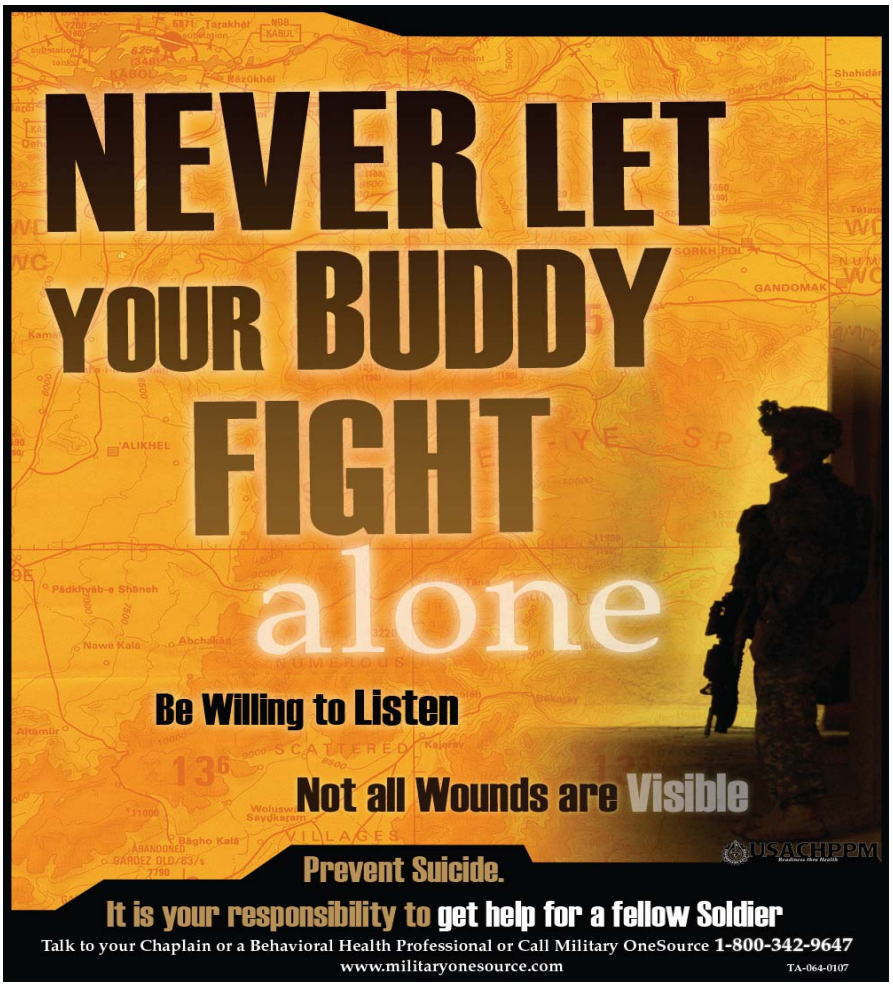
DEPARTMENT OF THE ARMY
DEPUTY CHIEF OF STAFF, G-1

ARMY SUICIDE PREVENTION PROGRAM



PROGRAM GUIDE
FOR INSTALLATIONS AND UNITS

A message from
Lieutenant General Michael D. Rochelle
Army Deputy Chief of Staff, G-1

The Army's strength rests in our People: our Soldiers, both serving and retired, Families and civilians, each a vital member of our institution. Suicide is a personal tragedy for all those affected, and is detrimental to the readiness of the Army. Therefore, suicide has no place in our professional force!

We all realize the inherent stress and burdens placed upon all of us. Our Army is defined based on 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 potential triggers and warning signs of suicide 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/providing behaviors as a sign of individual strength and maturity.

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 rests upon proactive, caring and courageous people 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 in The Army.

Army Strong!

MICHAEL D. ROCHELLE
Lieutenant General, USA
Deputy Chief of Staff, G-1

Headquarters
Department of the Army
Washington, DC
15 March 2008

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-HRPD, 300 Army Pentagon, Washington D.C. 20310-0300, ATTN: The Army Suicide Prevention Program Manager.

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Chapter One – Introduction

"One Suicide is One Suicide Too Many"
Sergeant Major of The Army Kenneth Preston

1-1. Magnitude of the Problem

Since the beginning of the Global War on Terror (GWOT), the Army has lost over 580 Soldiers to suicide, an equivalent of an entire infantry battalion task force. This ranks as the fourth leading manner of death for Soldiers, exceeded only by hostile fire, accidents and illnesses. Even more startling is that during this same period, 10 – 20 times as many Soldiers have thought to harm themselves or attempted suicide.

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, Family members, Department of the Army (DA) civilians, and retirees. Suicide behavior includes self-inflicted fatalities and non-fatal self-injurious events (gestures and attempts).

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

1. we have created and fostered an environment where all Soldiers, Family members, and DA civilians at risk for suicide will quickly be identified and receive successful intervention and appropriate care;
2. where help-seeking / providing behavior is encouraged and accepted as a sign of individual strength, courage and maturity, and;
3. where we seek to build the psychological resilience of our forces, and instill positive life-coping skills. These skills are reinforced by all leaders.

1-3. Deputy Chief of Staff, G-1 Statement

In 2008, following a 21% increase in the number of reported suicides within the Army from the previous year, the Deputy Chief of Staff, G-1,LTG Michael Rochelle, 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:

- Utilize a multidisciplinary approach
- Reduce the stigma of seeking mental health care
- Raise the awareness of junior leaders while instilling intervention skills
- Improve the access to behavioral health care

- Provide actionable intelligence to field commanders that includes lessons learned and trends analysis

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.

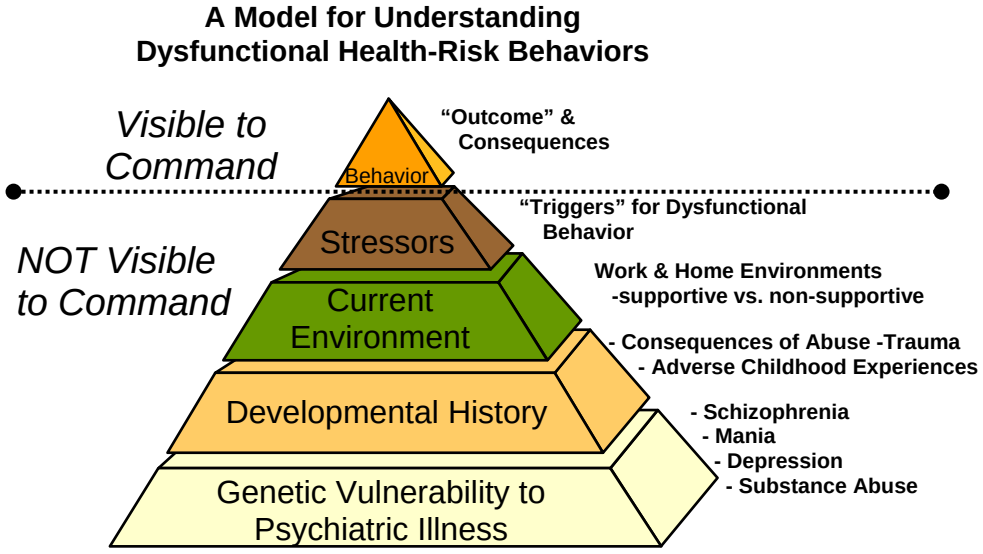

FIGURE 1

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:

- Feelings of overwhelming sadness and/or fear, or the seeming inability to feel emotion (emptiness),
- Decrease in the amount of interest or pleasure in all, or almost all, daily activities,
- Changing appetite and marked weight gain or loss,
- Disturbed sleep patterns, such as insomnia, loss of REM sleep, or excessive sleep (Hypersomnia),
- Psychomotor agitation or retardation nearly every day,
- Fatigue, mental or physical, also loss of energy,
- Intense feelings of guilt, helplessness, hopelessness, worthlessness, isolation / loneliness and/or anxiety,
- Trouble concentrating, keeping focus or making decisions or a generalized slowing and memory difficulties,
- Recurrent thoughts of death (not just fear of dying), desire to just “lay down and die” Or “stop breathing”, recurrent suicidal ideation without a specific plan, or a suicide Attempt or a specific plan for committing suicide,
- Feeling and/or fear of being abandoned by those close to the individual.

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 nearly half of the Army suicides within CY 2007 were in the rank of Sergeant or above (including commissioned officers).

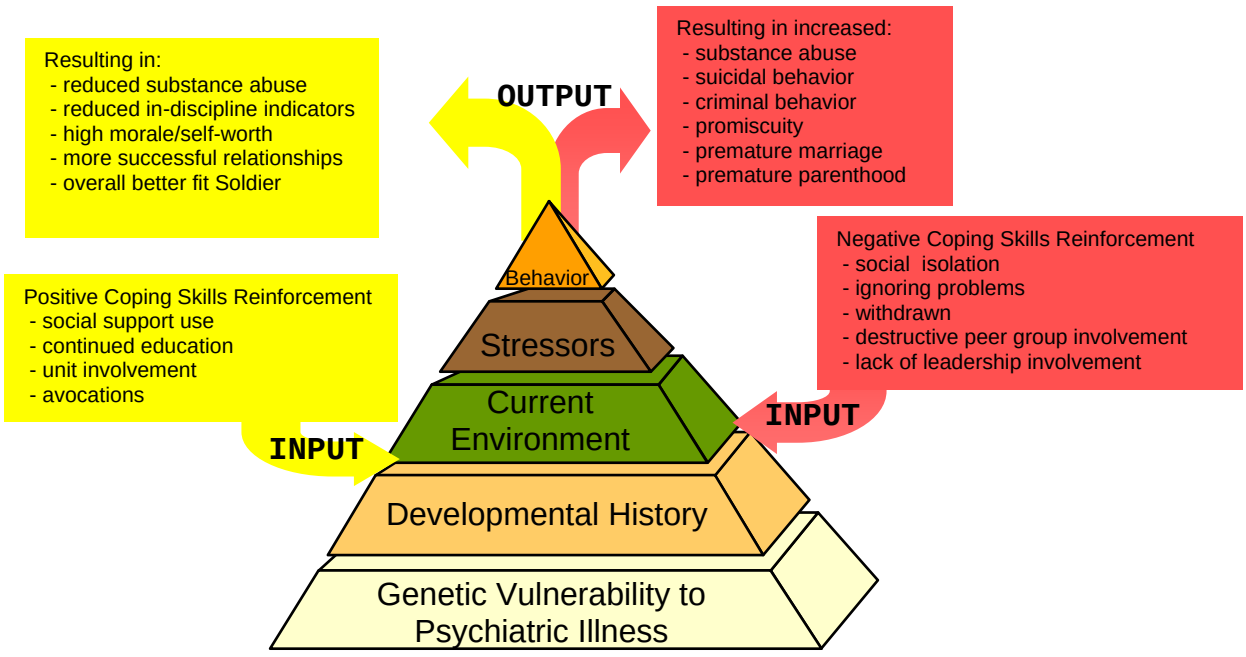

FIGURE 2

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"

The timing of suicide behavior in Soldiers often revolves around a significant emotional event, particularly those involving a loss, separation or any change in one's self-esteem and confidence are often linked together. Drugs or alcohol will often be used to "drown sorrows", but because these also disinhibit people, they make dysfunctional or self destructive behavior more likely, and should be avoided during times of crisis.

A review of the CY06 Army Suicide Event Report revealed that approximately **sixty-nine** percent of all Soldiers that died by suicide were experiencing "significant problems" within a personal, intimate relationship. In addition, about **thirty-seven** percent had just received or were pending some form of legal action (whether civilian or UCMJ). Approximately **eleven** percent were experiencing financial problems and **forty-eight** percent were known to job related 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 / risk factors for suicide.

- Loss of a significant, intimate relationship (divorce, separation, break-up).
- Loss of a job, rank (UCMJ or civilian legal action, separation).
- Loss of self-esteem (humiliation, pass over for promotion or schooling).
- Loss of financial security (pay loss/reduction, gambling debts, bankruptcy).
- Loss of a child custody battle.
- Loss of friendship or social status (social isolation or ostracism).
- Loss of a loved one to illness or death.
- Loss of freedom (incarceration).
- Loss of hope, power or feeling helpless.
- Loss or change in lifestyle (unwanted PCS, major/repeated deployment, retirement).
- Loss of good health (diagnosed with major illness, prolonged/sever stress).
- Work related problems (negative evaluation)
- History of previous suicide attempts.
- Substance abuse.
- History of depression or other mental illnesses.
- Family history of suicide or violence.

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 Army Suicide Event Reports 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.
- Having a desire to die.
- Formulating a plan to include acquiring the means to kill oneself.
- 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:

- Talk of suicide or killing someone else
- Problems with boyfriend/girlfriend or spouse
- Obvious drop in duty performance.
- Made previous suicide attempts.
- Drug or alcohol abuse.
- Social withdrawal.
- Acting bizarre or unusual (based on your knowledge of the person).
- Complaints of significant sleep difficulties.
- Unkempt personal appearance.
- Feelings of hopelessness or helplessness.
- Loss of interest in hobbies.
- Loss of interest in sexual activity.
- Physical health complaints, changes/loss of appetite.
- Giving away property or disregard for what happens to one’s property

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 is 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
- worthlessness
- 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. Building Psychological Resilience

Psychological resilience refers to an individual's capacity to withstand stressors and not manifest psychology dysfunction, such as mental illness or persistent negative mood. This is the mainstream psychological view of resilience, that is, resilience is defined in terms a person's capacity to avoid psychopathology despite difficult circumstances.

Psychological stressors or "risk factors" are often considered to be experiences of major acute or chronic stress such as described above. The central process involved in building resilience is the training and development of adaptive coping skills. The basic flow model (called the transactional model) of stress and coping is: A stressor (i.e. a potential source of stress) occurs and cognitive appraisal takes place (deciding whether or not the stressor represents something that can be readily dealt with or is a source of stress because it may be beyond one's coping resources). If a stressor is considered to be a danger, coping responses are triggered. Coping strategies are generally either be outwardly focused on the problem (problem-solving), inwardly focused on emotions (emotion-focused) or socially focused, such as emotional support from others.

Resilience refers to an individual's capacity to thrive and fulfill potential despite or perhaps even because of such stressors. Resilient individuals and communities are more inclined to see problems as opportunities for growth. In other words, resilient individuals seem not only to cope well with unusual strains and stressors but actually to experience such challenges as learning and development opportunities.

Whilst some individuals may seem to prove themselves to be more resilient than others, it should be recognized that resilience is a dynamic quality, not a permanent capacity. In other words, resilient individuals demonstrate dynamic self-renewal, whereas less resilient individuals find themselves worn down and negatively impacted by life stressors.

Our goal is to build resilience in our soldiers, we do this by tough, realistic training which allows them to prepare for and rehearse the stressful things they are likely to experience in Combat. A similar model of psychological resiliency training is being developed for coping with stress. Called BATTLEMIND, it seeks to prepare soldiers for the rigors of deployment and allow them to function rather than be worn down by it. Resilience training is very important to Suicide Prevention, because the stressors are predictable—we know why people kill themselves. We also know that not everyone subjected to the same situation chooses to end their life. Our challenge is to instill the mental tools that resilient people use to solve challenges in their lives to everyone we lead.

2-10. 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 or other intimate relationship.
- 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

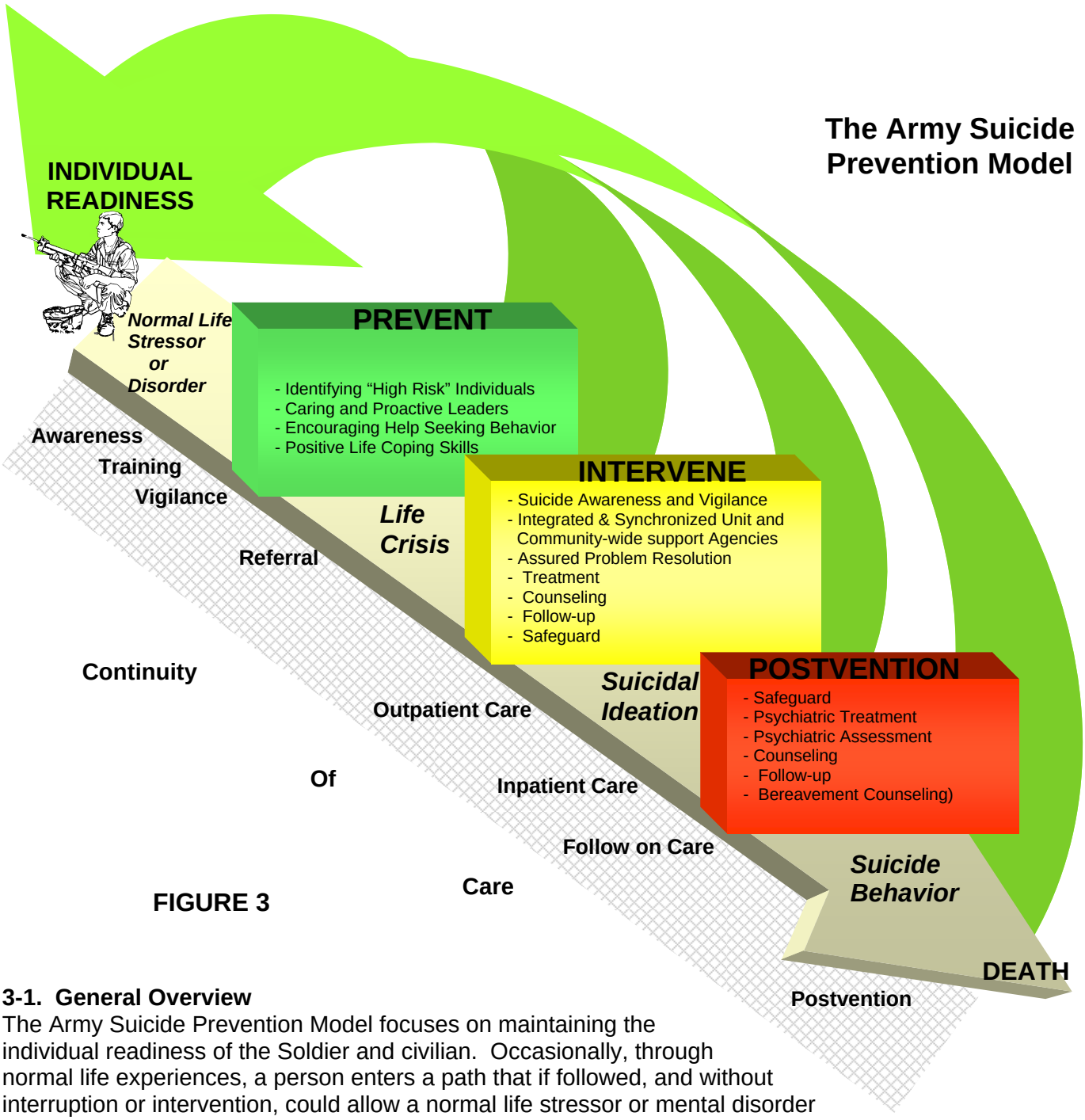

FIGURE 3

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 postvention. 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. Prevention. 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. Intervention. 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. Postvention. 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 or has attempted suicide. 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 (1st line leaders, battle buddies, Family members) to recognize those suicidal danger and warning signs and if recognized, take immediate, life-saving action, and to provide follow-up care for those who have attempted suicide. This barrier is color-coded "red" due to the severity of the situation. This individual is considering, has already decided to die by suicide, or has attempted 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 carry out 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

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/Providing Behavior
- Teach Positive Life Coping Skills
  - Total Physical, Spiritual, and Mental Health
  - Avoidance of Stress-inducing Behaviors

TABLE 1

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:

- 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 mental health official. 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

	ARMY	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 Strong Bonds seminars. Strong Bonds offers married couples an opportunity to strengthen their relationship through various instruction and exercises. The seminar targets those married couples who are interested in improving their communication skills and generally being better equipped to handle the stresses of married life, including child rearing. Programs such as this 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 receive this training throughout the deployment cycle phases. 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

TABLE 3

5-2. ACE (Ask, Care, Escort) Intervention Model

The suicide intervention program, ACE, is designed to help Soldiers become aware that they can take necessary steps to prevent suicides. It is aimed at Soldiers and leaders with a goal to make it easier for Soldiers to help fellow Soldiers who have thoughts of suicide. ACE will encourage Soldiers to question directly and honestly any buddy who exhibits suicidal behavior. This training will help Soldiers to avoid letting their fears of suicide govern their actions to prevent suicides.

What ACE Training Offers:
ACE is a gatekeeper (peer) early prevention intervention program that is evidence based.
ACE does not require training in formal counseling to be effective.
ACE teaches Soldiers how to recognize suicidal behavior in fellow Soldiers and the warning signs that accompany it.

- ACE targets those Soldiers most at risk for suicide and the least likely to seek help due to stigma.
- ACE increases a Soldier's confidence to ask if a buddy is thinking of suicide.
- ACE teaches Soldiers skills in active listening.
- ACE increases the opportunity to secure early intervention before a suicidal crisis.
- ACE encourages Soldiers to take a buddy directly to a Chaplain or behavioral health provider (Never leave a buddy alone).

ACE Training Objectives

- Build resiliency as a protective factor in the prevention of suicides.
- Foster individual and group responsibility for the well being of others.
- Raise the awareness of stigma and its negative effects on "help seeking."
- Teach participants the knowledge and skills for identifying, intervening, and referring suicidal Soldiers for help.
- Develop competence and confidence in the application of these skills.

- Teach participants to identify military community resources and make referrals for Soldiers in need of services.

Training Core Beliefs –
- Soldiers manage their own mental health
- Training is to be Soldier centered
- Training is to be exchange of information
- Simple
- Emphasis on the unit culture
- Duration of training (short, 4 hours)

5-3. 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 includes 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, 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).

5-4. 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

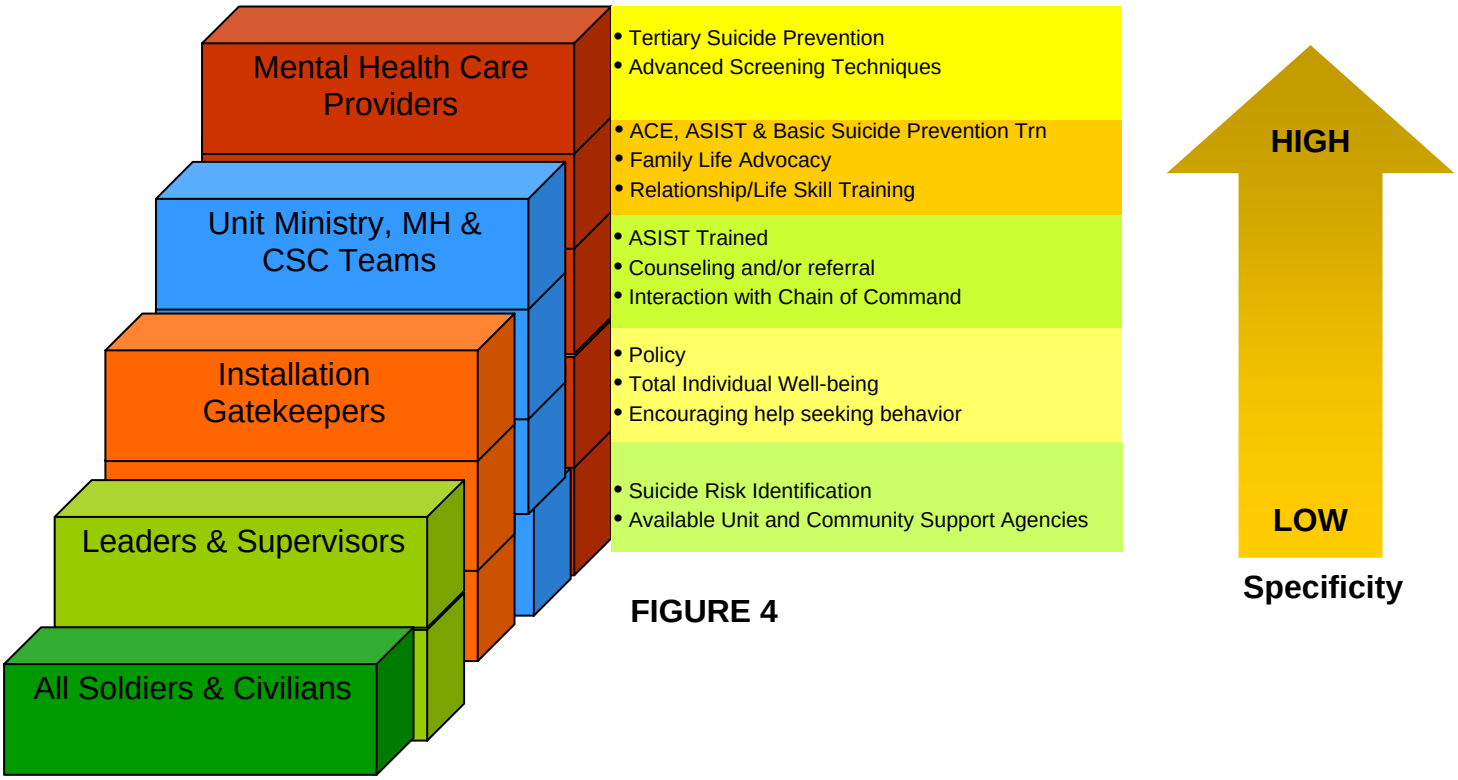

FIGURE 4

5-4a. 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 Army Suicide Event Reports reveal that those who died by 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.

5-4b. 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 / providing behavior. Civilian supervisors will also receive training that focuses on referral techniques/protocols for their employees.

5-4c. 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
ASAP 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

5-4d. 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 ACE / 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.

5-4e. Combat Stress Control Teams. 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. Graduates of the course who entered as candidates for chapter separation from the Army have returned to their units ready to assume their responsibilities and support the unit's mission.

5-4f. 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.

5-5. 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 F).

5-6. Integration and Synchronization – The Installation Suicide Prevention Task Force
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 task force or committee on each major installation, separate activity, community, Division, BCT, and other echelons as designated by the commander. This task force's main responsibilities are to establish, plan, implement, and manage the ASPP. It will maximize and focus available resources and ensure that the local unit ASPPs are "nested" within the overall plan.

The nation's 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 Task Force is to focus 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	-ASAP
-Civilian Personnel Office	-Youth Services	-DOD Schools	-IG
-Safety	-Dental	-Red Cross	
-Dept of Social Services			

In addition to determining the exact membership of the task force, 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 task force/committee 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 task force 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, ASAP, 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 task force/committee, refer to Chapter 2, DA PAM 600-24, Suicide Prevention and Psychological Autopsy, 30 September 1988. Army divisions, BCTs, and other large activities with adequate support interested in considering establishing their own suicide prevention program 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/

5-7. 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 – Postvention

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, has attempted suicide, and is in immediate danger for self-injurious behavior. If any Soldier, Family member, 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.

TABLE 4

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 die by suicide. Commanders must also ensure that the Soldier at risk does not have access to any means to die by 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 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.

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 in the Army. In the event of a 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.

Chapter Seven – Installation Action

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 Suicide Prevention Task Force/committee, 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 reporting system, called the Army Suicide Event Report (ASER) provides the epidemiological study of suicide demographics, plus address any concerns or issues that the commander(s) might have concerning a confirmed

Annex A – Strategy Metrics

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 MHOs develop a standardized briefing for Suicide Prevention Task Force/Committee's approval 2. Suicide Prevention Task Force/Committee 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 ACOMs & 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 (OBC, WLC)
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. Suicide Prevention Task Force/committee 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 ACE and/or 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 Suicide Prevention Task Force/Committee will develop its own charter, which addresses formal and "ad hoc" membership of the committee. 2. Each Suicide Prevention Task Force/Committee will develop and publish its own suicide prevention program plan
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 ACOM.
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 ACOMs. Programs will range from the installation level to ACOMs 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	Installation PAOs should be familiar with proper guidelines as provide by HQDA, OCPA and recommend that local news media adopt appropriate guidelines when reporting about suicides within the installation or local community.
Develop timely, actionable intelligence that gives leaders a quick analysis of each suicide or attempt that includes lessons learned, trend data and potential factors to watch.	Establish policies and procedures for the collection and analysis of behavioral health data

Annex B – Program Checklists

ARMY SUICIDE PREVENTION PROGRAM (ASPP) CHECKLIST

These checklists serve as guides that will assist commanders, leaders, and Soldiers in developing and supporting their own suicide prevention program.

- The ASPP is built around an integrated system of continuous initiatives and efforts that focus on prevention through the early identification of and intervention with Soldiers at risk for suicide.

- Every leader and Soldier must remain committed and involved in suicide prevention; it is part of our Warrior Ethos – "Never leave a fallen comrade."

- Suicide prevention is about Soldiers taking care of Soldiers. In the Army, we always take care of our battle buddies.

- For more information on resources to support local suicide prevention programs, visit the following websites:

- Army G-1 - www.armyg1.army.mil/hr/suicide.asp

- Center for Health Promotion and Preventive Medicine
  https://chppm-www.apgea.army.mil/dhpw/readiness/suicide.aspx

- Army Behavioral Health - www.behavioralhealth.army.mil

- Office of the Chief of Chaplains - www.chapnet.army.mil

- National Guard (Virtual Armory) - www.virtualarmory.com

- Military One Source - www.militaryonesource.com

SOLDIERS
The first line of defense and perhaps the most important person in suicide

	Know the warning and danger signs of suicide. Know the leading causes of suicide in the Army. Remain vigilant at all times!
	Take immediate action when suspecting someone is suicidal or if someone admits that they are contemplating suicide. Use the A.C.E. Intervention Model: **A**sk "Are you thinking about suicide?" (be direct and non-judgmental) **C**are for the Soldier: Safely remove lethal means; listen to the issues **E**scort the Soldier to helping professionals. Never leave the Soldier alone!
	Become aware of local helping services and protocols for use. See your chain of command, the Chaplain, Community Mental Health Clinic, or Army Community Services.
	Seek help at the first sign of stress or when having thoughts of suicide. This is a sign of courage and strength

FIRST LINE SUPERVISORS / LEADERS

	Know your Soldiers so you can recognize and even anticipate possible dysfunctional behavior. Promote the buddy system.
	Assess each Soldier's life-coping skills. Ask them situational questions. Seek opportunities to positively influence your Soldier's behavior.
	Ensure Soldiers receive suicide awareness and prevention training (coordinate with the Battalion Chaplain and/or the Unit Ministry Team)
	Create an atmosphere of inclusion for all Soldiers. Never ostracize any Soldier, regardless of their actions. Encourage help-seeking behaviors.
	Know what can trigger suicide: failed relationships, job-related problems, financial difficulties, legal problems, helplessness, guilt, etc.)
	Know some of the warning signs for mental health issues (loneliness, worthlessness, hopelessness, helplessness, guilt, etc.)
	Be the first to accept help, if needed. Be the first one to give help, if needed. Know what helping services are available: Chain of Command, Chaplain, mental health providers, Social Workers, Army Community Services, Military OneSource, etc.
	Reduce the perceived stigma regarding mental health care. Remember that most mental illnesses are a result of a sickness, not weakness and are treatable.

COMMANDERS

	Maintain vigilance, especially on high-risk Soldiers. Ensure members of your UMT have knowledge of possible life crises or pending UCMJ actions within your unit.
	Offer suicide awareness and prevention training for spouses and all significant others as part of the reintegration phase of deployment.
	Ensure all newly assigned Soldiers know the location and protocols for accessing installation support agencies.
	Include mental health topics in officer and NCO professional development classes
	Ensure your UMT has received formal suicide prevention training: 1. A.C.E. Intervention Training (preferred) 2. Living Works Applied Suicide Intervention Skills Training (ASIST) Workshop and/or 3. QPR (Question, Persuade, Refer) Triage and Risk Assessment Training
	Promote help-seeking behavior as a sign of strength and courage. Respect Soldier/counselor confidentiality when Soldier is not a threat to self or others, and if they are able to perform their prescribed duties.
	Develop well-defined procedures for registering and storing privately owned weapons. Ensure procedures are in place to restrict access to firearms during suicide watches.
	Ensure any Guard or Reserve Soldier attached for deployment, receive suicide awareness and prevention training and suicide screening prior, during, and after deployment.
	Ensure there are “Family Reunion” seminars for both Soldiers and Family members to assist in successful reintegration following an extended deployment.

UNIT MINISTRY TEAMS (UMTs)

	Become ACE trained. https://chppm-www.apgea.army.mil/dhpw/readiness/suicide.aspx Additional Training Resources are available at: Living Works: http://www.livingworks.net/ or QPR institute at http://qprinstitute.com/
	Download the USACHPPM Resource Manual for Suicide Prevention by visiting their website at https://chppm-wwwapgea.army.mil/dhpw/Readiness/suicide.aspx Prepare tailored suicide awareness and prevention training for “all ranks”, OPD, NCOPDs, and spouses using CHPPM’s Suicide Awareness Training for leaders and Soldiers.
	Keep commander informed on current suicide demographics. Check with local Community Health Promotion Council, Suicide Prevention Task Force, or the installation Suicide Prevention Coordinator. Explain high risk categories, such as those who are experiencing relationship problems, job-related problems, and legal and financial difficulties

INSTALLATION SUICIDE PREVENTION TASK FORCE / COMMITTEE
INSTALLATION SUICIDE PREVENTION COORDINATOR

	Establish suicide prevention program specifically tailored for your installation. Refer to AR 600-63 and DA Pam 600-24.
	Assist the installation and local commanders in implementing their respective programs.
	Ensure suicide prevention policies and procedures comply with applicable laws, regulations, and directives regarding privacy and public information.
	Ensure all assigned commanders and senior NCOs are familiar with the availability of support agencies and the procedures for referral.
	Ensure the availability of mental health personnel is adequate to meet the needs of the installation. Know who is available to conduct crisis assessment and/or intervention during non-duty hours.
	Ensure 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.
	Assist in coordinating training events (A.C.E., ASIST, or QPR).
	Strive for at least two qualified trainers that can sponsor training workshops throughout the installation. One of the two should be a Family Life Chaplain.
	Strive for at least one qualified trained person at each community support agency (ACS, ASAP, TMC, MPs, etc.)
	Review and publicize emergency procedures available to all Soldiers and Family members such as Crisis Hotlines and suicide awareness cards. Military One Source: 1-800-342-9647 National Suicide Prevention Lifeline: 1-800-273-8255
	Ensure newly assigned Soldiers are briefed on installation support agencies during in-processing.
	Ensure dependent school personnel are trained in identifying and referring individuals at risk for suicide.
	Review surveillance reports and, once identified, monitor the time it takes to get Soldiers into local helping agencies.
	Establish procedures for creating an Installation Suicide Response Team.
	In conjunction with members of the installation Suicide Prevention Task Force, review the Army Suicide Event Report (now DoDSER), CID case files, AR 15-6, Line of Duty investigation, and medical and personnel records to identify any trends and provide timely and adequate recommendations to the installation commander.

Annex C – 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 6-2b.

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 D – Abbreviations/Acronyms

AAFES – Army Air Force Exchange Service

AAS – American Association of Suicidology

ACE – Adverse Childhood Experiences

– Ask, Care, Escort

ACS – Army Community Service

ASAP – Alcohol and Substance Abuse Program

AIT – Advanced Individual Training

AMEDD – Army Medical Departments

ASER – Army Suicide Event Report

ASIST – Applied Suicide Intervention Skills Training

ASPP – Army Suicide Prevention Program

CDC – Center for Disease Control and Prevention

CID – Central Investigative Division

CCH – Chief of Chaplains

CPO – Civilian Personnel Office

CSA – Chief of Staff, Army

CY – Calendar Year

DCS, G-1PER – Deputy Chief of Staff, G-1

DoD – Department of Defense

ETOH – Ethyl Alcohol

FAP – Family Advocacy Program

FMWRC – Family, Morales, and Welfare Command

FORSCOM – Forces Command

GSW – Gunshot Wound

IET – Intial Entry Training

IG – Inspector General

IO – Investigating Officer

ISRT – Installation Suicide Response Team

ACOMs – Army Commands

MEDCOM – Medical Command

MH – Mental Health

MHO – Mental Health Officer

MP – Military Police

MTF – Medical Treatment Facility

MUSARC/RRC – Major United States Army Reserve Command/Reserve Readiness 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

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

SMA – Sergeant 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 E - References

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

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AR 600-63, Army Health Promotion

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 F – Useful Web Sites/Contacts

- American Assocation for Suicidology, (www.suicidology.org)
- Army Administrative Electronic Publication website, (www.usapa.army.mil/gils/)
- Army Behavioral Health, (http://www.behavioralhealth.army.mil/index.html)
- Army National Guard, (http://www.virtualarmory.com/WellBeing/suicide.aspx)
- Combat Readiness Center, (https://crc.army.mil/home/)
- Deputy Chief of Staff, G-1 Suicide Prevention Web Site, (www.armyg1.army.mil/hr/suicide.asp)
- Healthy People 2010, (www.health.gov/healthypeople)
- Installation Management Command, (www.imcom.army.mil/site/hr/asap.asp)
- Living Works Education, (www.livingworks.net)
- Military One Source, (www.militaryonesource.com)
- National Suicide Prevention Lifeline, (www.suicidepreventionlifeline.org/)
- Suicide Prevention Advocacy Network, (www.spanusa.org)
- Surgeon General's Call to Action, (www.surgeongeneral.gov/library/calltoaction)
- Tragedy Assistance Program for Survivors, (www.taps.org)
- U. S. Army Chaplains, (http://www.chapnet.army.mil/)
- 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
- National Lifeline: 1-800-273-TALK (8255)
- Military Once Source: 1-800-342-9647