BSRF are a great example of how to develop life-coping skills and will indirectly have a positive impact on reducing suicidal behavior.

Chapter Five – Intervention

The only thing that can save a human life is a human relationship!

5-1. Suicide Awareness and Vigilance

This phase deals with individuals who are dealing with a particular crisis, that left untreated, can lead to suicidal behavior. Suicide intervention can involve anyone. The strategy of the ASPP is to train everyone in basic suicide awareness so they can spot someone who is displaying suicidal warning or danger signals and know what actions to take to protect the person at risk. Leaders will ensure that all of their subordinates have received this training at some point in their career. Conduct refresher training as required.

INTERVENE

- **Suicide Awareness and Vigilance**
  - Targeted Training for Specific Audiences
- **Integrated & Synchronized Unit and Community-wide support Agencies**
  - Accountability for Prevention Programs
- **Assured Problem Resolution**

5-2. Applied Suicide Intervention Skills Training (ASIST)

Raising awareness and vigilance will invariably increase the number of "false-positives" or those who identified as at risk for suicide, but are not actually considering suicide. These "false-positives" could overwhelm community mental health resulting in increased workloads and longer referral times for those who are actually at risk. To reduce the number of "false-positives" and to assist the commanders in making an informed determination of suicidal risk, will require professional training (such as Living Works Applied Suicide Intervention Training – ASIST). This training must be easily accessible to the unit commanders, (a minimum of one person trained in every battalion). Such training is not just limited to chaplains. During Desert Shield and Storm, V Corps units sponsored many ASIST Workshops for unit leadership and civilians in preparation for an expected increase in the number of potential 'at-risk' individuals.

Founded as a partnership in 1983, Living Works Education is a public service corporation dedicated to providing suicide intervention training for front-line caregivers of all disciplines and occupational groups. The Living Works objective is to register qualified trainers in local communities, who in turn can prepare front-line gatekeepers with the confidence and competence to apply immediate "first-aid" suicide intervention in times of individual and family crises. The ASIST workshops include instruction on how to estimate suicidal risk and apply an intervention model that reduces the immediate risk of suicide. The purpose of ASIST is not to produce personnel qualified to diagnose mental disorders, or to treat suicidal individuals, but rather provide the immediate first aid response for those individuals until such time they can be referred to a trained, professional mental health care provider.

ASIST "T-2" is a two-day workshop that commanders should offer to all military and civilian gatekeepers. Each T-2 course is limited to approximately thirty individuals and requires two "T4T" level trainers.

ASIST T4T's. Each major installation should have at least two ASIST T4T qualified trainers that could conduct the ASIST T-2 workshops on their installations or within their geographical region. One of these two should be the installation Family Life Chaplain. Family Life Chaplains work closely with allied helping professionals within the installation and local community. In addition, part of their responsibilities include training Chaplains and their assistants assigned to Unit Ministry Teams. Family Life Chaplains have also received additional training that would enhance the ASIST training and would therefore be excellent candidates to sponsor and conduct the training. To become an ASIST "T4T" qualified trainer requires attendance of the five day trainers course taught by Living Works Education.

For every Family Life Chaplain in an installation, there should be an allied helping professional or mental health professional who will be the ASIST T4T training partner. This could be someone within the Family Advocacy Program, another Chaplain assigned to the post or installation, the Community Health Nurse, or any professional civilian or military counselor. Consider longevity, demeanor, ability (time) to conduct the workshops when deciding who should become an ASIST T4T.

ASIST Workshops. Each installation T4T team must conduct at least three ASIST workshops in the first year following the T4T qualification training. Priority candidates for this training are the primary and secondary installation gatekeepers as specified in para 6.3c.

For more information on Living Works, visit their web-site (address provided in Annex H).

5-3. Five Tiered Training Strategy

This training will be specialized, multi-tiered five specific groups, each with different responsibilities within ASPP. Figure 4 reflects these.

Army Suicide Awareness Training Model

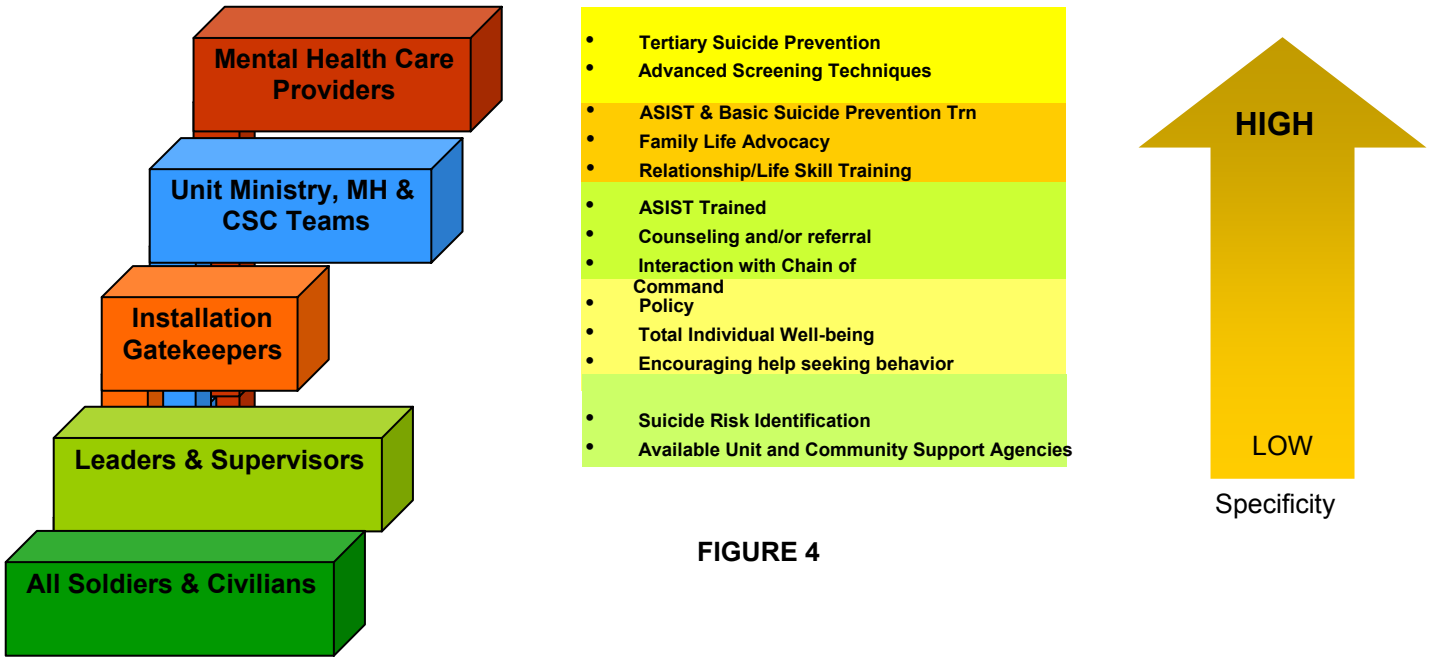


FIGURE 4

5-3a. Soldiers & Army Employees. All Army soldiers and civilian employees shall receive basic training stressing the importance of mental health, stress reduction, and life coping skills. They will also learn how to recognize suicide behavior and mental disorders that place individuals at elevated risk of suicide and how to react when they spot these issues. Most suicidal individuals give definite warnings of their suicidal intentions, but others are either unaware of the significance of these warnings or do not know how to respond to them. All soldiers and civilians should receive training on how to properly identify these warning signs and know what action to take.

They must realize they may be the only and/or last hope to save a fellow soldier or civilian. Many psychological autopsies reveal that those who committed suicide had told one of more of their fellow peers, but they did not believe the individual was serious or were embarrassed or afraid to intervene. Army units should turn to either their Unit Ministry Team, brigade or division mental health, combat stress control unit on post, or local mental health section for qualified instructors. Civilian supervisors should arrange training directly through the Installation Chaplains Office or local mental health department.

Unit commanders should also encourage suicide prevention training to all spouses through the Family Readiness Groups or other unit or installation spouse education/familiarization education classes/programs.

5-3b. Leadership Training. All Army leaders shall receive training on the current Army policy toward suicide prevention, how to refer their subordinates to the appropriate helping agency, and how to create an atmosphere within their commands of encouraging help-seeking behavior. Civilian supervisors will also receive training that focuses on referral techniques/protocols for their employees.

5-3c. Installation Gatekeepers. Installation gatekeepers, those individuals who in the performance of their assigned duties and responsibilities provide specific counseling to soldiers and civilians in need, will receive training in recognizing and helping individuals with suicide-related symptoms or issues. Gatekeepers can be identified as either a “primary gatekeeper” (those whose primary duties involve primarily assisting those in need and more susceptible to suicide ideation) and “secondary gatekeepers” (those whose might have a secondary opportunity to come in contact with a person at risk). The table below describes examples of each.

Primary Gatekeepers	Secondary Gatekeepers
Chaplains & Chaplain Assistants	Military Police
ADAPCP Counselors	Trial Defense Lawyers
Family Advocacy Program workers	Youth Services
AER Counselors	Inspector General Office
Emergency room medical technicians	DoD School Counselors
Medical Health Professionals	MWR Workers
Red Cross Workers	

5-3d. Unit Ministry Teams. Chaplains and their assistants belonging to each Unit Ministry Team will assume the lead in providing suicide prevention and awareness training for their respective units. All chaplains and assistants will therefore receive basic suicide prevention/awareness and ASIST T-2 Training as determined by the Chief of Chaplains. Utilizing the USACHPPM’s resource manual as a guide, each UMT should develop lesson

plans to provide the suicide prevention/awareness training to all ranks at the platoon and company level, and NCOPD and OPDs at the battalion level.

5-3e. Combat Stress Control Teams. The 85th Medical Detachment, Combat Stress Control, following the example first set by the Medical Activity and 1st Cavalry Division in the 1980s, conducts a "Combat Stress Fitness Course" once or twice a month at Fort Hood for soldiers referred directly from their units or by way of the mental health clinics. For five duty days, the students participate in classes and practical exercises on stress management, anger management and other life skills, taught by the CSC unit mental health officers and enlisted specialists in a military, not patient care, atmosphere. Finishing the course earns a certificate of completion which has positive value for advancement. Graduates of the course who entered as candidates for chapter separation from the Army have returned months later as soldiers of the quarter, to inspire the new class. The 98th CSC Detachment at Fort Lewis periodically conducts a similar program, both in garrison and in the field during field exercises. At Fort Bragg, the 528th CSC Detachment provides "train the trainer" courses to prepare unit leaders to give their own classes to the troops, including stress control and suicide prevention.

5-3f. Mental Health Professionals. Mental Health Care Professionals will develop advanced screening techniques that the command can use to identify soldiers and civilians in need of assistance with coping skills development and or who are potentially high risk for suicides. Mental health professionals, working with the Unit Ministry Teams, are required to actively educate leaders in suicide prevention and awareness.

5-4. USACHPPM Suicide Prevention Resource Manual
US Army Center for Health Promotion and Preventive Medicine has developed an excellent Suicide Resource Training Manual complete with lesson plans and slides. All units should use this resource manual in the preparation and execution of their suicide prevention training. An electronic version of this manual is available on the USACHPPM's web site (address provided in Annex H).

5-5. Integration and Synchronization – The Installation Suicide Prevention Committee
To integrate the available "pool of resources" within an installation and local community and synchronize these resources throughout the individual unit suicide prevention programs require a central controlling agency. This responsibility should fall to some form of a standing committee on each major installation and separate activity. This committee's main responsibilities are to establish, plan, implement, and manage the installation ASPP. It will maximize and focus available resources and ensure that the local unit ASPPs are "nested" within the overall installation plan.

In the Surgeon General's Call to Action, the Surgeon General places much emphasis on increasing awareness and enhancing intervention services at the community level. It is important that whatever the form of the local program, responsibilities must be clearly established and the installation commander closely monitors and supervises the progress of their specific suicide prevention program.

The intent of establishing an Installation Suicide Prevention Committee is to focus installation and community assets towards assisting in suicide awareness and prevention. Involvement of local agencies and unit training will have a synergistic affect, which will result in minimizing suicidal behavior. Although the exact composition will depend on the specific local requirements, the garrison or installation commander

should chair the standing committee and might involve representatives from the agencies listed below. Members could serve as either permanent or "ad hoc" members as the situation dictates.

Chair: Installation or Garrison Commander

Possible Members:

-ACS	-Trial Defense/SJA	-Family Advocacy	-PAO
-Provost Marshal	-CID	-Dept of Psychiatry	-AAFES
-Post Chaplain	-MWR	-Dept of Psychology	-ADAPCP
-CPAC	-Youth Services	-DOD Schools	-IG
-Safety	-Dental	-Red Cross	
-Dept of Social Services			

In addition to determining the exact membership of the committee, it is the installation commander's prerogative to determine how often the committee will meet or if the committee's responsibilities are included within another previously established installation committee, such as an installation risk/injury reduction committee. The actual name, composition and activities of the committee are at the discretion of the installation commander. If the commander determines that the size, location, or composition of the installation wouldn't sufficiently support such a committee, then that particular commander will coordinate with another installation commander for inclusion within their suicide prevention committee.

The ISPC should form subcommittees that meet on a more frequent basis. Subcommittees might include those responsible for monitoring training and preparing reports to HQDA, another might focus on postvention suicide reaction and would be responsible for preparing or reviewing the suicidal surveillance reports, and dispatching a critical event response team that would facilitate the healing process, provide assistance in arranging unit memorials, and prevent possible contagion or "copy cat" suicides. Another subcommittee might focus on the education/training of suicide prevention at the installation level.

Another important function of the ISPC will be to link installation agencies through a communications network that can share crucial information on potential suicidal soldiers. At a minimum, this will include the Family Life Chaplain, family advocacy, SJA, CID, ADACP, Red Cross, Financial Counselors and social services. These links should feed into the local Army mental health council for consolidation and if warranted, notifying the individual's appropriate commander of the potential suicidal risk.

For detailed recommendations on establishing an installation suicide prevention standing committee, refer to Chapter 2, DA PAM 600-24, Suicide Prevention and Psychological Autopsy, 30 September 1988. Army divisions and other large activities with adequate support interested in considering establishing their own suicide prevention program (previously referred to Suicide Risk Management Teams) should refer to Chapter 3, DA PAM 600-24. This is available on-line at the Army Administrative Electronic Publication website at www.usapa.army.mil/gils/

5-6. Commander's Involvement/Responsibilities

Unit commanders are accountable for their suicide prevention programs. This includes ensuring the proper training of unit personnel and ensuring that all leaders are actively engaged in the personal welfare of their soldiers.

Once a soldier or civilian experiencing a "life crisis," is identified, it is the responsibility of the commander to ensure that that individual not only receives the proper crisis intervention, but that the problem has been fully resolved. The referral doesn't end the commander's intervention responsibility, but only initiates the involvement which continues until the commander is completely assured that the particular crisis or disorder has been resolved. This includes properly safeguarding the person at risk while they are receiving the required, professional assistance from mental health care providers.

BH professionals that are treating individuals at risk for suicide should keep the commander informed, as well as making recommendations for safeguarding the individual during the treatment, (if the treatment is outpatient care). Clear and expedient communications flow is crucial between those who are treating the individual at risk and the individual's commander to ensure disclosure of all appropriate information to enable an accurate diagnosis.

Chapter Six – Secure

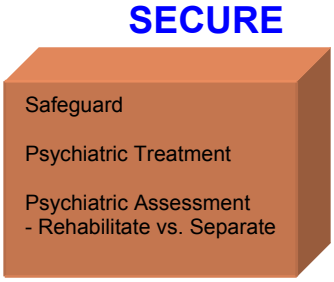


TABLE 4

6-1. Safeguard
This is perhaps our last opportunity to successfully prevent the individual from taking his or her life. At this point, the individual is now considering suicide and is in immediate danger for self-injurious behavior. If any soldier or civilian ever hears another person mention that they are considering suicide, or make any statements of an intention to die, such as, "I wish I were dead," or are displaying any of the suicide danger signs as contained in paragraph 2-7 and warning signs as contained in paragraph 2-8, then it is their responsibility and moral obligation to act.

If you suspect someone might be at risk for suicidal behavior, then the first step is to ensure the safety of the individual at risk. Talk to the individual, and listen. Ask the individual if they are considering suicide or "killing themselves." If their response is "yes," then ask if they have thought about how they would carry it out (a plan) and then determine if they have the resources to carry out the plan. This will enable you to determine the actual risk and will be useful information for the professional mental health care provider. If you believe the individual is at risk for suicide, then you must contact someone within the chain of command, a chaplain or UMT member, or the local medical treatment facility. Depending on the severity of the situation, you may have to contact the local emergency services including the military police. The main point to remember is to remain calm and don't panic and never leave the person at risk unattended.

Safeguarding for soldiers might include assigning a 24-hour watch over the individual until transfer of the individual to a local medical treatment facility or the risk has subsided. Also, if the commander feels that the individual is at risk for self-injurious behavior or is a potential danger to others, restrict the soldier to the unit area. If a soldier is determined to be at risk for suicide, and is placed on suicide watch, then other members within the unit must also be aware so that they unknowingly will not provide a method or means for the soldier to commit suicide. Commanders must also ensure that the soldier at risk does not have access to any means to commit suicide, which should include denying access to firearms, poisons, over-the-counter medications, alcohol, high places, rope, etc.

Commanders must realize that actions taken to protect a person or the public from potential harm, while shielding the at-risk person from public humiliation takes precedence over any other possible concern.

6-2. Behavioral Health Treatment
Ultimately, a professional mental health care provider at the local medical treatment facility will receive referrals for all individuals at risk for suicide. The professional mental health care provider will then determine or verify the actual risk and decide upon outpatient treatment or hospitalization.

6-3. Behavioral Health Assessment
Once admittance of a person to a hospital, it is the responsibility of the MHO to make an assessment the severity of the problem and a diagnosis on possible treatment and

prognosis for recovery. The MHO will make every effort to successfully rehabilitate the person and return them to duty. When appropriate, commanders should consider reassigning the person to another unit if in the opinion of the attending MHO and unit leadership that it would be beneficial to the person. Retain the person if successfully be rehabilitated. Mental health professionals will recommend initiation of separation procedures (medical or administrative) to the chain of command, if they assess unsuccessful rehabilitation of the person. In the case of separations, the mental health professional should recommend procedures to the commander for safeguarding the individual during the discharge, including whether or not the person is released back to his unit considering the impact on unit morale, readiness and possible contagion effects. The command will then make all efforts to prepare the person for the transition, with the priority on the individual's welfare.

Chapter Seven – Post-intervention Measures

It would be unrealistic to expect that any suicide prevention program will ever completely eliminate suicidal behavior. Despite our best efforts, there will always be some suicidal behavior that is unpreventable. In the event of an completed suicide, our efforts must focus on postvention strategies that expedite the healing process of surviving family members and members within the unit. Commanders must be aware of the potential danger of suicide contagion or "copy cat" behavior by other members within the command or, depending on the publicity of the suicide, within the installation.

7-1. Installation Suicide Response Team
The immediate time-period following a completed suicide can be very perilous as some members within the unit may feel some responsibility for the suicide and the possibility of suicide contagion also looms. Yet few company and even battalion level commanders have ever experienced a completed suicide within their units. To offset the risk, each major installation will establish policies and programs that offer immediate assistance to the commander following a completed suicide. This will include identifying members of an Installation Suicide Response Team (ISRT) that can offer assistance to the unit commander and or surviving members of a completed suicide. The membership of the ISRT will be determined by each ISPC, but at a minimum should include chaplains that can augment the UMT and help advise the commander regarding memorial services, and MHOs that can offer counseling and recommend procedures to expedite the recovery within the command. The goal of the ISRT isn't to replace the unit leadership or determine fault, but rather to advise and offer assistance.

7-2. Completed Suicide Reporting Procedures
IAW AR 600-63 & DA PAM 600-24, a psychological autopsy was required for all confirmed or suspected suicides, or those cases in which the manner of death is equivocal, or deaths resulting in accidents that are suspicious or when requested by the local USACIDC office. The purpose of the psychological autopsy was two-fold, to:

- provide the victim's commander with information about the death
- enable the Army to develop future prevention programs based upon lessons learned

However, the use of psychological autopsies has grown beyond its original function and now serves to promote the epidemiological study of suicide in the Army population. This is against the current DoD guidance which limits psychological autopsies for just those equivocal deaths or when ordered by either the medical examiner or the local USACIDC office. Therefore, a new multi-tiered reporting system will serve to provide the epidemiological study of suicide demographics, plus address any concerns or issues that the commander(s) might have concerning a confirmed or suspected suicide or determine the manner of the death. The three tiers of reporting are:

- Tier One - Army Completed Suicide Surveillance Report (CSSR)
- Tier Two - Army Suicide Analysis Report (SAR)
- Tier Three - Army Psychological Autopsy (PA)

7.2.a. Department of the Army Completed Suicide Report (CSR):
The purpose of the CSSR will be to capture the epidemiological data regarding the Army

suicide population. Beginning 1 January 2003, the CSR will be mandatory following every confirmed or suspected suicide of active duty soldiers, including ARNG and USAR soldier serving on active duty at the time of death.

The purpose of the CSR is not to assign blame. While understanding that determining any lessons learned is valuable, commanders should not take a “fault finding approach” to investigating suicides or suicide attempts, which would only serve to prolong the recovery period for the unit.

The CSR will be prepared by a MH professional, assigned by the local MEDCOM commander.

7.2.b. Army Suicide Analysis Report (SAR):
Completed by a trained MHO appointed by the local installation Director of Health Services (usually the hospital commander) after receiving a formal request from either from CID or victim's brigade commander or higher echelon commander at that installation. The SAR allows the commander an opportunity to present any concerns or questions regarding the death of a soldier or civilian to a professionally trained MHO. Any request for information would have a 30 day suspense for completion. This report would include the CSSR and additionally provide:

1) a narrative analysis which details both the developmental/historical events that predisposed the victim to suicide as well as a narrative description of the more current preceding antecedent precipitants.
2) a "lessons-learned" & recommendations section.
3) address any specific questions posed by the chain of command.

7.2.c. Army Psychological Autopsy (PA):
Completed only by a fellowship-trained forensic psychiatrist/psychologist. Initiated only at the request of the involved medical examiner doing the physical autopsy or CID investigator to resolve cases where there is an equivocal cause of death.

Annex A – Strategy Matrixes

STRATEGY 1: Develop Positive Life Coping Skills

OBJECTIVE	KEY ACTIONS
Instruct the "Understanding Dysfunctional Behavior Model" (as provided in Chapter 3) to officers and NCO's assigned to leadership positions	**1. Local MHO's develop a standardized briefing for ISPC's approval** **2. ISPC's publishes briefing on local web site or announces POC for scheduling the briefing** **3. Local commanders coordinate with local MHOs and conduct the training**
Encourage and support various life coping skills programs	**1. Identify pre-existing and emerging programs that focus on developing individual life coping skills such as: stress reduction, relationship building, financial management, preventing alcohol abuse** **2. Ensure that these programs are publicized and promoted throughout the installation and made available to soldiers (both active, reserves and retired), family members and Army civilian employees** **3. Evaluate successfulness of such programs. Share recommendations for improvements or information concerning new programs to HQDA for dissemination to other MACOMs & installations**
Build life resiliencies for those who respond to, counsel or treat suicidal patients or those exposed to suicides	**Develop services and programs, including training and education tailored for those who respond to suicides (emergency medical technicians, MP's, firefighters) or counsel those at risk (chaplains, counselors) that addresses their own exposure and potential risk. Include training/instruction on the unique requirements of providing initial assistance/counseling to surviving family members.**

STRATEGY 2: Encouraging Help Seeking Behavior

OBJECTIVE	KEY ACTIONS
Eliminate any policy which inadvertently discriminates, punishes or discourages a soldier from receiving mental health care	**All staffs and commands will conduct a complete policy review to identify any repercussions taken against soldiers for receiving mental health care. Validate those policies that should remain, eliminate those that are unwarranted.**
Educate commanders concerning confidentiality requirements as determined in objective 2.1 above	**Incorporate policy instruction in all PCC courses, including local installation company commander and 1SG Courses pre-command courses**
Ensure prompt and easy accessibility of Army and other helping agencies	**1. Educate soldiers, family members, Army civilian employees and retirees residing in the local community of the location and protocols for scheduling and receiving assistance from the available varying helping services (i.e., AER, American Red Cross, MH care)** **2. Incorporate education within installation in-processing procedures**
Foster a command climate that emphasizes help seeking behavior	**Periodic messages, announcements or statements from the senior leadership that encourages and recognizes help seeking behavior as a sign of individual strength and maturity**
Reduce the perceived stigma associated with receiving MH care	**Sponsor local programs that change perception toward mental care services. Programs should include adopting national programs, public service announcements and developing localized, targeted programs that involve varying media sources**
Increase visibility and accessibility to local civilian health and/or social services outreach program that incorporate mental health services and suicide prevention	**1. Coordinate with local civilian health and social services to identify which services and programs are available to soldiers and family members at risk for suicide.** **2. Develop promotional campaigns to publicize such services to soldiers, Army civilian employees and family members**

STRATEGY 3: Raising Awareness and Vigilance Towards Suicide Prevention

OBJECTIVE	KEY ACTIONS
Render assistance to those known or suspected of experiencing a major life crisis	**1. Develop systems that recognize when soldiers and civilian employees are experiencing a potential life crisis in an effort to anticipate potential dysfunctional behavior.** **2. Develop programs that can provide varying levels of supervision to soldiers recognized as experiencing a potential life crisis. Such programs can vary between assigning a "battle buddy" to help the individual through the crisis, to suicide watch if the individual has actual suicide ideations**
Educate all soldiers and Army civilian employees on basic suicide prevention, which at a minimum, will cover recognizing warning and danger signs and what action to take if they suspect someone is at risk for suicide	**1. Utilizing the USACHPPM Resource Manual on Suicide Prevention as a guide, educate all soldiers and Army civilian employees on basic suicide prevention. Although not mandatory, offer such training to family members.** **2. Ensure newly assigned soldiers and Army civilian employees have previously received the basic suicide prevention education. If not, provide training within 60 days upon reporting date.** **3. Incorporate basic suicide prevention in all IET training and OBC courses**
Instruct all NCO's, officers and Army civilian supervisors on recognizing symptoms of mental health disorder and potential "triggers" or causes of dysfunctional behavior	**1. Instruction will focus on educating leadership on the common symptoms of depression, substance abuse or other forms of mental disorder** **2. Incorporate formal education on 3.2 at all basic leadership courses (OBS, PLDC)**
Maintain Vigilance toward suicide prevention and awareness	**As required, conduct periodic "refresher" training or discussions on suicide prevention in preparation for an upcoming extended deployment or redeployment, or another highly stressful event, or as designated by commanders. Maintain vigilance by either formal training including presentations, small unit discussions or even through varying local and Army wide news services and media formats. ISPC can also promote various national programs such as National Suicide Prevention Week (normally in May) and National Mental Health Month (normally in October).**
Educate married soldiers and Army civilian employees on how to appropriately store and secure lethal means of self-harm	**Conduct public information campaign(s) or instruction designed to educate Army parents how to appropriately store and secure lethal means of self-harm including medications, poisons and firearms**
Educate all Army health care providers in suicide risk surveillance	**Educate all health care providers to identify potential suicidal danger and warning signs and what actions to take if they suspect one of their patients to be at risk**
Educate installation gatekeepers on recognizing behavioral patterns that place individuals at risk for suicide and equip them with effective intervention skills to effectively reduce the immediate risk	**Train and maintain at least 90% of all "primary gatekeepers" (as defined in para 6-3c) in ASIST (or similar professional training).** **Train and maintain at least 50% of all "secondary gatekeepers" (as defined in para 6-3c) in ASIST (or similar professional training)**
Educate all UMT and Family Life Chaplains suicide awareness and prevention	**Provide formal basic and advanced suicide prevention training for all UMT members. Training will include recognizing potential danger and warning signs, suicidal risk estimation, confidentiality requirements, how to reduce the immediate risk of suicide and how to conduct various suicide prevention training at the unit level**

Educate soldiers, Army civilian employees and spouses on the safe storage of privately owned firearms	**1. Determine which soldiers within a command has a privately owned firearm.** **2. Ensure those soldiers and Army civilian employees and their spouses that own personal firearms understand the importance of responsible firearm storage in preventing suicide and accidental homicide.** **3. Ensure soldiers seeking permission to purchase a firearm are not at risk for suicidal behavior or other dangerous behavior.** **4. Encourage those soldiers who own personal firearms stored off-post and are determined to be at risk for suicidal behavior or a danger to someone else, to store their weapon in the unit arms room or with a close friend until the crises has been resolved and the risk of suicide has been eliminated.**
Incorporate screening in medical treatment facilities	**Incorporate screening for depression, substance abuse and suicide risk as a minimum standard of care for assessment in primary care settings for all MEDCOM supported healthcare programs – as part of the clinical practice guidelines initiative being implemented in the AMEDD**

STRATEGY 4: Synchronizing, Integrating and Managing the Suicide Prevention Program

OBJECTIVE	KEY ACTIONS
Synchronize and integrate local community and installation suicide prevention programs	**1. Each ISPC will develop its own charter, which addresses formal and "ad hoc" membership of the committee.** **2. Each ISPC will develop and publish its own suicide prevention program plan. Forward a copy through the respective MACOM HQ to DAPE-HR-PR (ODCSPER)**
Reduce risk of contagion, provide counseling to surviving family members and expedite the unit personnel recovery	**Establish policies and procedures for the implementation of an Installation Suicide Response Team**

STRATEGY 5: Conduct Suicide Surveillance, Analysis and Reporting

OBJECTIVE	KEY ACTIONS
Capture data on the number of non-fatal suicide events such as attempts and gestures	**1. Determine pertinent data fields and develop the actual reporting format and procedures. Ensure format and procedures do not violate Federal, State or DoD regulatory or directives** **2. Implement reporting procedures** **3. Include statistics in monthly suicide surveillance update. Provide information to DCSPER and post information on the Army Suicide Prevention Web Site**
Conduct suicide surveillance in all Army MTF emergency rooms	**Ensure that health care providers that work in Army MTF emergency rooms receive proper training in identifying those individuals whose injuries might have been self-inflicted**
Increase percentage of soldiers keeping follow-up mental health appointments	**Establish procedures and guidelines that ensure soldiers keep their mental health care appointments, especially when considered at risk for suicide**
Identify and share effective suicide prevention programs	**Identify those proven programs and initiatives effective in reducing the risk of suicide and share those programs and initiatives with the various MACOMs. Programs will range from the installation level to MACOMs and also include "best-science methodology" as determined by the Surgeon General or other branches of the service.**
Assess availability of mental health and substance abuse treatment services for youth and DoD Schools	**Assess availability of mental health and substance abuse treatment services for youth to determined the need for school-based clinical services for DoD schools**
Improve reporting of suicidal behavior in news media	**1. All Army news services/media divisions will adopt recommendations/guidelines concerning reporting suicides as provided by the 1989 Health Resources and Services Administration workshop sponsored by the New Jersey Department of Health, or AAS, NIMH, CDC, or other established suicide prevention organization. The design of these recommendations is not to restrict the reporting of suicides, but change the manner in which the suicide is reported. These recommendations will minimize suicide contagion.** **2. Installation PAOs should be familiar with such guidelines and recommend that local news media adopt such guidelines when reporting about suicides within the installation or local community.**

Annex B - Checklists

The following checklists serve as a guide that will assist commanders in developing their own specific suicide prevention program.

All Soldiers.
As the first line of defense and perhaps the most important person in suicide prevention:
- ✓ Know suicidal danger & warning signs and the leading causes for suicides. Remain vigilant!
- ✓ Take immediate action when suspecting someone is suicidal or if someone admits that they are contemplating suicide.
- ✓ Become aware of local helping services and protocols for use.

First Line Supervisors/Leaders.
- ✓ Get to know your soldiers so that you can recognize and even anticipate possible dysfunctional behavior.
- ✓ Assess each of your soldier's life-coping skills. Seek opportunities to positively influence your soldier's behavior.
- ✓ Ensure proper training of all your soldiers in suicide prevention/awareness.
- ✓ Create an atmosphere of inclusion for all. Never ostracize any of your soldiers, regardless of their actions.
- ✓ Know potential triggers for suicide.
- ✓ Know potential warning signs for mental illness.
- ✓ Set the example, take advantage of available helping services.
- ✓ Reduce the perceived stigma regarding mental health. Remember that most mental illnesses are treatable and are a result of a sickness, not weakness.

Commanders
- ✓ Maintain vigilance. Ensure that members of your UMTs have knowledge of possible life crisis or pending UCMJ actions.
- ✓ Offer suicide prevention/awareness training for all spouses.
- ✓ Ensure all newly assigned soldiers are aware of the location and protocols for utilizing installation support agencies.
- ✓ Conduct OPD/NCOPDs for your units that focuses on some aspect of mental illness such as recognizing potential warning signs.
- ✓ Ensure that your UMTs have received formal suicide prevention training currently conducted at the Menninger Clinic and have also undergone the Living Works Applied Suicide Intervention Skills Training (ASIST) Workshop.
- ✓ Promote help-seeking behavior as a sign of strength. Working with the mental health provider, respect solder/counselor confidentiality when the soldier's mental health is not in question and when the soldier is not a threat to himself, not a threat to others, or if they are able to perform their prescribed duties.
- ✓ Develop well-defined procedures for registering and storing privately own weapons. Ensure procedures are in place that deny access to firearms during times of suicidal watch.
- ✓ Ensure any Guard or Reservists attached to your unit for deployment have received proper suicidal prevention training and screening prior to deployment.
- ✓ Ensure there are "family reunion" seminars for both soldiers and family members to assist in the successful integration of the soldier back into his family following an extended deployment.

Unit Ministry Teams (UMTs)

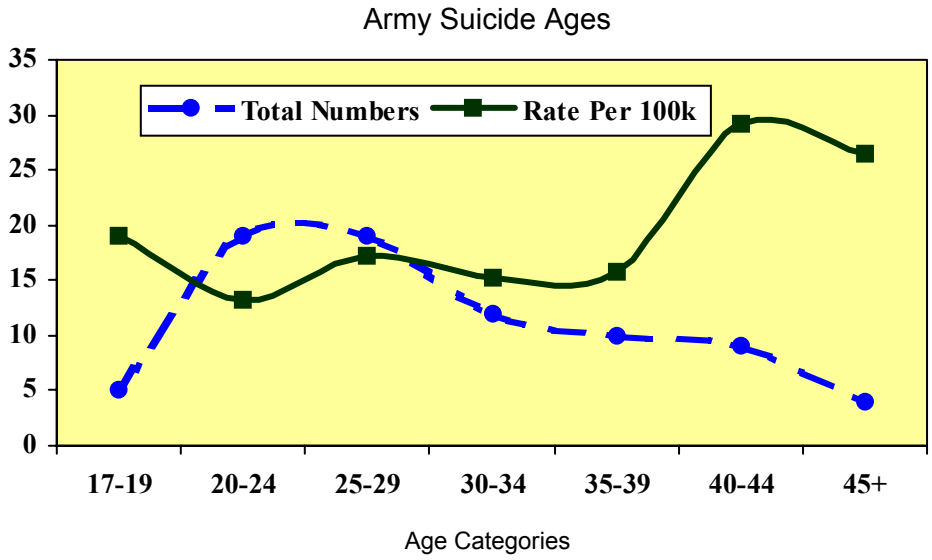
- ✓ Become ASIST T-2 trained
- ✓ Attend formal suicide prevention/awareness training hosted by the Chief of Chaplains (currently hosted by the Menninger Clinic in Topeka, Kansas)
- ✓ Download the USACHPPM Resource Manual for Suicide Prevention. Prepare suicide prevention/awareness training for "all ranks," OPDs and NCOPDs and spouses.
- ✓ Keep your commander informed on current suicide demographics. Explain those identified as "high" risk categories – such as those who are experiencing relationship problems, financial difficulties or pending UCMJ or other legal action.

Installation Suicide Prevention Standing Committee

- ✓ Establish suicide prevention program specifically tailored for your installation.
- ✓ Assist the installation and local commanders in implementing their preventative programs.
- ✓ Ensure that suicide prevention policies and procedures comply with applicable laws, regulations and directives regarding privacy and public information.
- ✓ Track the percentage of all assigned chaplains that have received the suicide prevention basic training at the Menninger Clinic.
- ✓ Ensure that all assigned commanders and senior NCOs are familiar with the availability of support agencies and the procedures for referral.
- ✓ Ensure that the availability of mental health personnel is adequate to meet the needs of the installation and that there is always someone available to conduct crisis intervention/assessment.
- ✓ Ensure that commanders are provided timely feedback from support agencies concerning the effectiveness of the treatment of their soldiers.
- ✓ Encourage stress management programs for soldiers and family members, especially during times of increased OPTEMPO or deployments.
- ✓ Track the number of ASIST T-4 (Trainer) and T-2 Level Crisis Intervention trained personnel on post.
    - Strive for at least two T-4 qualified trainers that can sponsor the T-2 level training. One of the two should be the Family Life Chaplain.
    - Strive for at least one ASIST T-2 trained personnel at each community support agency, SJA ,and MPs.
- ✓ Review and publicize emergency procedures available to all soldiers and family members such as Crisis Hotlines and suicide awareness cards.
- ✓ Ensure newly assigned soldiers are briefed on installation support agencies during in-processing.
- ✓ Are dependent school personnel trained in identifying and referring individuals at risk for suicide?
- ✓ Review surveillance reports and monitor the time that it takes to get soldiers into ADAPCP after identification of having an alcohol/drug problem.
- ✓ Establish procedures for creating an Installation Suicide Response Team

Annex C – Suicide Risk Comparison of Age Cohorts

Almost half of all suicides within the Army occur with soldiers 25 years of age or younger. However, maturity doesn't necessarily protect against suicidal behavior. In fact, older soldiers have a higher suicide rate than younger soldiers. As can be seen on Graph 1, although the greater incidence of suicides within the Army occur in younger soldiers (represented by the dashed line), the highest suicide rates occur in soldier over 40 (represented by the solid line).



GRAPH 1

By examining psychological autopsies, we find that younger soldiers are generally committing suicide as a result from insufficient or underdeveloped life coping skills. Suicides among older soldiers reveal a different profile of causes. These suicides often result from one or more clinical psychiatric disorders with associated problems that have accumulated over time. Many are facing a major life transition, such as a failed marriage or a promotion pass over. Others suffer from chronic substance abuse or a mood disorder. Unfortunately, many of these soldiers don't seek professional help, in part because of the perceived cultural and organization stigma associated with receiving mental health treatment.

To prevent both types of suicides requires two different, specific prevention strategies. Awareness training can generally prevent preplanned suicides as those who are planning their deaths usually give "warning: or "danger" signs that other, vigilant people should intercept. This strategy is contained in Chapter Six – Intervention.

Those unplanned, impulsive suicides are more challenging to prevent since the time from the decision, to the suicide act might be quick and not long enough for the potential suicide victim to display any warning signs. To prevent these types of suicide requires programs that prevent the individual from ever considering suicide as a viable option, which means developing their life coping skills so that when faced with a particular stressor, they will have the means to handle it without it turning into a crisis and potential suicide. This strategy is contained in Chapter Five – Prevention.

Younger Age Group	Older Age Group
Impulsive, lacks coping skills	MDD (Major Depression) or serious heavy ETOH (alcohol) use
Poor adjustment to military settings	Good previous adjustment to Army
Situational stressor	Major loss or transition issue
Suicidal behavior happens with little forethought	Contemplating suicide for some time as part of a biological disease process
Immature	Mature person whose biology or complicated past (or often both) has caught up to him
Engages in acting out behavior that is often hard for superiors to miss	Quietly withdraws from those who might notice; behavior of social withdrawal and his accompanying internal feelings of shame are easy to miss
First term of enlistment—not that concerned about career impact	Career soldier; concerned that MH contact will be seen as weakness and will hurt his career
Will often confide to anyone who is interested	Shame, a symptom of MDD and often of ETOH dependence, makes it difficult to tell anyone and magnifies fears about "the Army" finding out
Often lives in barracks and eats in dining facility; used to superiors being aware of details of his "personal life"	Lives in housing or off base; has erected certain barriers between his duty day and his personal life
	Assurances of confidentiality and assurances that getting treatment for a MH problem is not career damaging (stigma) become very important in combating the shame (which is part of the biological disease process) and thus allowing the soldier to feel it is "safe" to come forward and get help. It is important that these beliefs are in place before the soldier gets depressed (thus the importance of this campaign which promotes both a culture change from above and a training component which gets the word out below). Once the soldier is clinically depressed the symptoms of shame and social withdrawal make it very difficult to reach him.
Usually a facilitating "gatekeeper" helps him get to MH (chain of command or others)	Usually self referred to MH; may have conferred with a colleague; tends to tell chain of command as a last resort or not at all
Goes to MH with little thought of negative ramifications if directed or suggested by chain of command	Has viewed MH as a place where problem soldiers go—often to facilitate separation from the service
Early intervention may prevent acting out behavior and may facilitate development of more mature coping skills	Early intervention prevents progression from mild depression to serious biological depression; both depression and early alcohol dependence, particularly in those who have previously made a good occupational and social adjustment; are usually very responsive to treatment
Command is already aware of the problem since MH contact was either command directed or encouraged by a member of chain of command—a dialogue with MH is already underway	Command is often not aware of the problem up front; if the problem is serious, the MH professional needs to inform command either with the patient's consent (which he is usually willing to give after he has overcome his shame and entered into treatment) or via a profile If it is a mild depression, the patient may choose to keep it confidential (like any other medical problem that is not going to interfere with his performance of duty)
For the younger cohort, this tension (confidentiality vs. command's need to know) is less of an issue; command usually already knows; in those cases where they don't, the soldier is usually close to getting into some kind of difficulty, thus making it in his best interest to be proactive and letting his superiors know that he is addressing the underlying issues, before real trouble hits For this cohort, MH contact, in actual practice, looks almost like ADAPCP and Family Advocacy, which are command programs	For the older cohort MH patient, here is a built in tension between these two essential components: Command's need to know (which is always there in the serious cases; it is the MH professional's responsibility to inform command—by profile if necessary) vs. Assurances of confidentiality (so important in countering the shame of clinical depression: makes it safe for the soldier [or for his colleague in whom he may have confided] to believe it is safe to "self refer" early in the process and get the needed care for a very treatable condition)

Annex D – Definitions.

Anxiety disorder – an unpleasant feeling or fear or apprehension accompanied by increased physiological arousal, defined according to clinically derived standard psychiatric diagnostic criteria.

Behavioral health services – health services specially designed for the care and treatment of people with mental & behavioral health problems, including mental illness. Identical to the definition of mental health services.

Biopsychosocial approach – an approach to suicide prevention that focuses on those biological and psychological and social factors that may be causes, correlates, and/or consequences of mental health and mental illness and that may affect suicidal behavior.

Bipolar disorder – a mood disorder characterized by the presence or history of manic episodes, usually, but not necessarily, alternating with depressive episodes.

Cognitive/cognition – the general ability to organize, process, and recall information.

Comprehensive suicide prevention plans – plans that use multifaceted approaches to addressing the problem; for example, including interventions targeting biopsychosocial, social, and environmental factors.

Comorbidity – the co-occurrence of two of more disorders, such as depressive disorder with substance abuse disorder.

Connectedness – closeness to an individual, group or people within a specific organization; perceived caring by others; satisfaction with relationship to others, or feeling loved and wanted by others.

Contagion – a phenomenon whereby susceptible persons are influenced toward suicide behavior as a result of some other suicide behavior via personal proximity or other source of influential information.

Depression – a constellation of emotion, cognitive and somatic signs and symptoms, including sustained sad mood or lack of pleasure.

Epidemiological analysis – empirical examination of the incidence, distribution and potential risk factors for suicide.

Equivocal Death – a death in which the means or circumstances are unclear, uncertain, or undecided.

Gatekeepers – those individuals within a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate. Identified as either a “primary” or a “secondary” gatekeeper as defined in para 5-3c.

Health – the complete state of physical, mental, and social well being, not merely the absence of disease or infirmity.

Healthy People 2010 – the national prevention initiative that identifies opportunities to improve the health of all Americans, with specific and measurable objectives to be met by 2010.

Indicated prevention intervention – intervention designed for individuals at high risk for a condition or disorder or those who have already exhibited the condition or disorder.

Intentional – injuries resulting from purposeful human action whether directed at oneself (self-directed) or others (assaultive), sometimes referred to as violent injuries.

Intervention – a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition.

Means – the instrument or object whereby a self-destructive act is carried out.

Means restriction – techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

Methods – actions or techniques which result in an individual inflicting self-harm (i.e., asphyxiation, overdose, jumping).

Mental disorder – a diagnosable illness (using guidelines contained in the APA's DSM-IV or later editions) characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with an individual's cognitive, emotional, occupational or social abilities; often used interchangeably with mental illness.

Mental health – the capacity of individuals to interact with one another and the environment in ways that promote subjective well-being, optimal development and use of mental abilities.

Mental health problem – diminished cognitive, social or emotional abilities, but not sufficient to meet the criteria for a mental disorder.

Mental health services – health services that are specially designed for the care and treatment of people with mental health problems, including mental illness. Identical to the definition of behavioral health services.

Mental illness – see mental disorder.

Mood disorders – a term used to describe all those mental disorders that are characterized by a prominent or persistent mood disturbance; disturbances can be in the direction of elevated expansive emotional states, or, if in the opposite direction, depressed emotional states.

Morbidity – the relative frequency of illness or injury, or the illness or injury rate, in a community or population.

Non-fatal suicide events – any intent to inflict self-harm that does not result in death, but with apparent motivation to cause one's own death.

Personality disorders – a class of mental disorders characterized by deeply ingrained, often inflexible, maladaptive patterns or relating, perceiving, and thinking of sufficient severity to cause either impairment in functioning or distress.

Post-intervention – a strategy or approach implemented after a crisis or traumatic event has occurred.

Post-event data collection – required data collection and review process in the aftermath of a suicide to improve suicide prevention efforts.

Prevention – a strategy or approach that reduces the likelihood of risk of onset, or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors.

Protective factors – factors that make it less likely that individuals will develop a disorder. Protective factors may encompass biological, psychological or social factors in the individual, family and environment.

Psychiatric disorder – see mental disorder.

Psychiatry – the medical science that deals with the origin, diagnosis, prevention, and treatment of mental disorders.

Psychology – science concerned with the individual behavior of humans, including mental and physiological processes related to behavior.

Public informational campaigns – large scale efforts designed to provide facts to the general public through various media such as radio, television, advertisements, newspapers, magazines, and billboards.

Rate – the number per unit of the population with a particular characteristic, for a given unit of time.

Resilience – capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

Risk factors – those factors that make it more likely that individuals will develop a disorder. Risk factors may encompass biological, psychological or social factors in the individual, family and environment.

Screening – administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment.

Screening tools – those instruments and techniques (questionnaires, check lists, self-assessments forms) used to evaluate individuals for increased risk of certain health problems.

Selective prevention intervention – intervention targeted to subgroups of the population whose risk of developing a health problem is significantly higher than average.

Self-harm – the various methods by which individuals injure themselves, such as self-laceration, self-battering, taking overdoses or deliberate recklessness.

Self-injury – see self-harm.

Social services – organized efforts to advance human welfare, such as home-delivered meal programs, support groups, and community recreation projects.

Social support – assistance that may include companionship, emotional backing, cognitive guidance, material aid and special services.

Stigma – an object, idea, or label associated with disgrace or reproach.

Substance abuse – a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use. Includes maladaptive use of legal substances such as alcohol; prescription drugs; and illicit drugs.

Suicidal act (also referred to as suicide attempt) – a potentially self-injurious behavior for which there is evidence that the person probably intended to kill himself or herself; a suicidal act may result in death, injuries, or no injuries.

Suicide behaviors – includes a broad range of self-destructive or self-injurious behaviors, including threats, attempts and completions.

Suicidal ideation – self-reported thoughts of engaging in suicide-related behavior.

Suicidality – a term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and completed suicide.

Suicide - death resulting from the intention of the deceased to cause his or her own death.

Suicide attempt – a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries.

Suicide survivors – family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide.

Suicide threat - statement expressing or implying an intent to cause one's own death.

Suicide-related behaviors — intentional behaviors potentially resulting in serious injury or risk but may be motivated by an individual's desire for assistance rather than an intent to cause his or her own death.

Surveillance – Service directed data collection and review process designed to improve suicide prevention efforts through analysis and interpretation of health data with timely dissemination of findings.

Unintentional – term used for an injury unplanned or accidental injuries.

Universal preventive intervention – intervention targeted to a defined population, regardless of risk.

Annex E – Abbreviations/Acronyms

AAFES – Army Air Force Exchange Service

AAS – American Association of Suicidology

ACE – Adverse Childhood Experiences

ACS – Army Community Service

ADAPCP – Alcohol and Drug Abuse Prevention and Control Program

AIT – Advanced Individual Training

AMEDD – Army Medical Departments

ASIST – Applied Suicide Intervention Skills Training

ASPP – Army Suicide Prevention Program

BSRF – Building Strong and Ready Families

CDC – Center for Disease Control and Prevention

CFSC – Community & Family Support Center

CID – Central Investigative Division

CCH – Chief of Chaplains

CPO – Civilian Personnel Office

CSA – Chief of Staff, Army

CSSR – Completed Suicide Surveillance Report

CY – Calendar Year

DCSPER – Deputy Chief of Staff for Personnel

DoD – Department of Defense

ETOH – Ethyl Alcohol

FAP – Family Advocacy Program

GSW – Gunshot Wound

IET – Intial Entry Training

IG – Inspector General

IO – Investigating Officer

ISRT – Installation Suicide Response Team

ISPC – Installation Suicide Prevention Committee

MACOMs – Major Army Commands

MEDCOM – Medical Command

MH – Mental Health

MHO – Mental Health Officer

MP – Military Police

MTF – Medical Treatment Facility

MUSARC/RSC – Major United States Army Reserve Command/Regional Support Command

MWR – Morale, Welfare, and Recreation

NAMI – National Alliance for the Mentally Ill

NCHS – National Center for Health Statistics

NGB – National Guard Bureau

OCCH – Office of the Chief of Chaplains

ODCSPER – Office of the Deputy Chief of Staff for Personnel

ODPHP – Office of Disease Prevention and Health Promotion

OTSG – Office of the Surgeon General

PA – Psychological Autopsy

PAO – Public Affairs Office

RAP – Recruit Assessment Program

SAR – Suicide Analysis Report

SMA – Sergeants Major of the Army

SPRRC – Suicide Prevention Risk Reduction Committee

TJAG – The Judge Advocate General

TSG – The Surgeon General (Army)

TRADOC – Training and Doctrine Command

UCMJ – Uniform Code of Military Justice

UMT – Unit Ministry Team

USACHPPM – US Army Center for Health Promotion and Preventive Medicine

USACIC – US Army Central Investigation Command

USARC – US Army Reserve Command

USC – United States Code

VA – Veterans Administration

VCSA – Vice Chief of Staff, Army

WRAIR – Walter Reed Army Institute of Research

WRAMC – Walter Reed Army Medical Center

Annex F - References

1. Healthy People 2010, Office of Disease Prevention and Health Promotion, U.S. Department of Health of Human Services

2. National Alliance for the Mentally Ill Fact Sheet, October 2000

3. Tondo L, Baldessarini R, Suicide: An Overview, Psychiatry Clinical Management, Volume 3, 2001.

4. Zill, Robinson, The Generation X, American Demographics, 1995, 24-33.

5. Felitti V, Anda R, Nordenberg D, Williamson D, Spitz A, Edwards V, Koss M, Marks J, Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Deaths in Adults: The Adverse Childhood Experiences (ACE) Study, American Journal of Preventive Medicine, 1998; 14(4)

6. Legree, Generation X: Motivation, Morals, and Values, Army Research Institute Special Report, June 1997

7. Naval Health Research Center Report #95-26, Pre-enlistment Maltreatment Histories of U.S. Navy Basic Trainees: Prevalance of Abusive Behaviors, 1995

8. Hendin, H., Chapter 33, Psychiatric Emergencies, The Psychiatric Syndromes

9. Jobes D, Mann R, Reasons for Living versus Reasons for Dying: Examing the Internal Debate of Suicide, Suicide and Life-Threatening Behavior, Vol. 29(2), Summer 1999

Other References

Shaffer D, Suicide and Suicide Prevention in the Military Forces, A Report of a Consultation, Aug 97

National Strategy for Suicide Prevention, Goals and Objectives for Action, May 2001

<u>Military</u>

DA PAM 600-24, Suicide Prevention and Psychological Autopsy

AR 600-5, Health Promotion

AR 190-40, Serious Incident Report

DoD Suicide Prevention and Risk Reduction Committee Charter

Annex G – Useful Web Sites/Contacts

- American Assocation for Suicidology, (www.suicidology.org)
- American Foundation for Suicide Prevention, (www.afsp.org)
- Army Administrative Electronic Publication website, (www.usapa.army.mil/gils/)
- Living Works Education, (www.livingworks.net)
- Healthy People 2010, (www.health.gov/healthypeople)
- National Suicide Prevention Web site (copies of the National Strategy Summary Booklet) (www.mentalhealth.org/suicideprevention)
- ODCSPER Suicide Prevention Web Site, (www.odcsper.army.mil/default.asp?pageid=66f)
- Organization of Attempters and Survivors of Suicide in Interfaith Service, (www.oassis.org)
- Suicide Awareness\Voices of Education, (www.save.org)
- Suicide Prevention Advocacy Network, (www.spanusa.org)
- Surgeon General's Call to Action, (www.surgeongeneral.gov/library/calltoaction)
- U.S. Army Center for Health Promotion and Preventive Medicine, (chppm-www.apgea.army.mil)

Phone Numbers:

- **National Suicide Hotline: 1-800-suicide (800) 784-2433**

Army Suicide Demographics
Suicide can affect anyone, regardless of rank, age, sex, MOS, race or ethnicity. Although there are no select demographics that will accurately predict suicidal behavior with certainty, it is important to examine the Army suicide population in an attempt to infer potential suicide risk indicators for use in prevention efforts (an updated briefing of the previous calendar year as well as the current monthly Army suicide statistics and demographics can be found at the Army G-1 HRPD website). Our vigilance and awareness must extend to everyone in The Army. It is also important not to use demographics to “profile” or “discriminate” at-risk populations.

Suicide Methods
Suicide by self-inflicted gun shot wound (GSW) was the most common method chosen by soldiers, followed by hanging, carbon monoxide poisoning and drug overdose. Other methods include poisoning, burns, jumping and stabbing. Nationally, suicide by firearms was the most chosen method resulting in fifty-seven percent of all suicidal deaths in the United States. Generally, men tend to choose more violent, lethal means (GSW, hanging, and jumping). Women generally prefer less-violent means (drug overdose, and wrist cutting) but recent data suggest an increasing use of firearms by American women.

According to AAS, those who own a gun are 32 times more likely to commit suicide than those who do not own a gun. This figure doesn’t suggest that people who own guns are more likely to be suicidal, but rather the potential impact of having an immediate, convenient and highly lethal means to carry out the suicide act once the decision has been made. In fact, approximately 83 percent of fatal gunshot wounds are associated with suicides, compared to 7 percent for homicides committed by relatives, 3 percent associated with accidents, and only 2 percent of deaths involving strangers. Purchasing a weapon is associated with a dramatic increase in the risk of suicide in the ensuring year following the purchase.

Student Handout 3

This student handout contains 15 pages of slides, 6 slides on each page on current statistics and facts. Give this handout to the students to facilitate the presented instruction.

Suicide Prevention Leader Training

Every one matters!

Expectations

- I will:
  - ✓ Profile basic demographics for the Army Suicide Population
  - ✓ Offer a "101 level" explanation of suicide behavior
  - ✓ Explain your role in minimizing the risk of suicide for yourself and your soldiers

Suicide
Statistics and Factoids

There are approximately 1 million suicides in the world every year.

That's one death to suicide every 40 seconds.

Trivia Question:

Which industrialized country is the only country in the world where the female suicide rate is higher than the male rate?

Trivia Question:

Which industrialized country is the only country in the world where the female suicide rate is higher than the male rate?

Answer: CHINA

1

There was 28,322 confirmed suicides within the United States during 2001

(that's one every 18 minutes)

One in every 100 deaths within the United States is by suicide

More Americans kill themselves, than are killed by others

*Suicide: 11th leading cause of death**
*Homicide: 16th leading cause of death**

(data provided by CDC for 2001)

Within the U.S., more deaths result from suicide than by drunken drivers

Within the U.S., 2 times as many people die from suicide than HIV

Depression is more widespread than heart disease, cancer and AIDS

During the Vietnam Conflict, four times the number of Americans died by suicide than died in combat.

In the past 20 years, 200,000 more people died of suicide than died of AIDS

Suicide is the SECOND leading cause of death within the United States for those between the ages of 25-34

Suicide is the THIRD leading cause of death within the United States for those between the ages of 15-24

Between 1952-1995, suicide among adolescents & youth increased 300%

American Association of Suicidology estimates that 80% of all suicides give some form of warning or signal before killing themselves

3

Approximately 80% of suicides that occur within the U.S. are males

Approximately 90% of suicides that occur within the U.S. are white

On average, there is a suicide attempt every minute within the United States

Within the United States, there are approximately 566,640 treated in emergency rooms every year for self-inflicted injuries

141,660 required hospitalization

The American Association of Suicidology estimates that 1 in every 17 Americans (6%) had thoughts of suicide in the past 12 months.

A 1999 survey of high school survey indicates that 8.3% of those surveyed reported making a suicide attempt within the past year. That's approximately 1.3 million students nationwide.

United States Army Suicide

Statistics and Factoids

CSA Statement:

"It is our responsibility to help our soldiers, families and civilians understand how to identify at-risk individuals, recognize warning signs and know how to take direct action."

General Eric K. Shinseki
Army Chief of Staff

Quote from a Soldier's Suicide Note

"Goodbye, because I'm going to stop the pain. No one wants to help so I feel that I only have one choice."

During the 1990's,

- 803 soldiers killed themselves

During the 1990's,

- suicide was the 2nd leading cause of death

During the 1990's,

5 times more soldiers died by suicide than by hostile fire

5

Only 1 in every 5 soldiers who commit suicide have been seen by an Army Behavioral Health Professional

According to a DoD Survey, 17.8% of those soldiers surveyed believed they needed some form of behavioral health counseling

According to a DoD Survey, 17.8% of those soldiers surveyed believed they needed some form of behavioral health counseling

- but only 5.6% actually went to a behavioral health professional

Trivia Question:

Who was the highest member with DoD to commit suicide?

Trivia Question:

Who was the highest member with DoD to commit suicide?

Secretary of Defense Secretary James Forrestal

Trivia Question:

Which rank within the Army has the highest suicide rate?

6

Trivia Question:

Which rank within the Army has the highest suicide rate?

Staff Sergeant
(Rate of 16 per 100K for CY 01)

Quote from a Soldier's Suicide Note

"The Army will help if you know how to help yourself. That's the problem, I don't know how to help myself."

The youngest soldier that killed himself last year was 18 years old.

The oldest soldier that killed himself last year was 52 years old.

10 Army employees and 8 Army spouses/family members were known to have committed suicide last year – the youngest was 14 years old.

A failed, intimate personal relationship is mentioned as a contributing factor in Army suicides in 75% of cases

7

50% of all soldiers who commit suicide were facing or had recently faced some form of legal or UCMJ action.

Firearms accounted for 67% of all suicides within the Army last year.

Quote from a friend to a soldier's father

"it's all right because they (the Army) are trained to take care of him."

The next day, PV2 Nolan Stites jumped from his 3rd floor barracks window and fell to his death.

Suicide Prevention Leader Training

Every one matters!

Can Suicide be Prevented?

- **CHALLENGES**: Soldiers who complete suicide:
  - Rarely seek help through the chain of command, Chaplaincy or Behavioral Health (< 1/5 of all completed suicides have seen BH).
  - Often don't show "classic" warning signs of suicide in the unit.
  - Frequently choose very lethal means and act privately, precluding rescue.

DoD Survey of Health Related Behavior

"Stigma"

	Army
Perceived Need for Mental Health Counseling:	17.8%
Receipt of Mental Health Counseling from military Mental Health Professional:	5.6%
Perceived Damage to Career:	
Definitely Will:	17.7%
May or May Not:	58.1%
Definitely Will Not:	24.2%

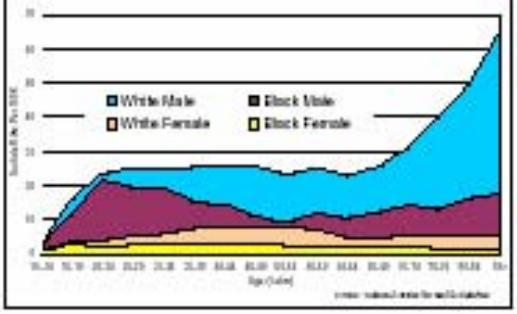
U.S. Leading Causes of Deaths - 1999

Age Groups

	1-14	15-24	25-34	35-44	45-54
1st	Unintentional Injury	Unintentional Injury	Unintentional Injury	Malignant Neoplasms	Malignant Neoplasms
2nd	Malignant Neoplasms	Homicide	Suicide	Unintentional Injury	Heart Disease
3rd	Homicide	Suicide	Homicide	Heart Disease	Unintentional Injury
4th	Congenital Malformations	Malignant Neoplasms	Malignant Neoplasms	Suicide	Cerebrovascular Dis.
5th	Heart Disease	Heart Disease	Heart Disease	HIV	Chronic Lower Respiratory Dis.
6th	Suicide	Congenital Malformations	HIV	Liver Disease	Diabetes Mellitus
7th	Chronic Lower Respiratory Dis.	Chronic Lower Respiratory Dis.	Diabetes Mellitus	Homicide	Liver Disease
8th	Other Neoplasms	HIV	Cerebrovascular	Cerebrovascular	Suicide

Source: National Center for Health Statistics, 2001

U.S. Suicide Rates by Age, Race, and Gender (1997)



Gender Comparison

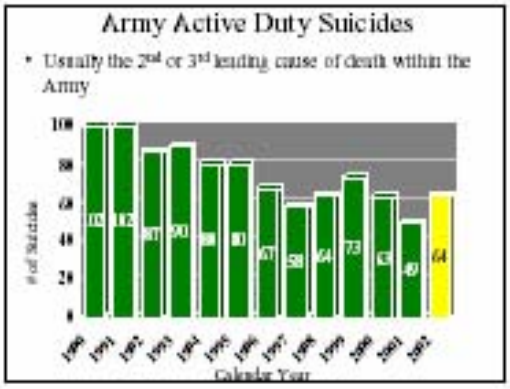
- Males complete – females attempt
- Reasons:
  - Female rate of alcohol abuse 1/5 of males
  - Numerous & more flexible coping devices in females
  - Females have stronger negative attitudes towards completed suicides, more positive towards attempts
  - Females are more likely to ask help
  - Females have more extensive social support systems
  - Cultural emphases on males to be competitive, impulsive, decisive, and being "strong"
  - Women tend to have less access to lethal means
  - Failure in primary adult male role more visible and obvious than failure in primary female role

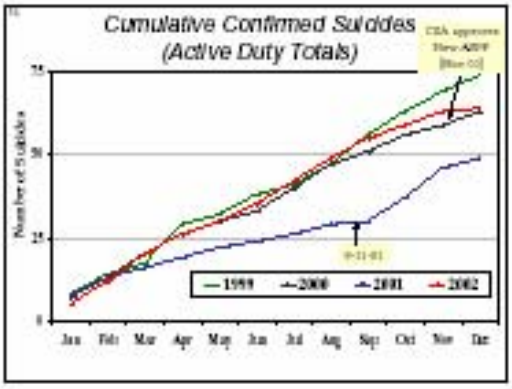
Race Comparison

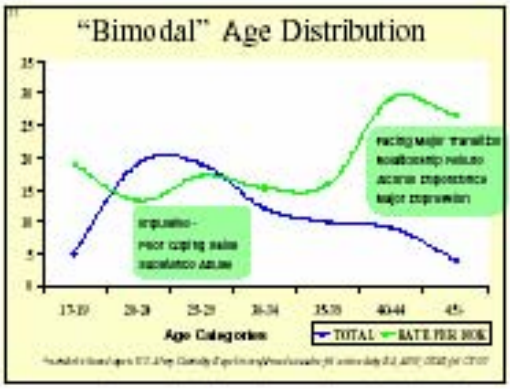
- Suicide rates higher in whites
- Reasons:
  - Societal discrimination causes a cultural response
    - Blacks externalize aggression, whites internalize
  - Historical discrimination created "survival strategy" centered on ties to family and church
  - Acceptability towards suicide higher in whites – "suicide is a white thing"

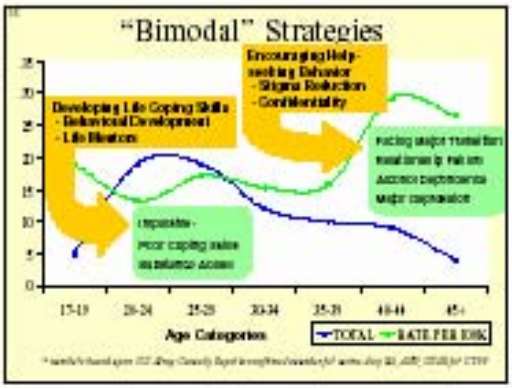
Magnitude of the Problem

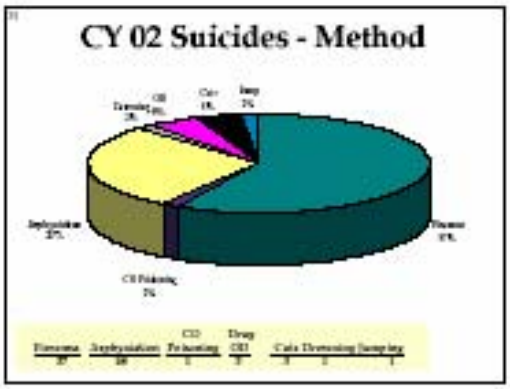
"People have one thing in common, they are all different."
ZEND

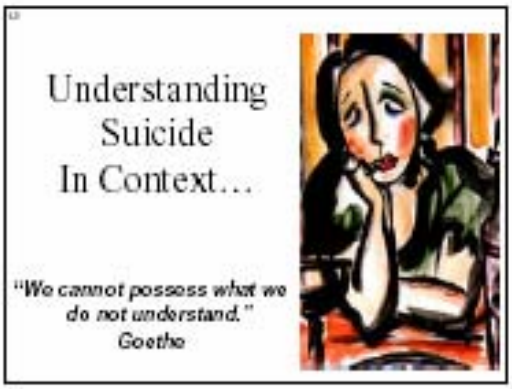

Army Active Duty Suicides
• Usually the 2nd or 3rd leading cause of death within the Army
# of Suicides
Calendar Year


Cumulative Confirmed Suicides
(Active Duty Totals)
Number of Suicides
1999
2000
2001
2002


"Bimodal" Age Distribution
Age Categories
TOTAL
RATE PER 100K


"Bimodal" Strategies
Developing Life Coping Skills
- Behavioral Development
- Life Blueprint
Encouraging Help-seeking Behavior
- Stigma Reduction
- Confidentiality
Age Categories
TOTAL
RATE PER 100K


CY 02 Suicides - Method


Understanding
Suicide
In Context…
"We cannot possess what we do not understand."
Goethe

A Model for Dysfunctional Behavior

Psychiatric dx:
- Schizophrenia
- Mania
- Depression
- Substance Abuse

A Model for Dysfunctional Behavior

"The best predictor of future behavior is past behavior."

Resulting in varying degrees of life coping skills

Consider our "Inputs"

- Our current cohorts of DoD recruits arrive at IET with significant developmental "baggage"
  - approx. 40% self-report having been raised in homes where they were physically &/or sexually abused &/or neglected*
  - > 40% come from 'non-traditional' homes without 2 consistent parenting figures**
  - > 20% of HS students had seriously considered attempting suicide during a 12 month period***
  - 8% of HS students reported making a suicide attempt in the preceding 12 month period***

The ACE Study*

- The largest study of its kind ever done to examine the health and social effects of adverse childhood experiences throughout the lifespan

- Summary of Findings:
  - Adverse Childhood Experiences (ACE's) are very common
  - ACEs are strong predictors of health risk behaviors in adolescence and adult life (e.g. substance abuse, etc.)

* Felitti, Anda, et al. Relationship of Childhood Abuse & Household Dysfunction to Many of Leading Causes of Death in Adults. American Journal of Preventive Medicine. 1998; 14(4):245

"ACE" Study Population Data

Adverse Childhood Experiences (ACEs) are Common in the Population

Household Exposures:

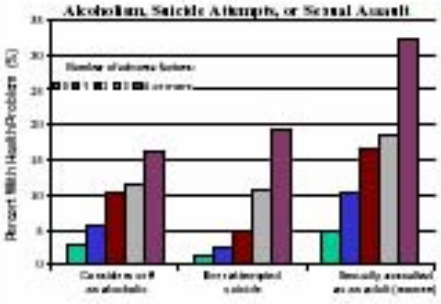
Alcohol abuse	23.5%
Mental illness	18.8%
Battered mother	12.5%
Drug abuse	4.8%
Criminal behavior	3.4%

Childhood Abuse:

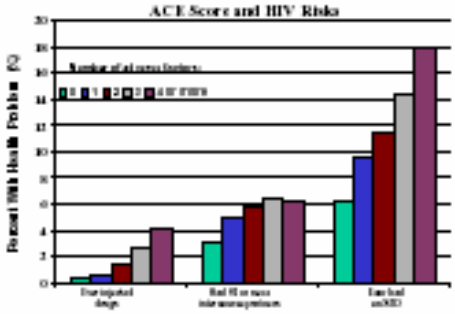
Psychological	11.0%
Physical	30.1%
Sexual	19.9%

ACE SCORE	PREVALENCE
0	47.9%
1	24.9%
2	13.1%
3	7.3%
4 or More	6.8%

"ACE" Study Population Data



"ACE" Study Population Data



A Model for Dysfunctional Behavior

A Model for Dysfunctional Behavior

Life-Cycle Behavioral "Pitfalls" of the 1st term Soldier

Behavioral "pitfalls" that can lead to dysfunction, potential suicide behaviors & premature attrition:

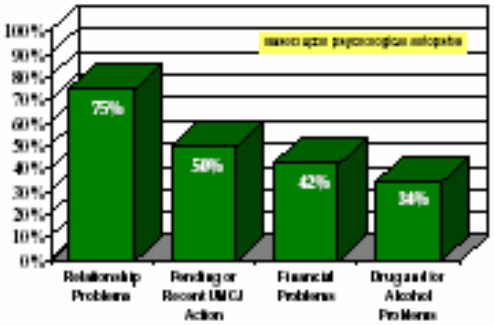
- Promiscuity & Impulsivity
- Premature marriage and Parenthood
- Family Violence
- Distrust/Disdain of authority figures; Loyalty issues
- Excessive debt/$ problems
- Dysfunctional behaviors resulting in UCMJ
- Inability to form positive supportive relationships
- Substance abuse & other major psychiatric disorders
- Family of origin problems - acute & unresolved from past

Potential Suicidal "Triggers"

LOSS OF:

- a loved one to illness or death
- a significant, intimate relationship
- a child custody battle
- friendship or social status (social isolation or ostracism)
- a job or rank (UCMJ or civilian legal action, separation)
- freedom (incarceration)
- financial security (pay loss, excessive debts, bankruptcy)
- self-esteem (humiliation, pass over for promotion or schooling)
- hope (feeling helpless)
- or change in lifestyle (unwanted PCS, major deployment)

Potential "Triggers"



Psychological Reasons for Suicide

- **Death as retaliatory abandonment**
  - Killing self to "get back at" person who abandoned you.
- **Death as self-punishment**
  - Torturing/Killing self to atone for guilt/shame.

Potential Indicators/Predictors of Dysfunctional Behavior

- Impulsiveness or violent traits
- Previous self-injurious acts
- Excessive anger or agitation
- Excessive alcohol use
- Heavy smoking
- Sleeping or eating disorder

RISK

Highest when:

- The person [illegible] may get worse.
- The proble[illegible] and helplessness.
- Think[illegible] torment.
- Judg[illegible] fuel by use of alcohol or other substances.
- Lethal means are available.

Suicidal Danger Signs Include:

- Talking or hinting about suicide.
- Formulating a plan to include acquiring the means to kill oneself.
- Having a desire to die.
- Obsession with death including listening to sad music or poetry or artwork.
- Themes of death in letters and notes.
- Finalizing personal affairs.
- Giving away personal possessions.

DANGER SIGNS MUST BE ACTED UPON IMMEDIATELY!

Suicidal Warning Signs Include

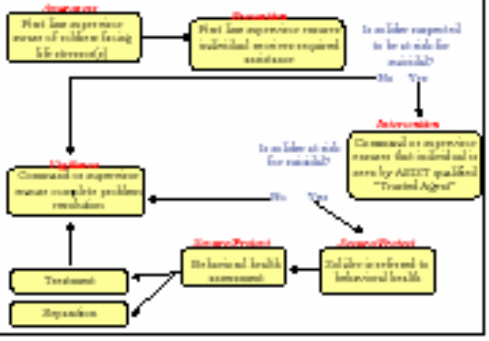
- Obvious drop in duty performance.
- Unkempt personal appearance.
- Feelings of hopelessness or helplessness.
- Family history of suicide.
- Made previous suicide attempts.
- Drug or alcohol abuse.
- Social withdrawal.
- Loss of interest in hobbies.
- Loss of interest in sexual activity.
- Reckless behavior, self-mutilation.
- Physical health complaints, changes/loss of appetite.
- Complaints of significant sleep difficulties.
- Frequent physical complaints and medical appointments

"Knowing is not enough, we must apply. Willing is not enough, we must do."

Goethe

13

Model for Unit Suicide Prevention



All Soldiers

- ✓ Know suicidal danger and warning signs and leading causes for suicides
- ✓ Become aware of local helping services
- ✓ Take immediate action when suspecting someone is at risk for suicide
- ✓ Never ostracize any member of your team
- ✓ REMAIN VIGILANT!

First Line Supervisors

- ✓ Get to know your soldiers
  - Assess solder's life-coping skills
  - Know when your soldiers are experiencing a "life crisis"
  - Anticipate dysfunctional behavior
- ✓ Know potential suicide triggers & warning signs for mental illness
- ✓ Promote help-seeking behavior
  - Assist in reducing stigma regarding mental health
  - Set the example - take advantage of helping services
- ✓ MAINTAIN AWARENESS AND VIGILANCE!

Commanders

- ✓ Offer suicide prevention/awareness training to spouses
- ✓ Conduct OPD's and NCOPD's that focus on some aspect of mental health
- ✓ Promote life-coping skills development & help-seeking behaviors
- ✓ Develop well-defined procedures for storing P.O.W.s
- ✓ Conduct "family reunion" seminars during extended deployments
- ✓ Ensure your UMT members are ASIST qualified

Summary

- **Suicide** is substantially **preventable** in the Army, IF:
  - we target those **at risk** of or currently suffering from treatable mental/behavioral disorders(primarily substance abuse/mood dz);
  - we minimize **stigma** associated with accessing mental health care;
  - leaders **know** and **care** about their peers & subordinate soldiers;
  - leaders constructively **intervene early** on in their soldier's problems;
  - leaders pay close attention & provide constructive interventions to those small % of peers and subordinates **facing major losses** from legal, marital, occupational or financial problems

If you come in contact with someone at risk:

- Remain calm – don't panic!
- **Listen!** Allow the person at risk an opportunity to share their thoughts. Shape the conversation around their feelings, not yours.
- Never leave the person at risk alone.
- Share what has happened with the soldier's chain of command.

Suicide Prevention
Leader Training

Every One Matters!

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