BY MEYER MOLDEVEN

Suicide

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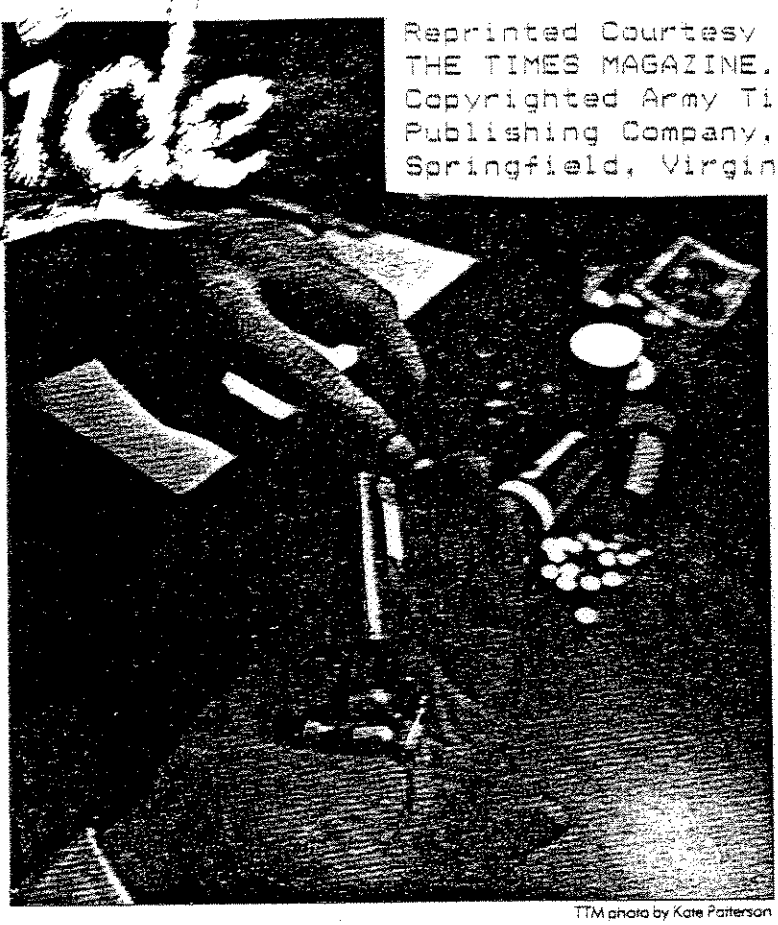
Prevention Must Be Everybody's Business



TTM photo by Kate Patterson

Estimates on the number of yearly suicides in the United States run from 25,000 to more than 50,000. The figure could be even higher, since many suicides are masked to look like accidents. And professionals estimate about eight suicide attempts for every one that succeeds.

The services are not exempt from this tragic phenomenon. A 1983 study by the Air Force Office of Special Investigations (OSI) showed that suicide was the fourth leading cause of death among active duty members.

The services do not keep statistics on suicide among dependents. But last year's well-publicized suicide of Army dependent Danny Holley at Fort Ord, Calif., showed us all too clearly that teenagers are especially vulnerable to suicidal feelings.

I have long advocated an organized suicide prevention effort within the military — one that would include training and involvement of *all* its people, not just those in the medical and mental health fields. Suicide prevention should be everybody's business, just as first aid and cardiopulmonary resuscitation (CPR) are.

Based on my own work in the Air Force inspector general field and as a volunteer suicide prevention worker, I believe that important roles can be played by security police, legal and personnel officers, chaplains, social actions workers, family service centers and many others. The chain of command — from commanders through first-line supervisors — should be deeply involved.

Over the past two decades, civilian communities have expanded their crisis intervention agencies enormously. There are now literally thousands of professional, para-professional and volunteer groups that can be helpful in suicide prevention. There are round-the-clock hot lines in almost every community. But do you — and others on your base — know how, when and why to call on them?

Commanders should be willing to plan and to commit resources to deal with suicide prevention in an orderly manner. They and appropriate agencies on base should be familiar with civilian resources, and have established procedures for using them. I believe the following questions deserve your consideration:

- Does your base have a program whereby supervisors and co-workers who might be confronted with suicidal people are trained to recognize the warning signs and refer potential suicides to professionals?

There *are* warning signs preceding many suicides. The Air Force OSI study of more than 200 active duty suicides found that about 47 percent of the suicide victims "gave clear, unmistakable indications of their intentions. Many of them not only told friends and co-workers of their intention to commit suicide, but told them how, where or when they intended to do it." Have *you* been taught what to do if confronted with such signals?

- Are any base personnel — especially security police, social actions or family support workers — trained in crisis intervention techniques? Are any of them volunteer workers in the local community's suicide prevention programs?
- Does your base have any sort of arrangement with local suicide prevention centers or hot lines so that a civilian crisis worker can contact the base for information or assistance? Do civilian volunteers know exactly whom to call for help when a military person or dependent threatens suicide?
- Do your base officials routinely check with local crisis clinics to find out the number and types of distress calls being received from military people? Is the information analyzed to determine trends or patterns?
- Do your base mental health workers give talks to active duty and dependents' groups on this subject? Are civilian experts on suicide prevention brought on base to explain their services?

Suicide rates in the military are believed to be lower than that of the general population. But this is no reason to be complacent. The OSI study concluded that the suicide rate was probably lower because service members are 100 percent employed, are younger than the general population and have easier access to health care. Nevertheless, the study warned: "Considering that on an average of once every six days an Air Force member takes his or her own life, the problem of suicide is worthy of serious attention."

I believe suicide prevention deserves the attention of *all* of us. Our efforts can only help save the lives of those around us. □

Meyer Moldeven is a retired Air Force civilian and an experienced suicide prevention worker.

DEPARTMENT OF THE ARMY
WASHINGTON, D.C. 20310

2/22/83

MEMORANDUM FOR MAJOR COMMANDS AND STAFF AGENCIES

Suicide is a tragedy for families and for the Army. Both are diminished by every loss of a person of promise. Those who knew the lost one search their minds for clues they might have missed, and wonder, helplessly, what caused such a final act.

The best advice available tells us that caring leadership and a responsible, broad-based support system are the keys to effective suicide prevention. We know that 80 percent of Army suicide victims give some warning they are in trouble. Leaders must listen to and see these warnings so that they can identify the soldier's problems and act responsibly as well as in time.

Commanders must sensitize leaders at all levels to this issue and improve responsiveness of soldier support programs. With all of the solid emphasis placed on caring leadership, on family support programs, and unit cohesion, we can reduce the Army's suicide tragedy.

The Department of the Army has developed a Suicide Prevention Strategy designed to help commanders deal with this problem. Commanders must use this plan and complement it with initiatives tailored to specific needs.

In an Army that truly cares about soldiers and families, no person should be nameless, faceless, or anonymous. We challenge all leaders to care enough for our people to save them.

JOHN A. WICKHAM, JR.
General, United States Army
Chief of Staff

John O. Marsh, Jr.
Secretary of the Army

(Excerpts pertaining to suicide prevention and psychological autopsy.)

ARMY REGULATION 600-63

Headquarters
Department of the Army
Washington, DC
Effective 17 December 1987

PERSONNEL - GENERAL
Army Health Promotion

Summary. This regulation prescribes policy, responsibilities, and procedures for the Army Health Promotion Program.

Applicability. This regulation applies to the Active Army, Army National Guard, U.S. Army Reserve, and civilians employed by the Army.

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Section II Responsibilities

1-8 The Surgeon General (TSG)

i. Overseas the technical aspects of Army training programs in suicide prevention.

j. Assures that Army Medical Department (AMMEDDs) provide--

(2) Training for health care providers in suicide risk identification and treatment for patients who may be at increased risk of suicide.

1-20 Medical Department Activity/Medical Center (MEDDAC/MEDCEN) commanders

d. Develop protocols for the identification and management of suicidal patients in each patient care unit of the medical treatment facility (MTF) and provide in-service suicide prevention training for health care providers.

e. Provide a mental health officer to conduct a psychological autopsy when required by this regulation.

Chapter 2

Health Promotion Policies

2-8. Suicide Prevention

a. Suicide prevention is the concern of every leader, commander, supervisor, soldier, and Army civilian.

b. A coordinated program for suicide prevention will be established at every Army installation, community, and activity in accordance with the policies set forth in chapter 5.

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Chapter 5

Suicide Prevention and Psychological Autopsy

This chapter sets guidelines for establishing the Army Suicide Prevention Program (ASPP). This program --

a. Supports the Army's goal to reduce the suicide risk for AC and RC

soldiers, Army civilians, and AC family members.

b. Establishes requirements for suicide risk identification training.

c. Outlines responsibilities for the ASPP.

d. Requires a psychological autopsy for specified deaths.

5-2 Army Suicide Prevention Program

A coordinated suicide prevention program will be established at every Army installation or community and separate activity.

ASPPs will provide --

a. A suicide prevention education awareness program for both military and civilian leaders, managers, and supervisors as well as family members. This program will train personnel in suicide risk identification and in procedures for crisis intervention and referral.

b. For the concentration of mental health and UMT (unit ministry team) resources to provide assistance as required to organizations and their members following the suicide of a soldier or Army civilian.

c. Assistance for families who have experienced the loss of a family member to suicide to the extent permitted by applicable laws and regulations.

5-3 Suicide Prevention Task Force.

a. Each installation/community will establish, plan, implement, and manage the local ASPP.

b. Installation and community commanders may assign the suicide prevention mission to the installation HPC (Health Promotion Council) or may elect to establish a separate Suicide Prevention Task Force (SPTF) to function as a subcommittee of the HPC. When using the HPC to manage the ASPP, care must be taken so that suicide prevention does not take a second place to other responsibilities of the council. Responsibilities of HPC members, with respect to suicide prevention, must be clearly established. Where a separate SPTF has not been established, the HPC will perform all the duties given to the SPTF.

5-4 Coordination of helping services.

a. ASPPs will make provision for the coordination of services provided by military and civilian helping agencies such as the Community Mental Health Service (CMHS), UMTs and the Chaplain Family Life Center, Army Community Services (ACS), the Alcohol and Drug Abuse Prevention and Control Program, American Red Cross, Youth Activities (YA), Child Development Services (CDS), local public schools or DODDS, and other agencies as appropriate.

b. This coordination will include information about and planning for programs and services as well as information pertaining to specific clients, if it is in the best interests of the client and done with regard to the requirements of client confidentiality. Non-Army persons are not permitted at meetings where information about individual cases is discussed without permission of the individual concerned.

5-5 Training

a. Sequential and progressive suicide risk identification training will be integrated, without increasing the length of the program of instruction, into every Army leadership development course conducted by the Army school system. Specifically, this information will be provided at all levels of the Noncommissioned Officer Education System (NCOES) and officer leadership courses. At a minimum, students will receive a

copy of DA Pam 600-70, or a locally produced information pamphlet containing essentially the same information. Students will also be given the opportunity to view the Army videotape "Suicide Prevention," SAVPIN 701299DA (TVT 8-93).

b. Formal training in suicide prevention and suicide risk identification will be presented as part of the unit level officer and NCO professional development courses.

c. Regularly scheduled installation level courses for civilian supervisors and designated CPO personnel will include training in suicide prevention.

d. Helping professionals (physicians, nurses, psychologists, social workers, chaplains, and counselors) and military police will receive regular in-service training in suicide prevention and crisis intervention.

e. Army mental health officers will provide the technical expertise for all suicide prevention education/awareness training. It is the role of the mental health officers to "train the trainers" in all suicide prevention education programs.

f. Unit ministry teams (chaplains and chaplain assistants) will be trained by mental health officers in suicide prevention and suicide risk identification. Chaplains will assist mental health officers by providing suicide prevention education awareness training. This is a staff function at battalion or lower levels for the chaplain.

g. Army Community Services (ACS) personnel will be trained by mental health officers and will conduct a suicide prevention education program for family members. In-servise training in suicide prevention for the staffs of ACS, YA, and CDS will be coordinated by the ACS officer/director and may be conducted by mental health officers or chaplains. ACS personnel will not be used to conduct suicide prevention training for military units or soldiers.

5-6 Family member suicide prevention program (FMSPP).(This paragraph was revised 30 November 1992)

a. The FMSPP will be implemented by the installation staff chaplain through the Unit Ministry Team (UMT), in coordination with the SPTF or HPC. It is intended to promote an understanding of suicide in the community. The chaplain will coordinate, provide, and/or conduct an education awareness program for family members to help them recognize the signs of increased suicide risk, and to learn about referral sources for friends and family members. Educational programs will focus on (but not be limited to) three groups: parents, teenagers, and spouses.

b. Where appropriate, soldier and family member suicide education and awareness may be conducted concurrently. Though the content will be clearly prescribed, the context of the education and awareness activities is at the discretion of the chaplain. Available operational and training funds may be used to support both the chaplain UMT training mission and the conduct of suicide prevention education and awareness activities. Chaplains are encouraged to be innovative and creative when determining possible education and awareness systems. All existing religious and spiritual fitness programs, stress management programs, and community/family programs as well as all other available military and civilian resources and programs should be viewed as contributory to and/or significant components in the overall family member suicide prevention education and awareness program.

c. In his capacity for oversight of the technical aspects of Army training programs in suicide prevention , the Surgeon General will, in collaboration with the Chief of Chaplains, establish the basic content for family member suicide prevention and awareness training.

d. The Chief of Chaplains, in close coordination with The Surgeon General,

will establish the minimum chaplain training standards and ensure that all chaplains and chaplain assistants conducting family member suicide prevention and awareness activities are adequately trained by CMHS personnel in basic family member suicide prevention and awareness skills.

e. The primary mission of the chaplain UMT in the FMSPP is education and awareness. UMT personnel will refer any suicidal individual to the MTF or CMHS. Chaplains will not provide clinical services or crisis intervention counseling to any suicidal individual. UMT personnel may undertake post-intervention actions in their role as primary staff officers, unit or community pastors, or as advisors to the commanding officer referring individuals to the MTF or CMHS.

5-7 Reporting and data analysis

a. Suicides and suspected suicides of AC and RC soldiers, AC family members, and Army civilians will be reported immediately to the military police for preparing a Serious Incident Report (SIR) to HQDA in accordance with AR 190-40. Those cases involving Army jurisdiction will be referred by the military police to the local United States Army Criminal Investigation Command (USACIDC) field element for appropriate investigation in accordance with AR 195-2.

b. The SPTF will collect and analyze local data on suicide attempts. This analysis will include the numbers of high, medium, and low lethality attempts by category of personnel and by unit. Data reflecting the reasons for suicide attempts will be collected.

5-8 Psychological Autopsy

a. As provided in AR 195-2, a psychological autopsy will be conducted by a mental health officer and provided to USACIDC for deaths that meet the criteria established below. Subjects for investigation include all AC soldiers and all RC soldiers who are on active duty or active duty for training, and any active member of other armed forces of the United States assigned or attached to an Army unit or installation under any of the following conditions --

1) Confirmed or suspected suicides.

(2) Single car motor vehicle accidents with no survivors when requested by the commander of the local USACIDC office.

(3) Accidents involving unusual or suspicious circumstances: for example, deaths due to substance abuse, or resulting from self-inflicted gunshot wounds.

(4) All cases in which the mode (manner) of death is equivocal. That is, death cannot be readily established as natural, accidental, a suicide, or a homicide.

(5) Other cases when requested by the commander or special agent in charge of the local USACIDC.

b. The report of the psychological autopsy will be included in the CID Report of Investigation as provided in AR 195-2.

c. Reports of psychological autopsy are sent by the preparing officer through the MACOM to each of the following --

1) HQDA (SGPS-CP-F), 5111 Leesburg Pike, Falls Church, VA 22041-3258

(2) HQDA (DAPE-MPH) 5111 Leesburg Pike, Falls Church, VA 22041-3258

(3) Commander. Walter Reed Army Institute of Research, Attn: SGRD-UWI-A , WASH DC 20307-5100

Headquarters
Department of the Army
Washington, DC
30 September 1988

Department of the Army
Pamphlet 600–24

Personnel—General

Suicide Prevention and Psychological Autopsy

This UPDATE printing publishes a new Department of the Army pamphlet.

By Order of the Secretary of the Army:

CARL E. VUONO
General, United States Army
Chief of Staff
Official:

WILLIAM J. MEEHAN II
Brigadier General, United States Army
The Adjutant General

Summary. This pamphlet explains the policies and procedures for establishing the Army Suicide Prevention Program and for conducting a psychological autopsy.

Applicability. This pamphlet applies to the Active Army, the Army National Guard, and the U.S. Army Reserve.

Impact on New Manning System. This pamphlet does not contain information that affects the New Manning System.

Interim changes. Interim changes to this pamphlet are not official unless they are authenticated by The Adjutant General. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

Suggested improvements. The proponent agency of this pamphlet is the Office of the Deputy Chief of Staff for Personnel. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA-DAPE-MPH), WASH DC 20310–0300.

Distribution. Active Army: B, C, D; ARNG: B, C; USAR: B, C.

Contents (Listed by paragraph number)

Chapter 1
Introduction

1–1. Purpose
This pamphlet sets forth policy and procedures for establishing the Army Suicide Prevention Program (ASPP) and conducting psychological autopsies. It provides guidance for all suicide prevention activities of the Army and for any psychological autopsies. It provides the rationale, circumstances of use, and guidance for reporting of psychological autopsies.

1–2. References
a. Required publications.

(1) AR 195–2, Criminal Investigation Activities. (Cited in paras 2–4*i*(1) and 3–7*d*.

(2) AR 600–63, Army Health Promotion Program. (Cited in para 5–1*a*.)

b. Related publications. A related publication is merely a source of additional information. The user does not have to read it to understand this regulation.

(1) DA Pam 600–70 (United States Army Guide to the Prevention of Suicide and Self-Destructive Behavior).

(2) AR 40–216, Neuropsychiatry and Mental Health.

(3) AR 600–8–1, Army Casualty and Memorial Affairs and Line of Duty Investigations.

(4) DA Pam 600–70, U.S. Army Guide to the prevention of Suicide and Self-Destructive Behavior.

1–3. Explanation of abbreviations and terms
Abbreviations and special terms used in this publication are listed in the glossary.

Chapter 2
Suicide Prevention

2–1. The Army Suicide Prevention Program
Suicide prevention must be the business of every leader, supervisor, soldier, and civilian employee in the Army. To facilitate this effort, a coordinated program for suicide prevention is needed at every Army installation and separate activity.

2–2. Suicide Prevention Task Force
a. Each installation establishes a committee to plan, implement, and manage the local ASPP. The membership of this committee will be tailored to meet local needs.

b. Installation commanders may assign the suicide prevention mission to the installation Health Promotion Council or may elect to establish a separate Suicide Prevention Task Force (SPTF) to function as a subcommittee of the Health Promotion Council. When using the Health Promotion Council to manage the ASPP, care must be taken so that suicide prevention does not take a second place to other responsibilities of the council. Responsibilities of the council members, with respect to suicide prevention, must be clearly established.

c. The SPTF should consist of the following personnel or their local equivalent:

(1) The Director of Personnel and Community Activities (DPCA).

(2) The Director of Plans and Training (DPT).

(3) Installation and division chaplains.

(4) The Director of Health Services (DHS).

(5) The division surgeon.

(6) The Chief, Community Mental Health Service.

(7) The division mental health officer.

(8) The public affairs officer (PAO).

(9) The civilian personnel officer (CPO).

(10) The provost marshal.

(11) Commander or special agent-in-charge of supporting U.S. Army Criminal Investigation Division Command (USACIDC) element.

(12) The staff judge advocate (SJA).

(13) The Alcohol and Drug Control Officer (ADCO).

(14) The Army community services officer (ACS).

(15) A representative of the post family member schools.

(16) Other installation and community agencies as needed.

2–3. Functions of the Suicide Prevention Task Force
The Suicide Prevention Task Force will—

a. Coordinate program activities and the suicide prevention activities of the command, interested agencies, and persons.

b. Evaluate the program needs of the installation and make appropriate recommendations to the commander.

c. Review, refine, add, or delete items to the program based on an on-going evaluation of needs.

d. Develop awareness training about installation suicide prevention activities and identify appropriate forums for training.

e. Evaluate the impact of the pace of training and military operations on the quality of individual and family life in the total military community.

f. Recommend command policy guidance about training and operations issues to assure that soldiers and their leaders have sufficient opportunity for quality family life.

g. Be aware of publicity generated with respect to suicides in the community and develop public awareness articles for publication.

h. Meet at the discretion of the task force presiding officer.

i. In the event of a suicide, review the results of the psychological autopsy to look for the possible causes of the suicide and, if necessary, evaluate the prevention effort and make recommendations to the commander.

j. Coordinate with civilian support agencies as necessary.

2-4. Functions of the Suicide Prevention Task Force members

The following list of specific functions for task force members and other installation staff agencies is provided as a guide for the efficient operation of the SPTF.

a. The Director of Personnel and Community Activities—

(1) Serves as the presiding officer of the Suicide Prevention Task Force and coordinate the efforts of task force members.

(2) Serves as the point of contact for program information and advice to the commander and to major subordinate commands.

(3) Integrates suicide prevention into community, family, and soldier support programs as appropriate.

b. The Director of Plans and Training—

(1) Serves as the task force presiding officer in the absence of the DPCA.

(2) Informs the task force of the current training and operational requirements of the command and estimates the impact of their requirements on the quality of life within the area served by the task force.

(3) Develops policy to assure that the impact of the pace of operations on individual and family quality of life be considered in planning for all training and operational requirements.

c. Division and installation chaplains—

(1) Advise installation and unit commanders on moral and ethical issues and other stress factors that may result in an increased number of people at risk.

(2) Assure that all chaplains within the command are trained to identify individuals who may be at increased risk of suicide and make an appropriate referral. This training will be conducted with the assistance of local mental health officers.

(3) Provide the training expertise that will assist the command in the education-awareness training process. Unit chaplains will be the cornerstone of the effort to provide and will assist unit level suicide prevention training for leaders, supervisors, soldiers, and civilian employees. Chaplains will advise and assist other staff members and task force members in satisfying identified training needs in this area.

d. The Director of Health Services—

(1) Assesses and advises the installation commander on stress factors that may result in increased numbers of persons at risk.

(2) Provides mental health officers to train other trainers in the post education—awareness program.

(3) Assures that the training provided by chaplains and other staff agencies such as ACS and the Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) is appropriate.

e. The division surgeon—

(1) Assures that division health care providers are trained in crisis intervention techniques using periodic in-service education.

(2) Serves as liaison with the Medical Department Activity (MEDDAC) Mental Health Service and the Division Mental Service.

(3) Coordinates training activities with the division and installation chaplains.

f. The Army Community Services Officer—

(1) Serves as the staff officer responsible for the Family Member Suicide Prevention Program.

(2) Continues operation of advocacy and out-reach programs dealing in areas of stress and family violence.

(3) In coordination with SPTF and PAO, heightens public awareness of the support and helping mechanisms available within the community.

(4) Conducts appropriate in-service training to maintain the level of awareness of ACS staff members including volunteers who routinely assist soldiers, civilian employees, and family members who might be at risk of suicide.

(5) Emphasizes support agencies and mechanisms during family member orientations and other appropriate briefings.

(6) Serves as the specific task force participant responsible for coordinating with civilian support agencies.

g. The Public affairs officer coordinates the community awareness needs of the task force.

h. The provost marshal—

(1) Ensures that military police forces respond to potential suicide situations discretely and cautiously to avoid increasing stress (Normally the use of emergency equipment (lights or sirens) would be inappropriate).

(2) Provides feedback information to the task force, as appropriate, on any suicide related events that may have occurred on post.

(3) Reinforces instruction presented at the U.S. Army Military Police School concerning identification of persons at risk for suicide, and emphasizes that actions taken by military police in the line of duty may cause some people to be at increased risk of suicide. An example might be a teenager who has been arrested for shoplifting and is greatly embarrassed about his or her behavior. Awareness training, using the assistance and advice of chaplains and mental health professionals, may be conducted at in-service training and professional development classes.

(4) Establishes liaison with local civilian police agencies, as appropriate, to coordinate community suicide prevention programs and procedures.

i. Commander or special agent-in-charge of the supporting USACIDC element—

(1) Investigates all suicides or suspected suicides (see AR 195-2).

(2) Establishes liaison with local civilian police agencies, as appropriate, to obtain information regarding suicide related events involving military personnel, their families, or civilian employees, which may have occurred off-post, and provide such information to the task force. Such liaison activity will be in compliance with applicable statutes of the local civilian community.

(3) As allowed by appropriate regulations, provides the task force extracts from the Criminal Investigation Division (CID) reports of investigation (including psychological autopsy), which may be useful in understanding the reasons for a suicide and in formulating future prevention plans.

j. The staff judge advocate provides suicide prevention awareness training for the personnel of the staff judge advocate and trial defense service personnel using the advice and assistance of the chaplains and mental health professionals. Trial defense service personnel and legal assistance officers may assist soldiers, family members, and, in certain circumstances, civilian employees who are in crisis, not only from administrative and legal actions, but also from other causes. The administrative and legal actions initiated against some persons may cause them to be at increased risk of suicide. Identifying persons at risk of suicide and referring them to the proper support person or agency is crucial.

k. The civilian personnel officer—

(1) Assures that local programs take into consideration the needs of the civilian work force.

(2) Is responsible for coordinating the training for civilian managers and supervisors.

l. The alcohol and drug control officer—

(1) Advises the commander as to the impact of alcohol and drug abuse on suicide risk.

(2) Assures that the Alcohol and Drug Abuse Prevention and Control Program staff are trained in suicide risk identification factors and in the management of suicidal clients.

m. Commanders—

(1) Coordinate and conduct awareness training for subordinate leaders.

(2) Assure that subordinates are aware of assistance agencies.

(3) Refer individuals who are identified as having personal or emotional problems to an appropriate source of help. It is essential that commanders follow through to assure that the problem is either resolved or continuing help is being provided.

(4) Send a representative of the Family Member School System to the SPTF. The Family Member School System representative should coordinate training for school personnel in identifying and referring individuals at risk for suicide.

2-5. Strategy

a. The strategy and supporting elements of the ASPP are based on the premise that suicide prevention will be accomplished by leaders through command policy and action. The key to the prevention of suicide is positive leadership and deep concern by supervisors of military personnel and civilian employees who are at increased risk of suicide.

(1) Once identified as being at increased risk, military personnel will be referred to appropriate helping agencies such as the Community Mental Health Service (CMHS) or emergency room of the medical treatment facility and tracked by the unit commander to assure problem resolution.

(2) Civilian employees identified to be at increased risk will be encouraged to seek assistance from appropriate civilian agencies.

b. Leaders must know their subordinates and assure that timely assistance is provided when needed. Installation commanders must emphasize the importance of suicide prevention through the publication of command letters, directives, and instructions as appropriate.

c. It is the Army's goal to prevent suicide for soldiers, family members, and civilian employees. However, it must be recognized that in some people, suicidal intent is very difficult to identify or predict, even for a mental health professional. Some suicides may be expected even in units with the best leadership climate and most efficient crisis intervention and suicide prevention programs. Therefore, it is important to redefine the goal of suicide prevention as being suicide risk reduction. Suicide risk reduction consists of reasonable steps taken to lower the probability that an individual will commit acts of self-destructive behavior.

d. The ASPP provides a systematic framework in which commanders may work to lower the risk of suicide for soldiers, family members, and civilian employees. This will lead to lower suicide rates in the Army and will impact significantly on the loss of life and productivity that can result from suicidal behavior.

2–6. Signs of depression and immediate danger signals

a. Depression is characterized by the following symptoms:

(1) Poor appetite or significant weight loss or increased appetite or significant weight gain.

(2) Change in sleep habits, either excessive sleep or inability to sleep.

(3) Behavioral agitation or a slowing of movement.

(4) Loss of interest or pleasure in usual activities or decrease in sexual drive.

(5) Loss of energy or fatigue.

(6) Complaints or evidence of diminished ability to think or concentrate.

(7) Feelings of worthlessness, self-reproach, or excessive guilt.

(8) Withdrawal from family and friends.

(9) Drastic mood swings.

(10) Sudden change in behavior.

b. Immediate danger signals are—

(1) Talking about or hinting at suicide.

(2) Giving away possessions or making a will.

(3) Obsession with death, sad music or sad poetry. Themes of death in letters or art work.

(4) Making specific plans to commit suicide and access to lethal means.

(5) Buying a gun.

Chapter 3
Program Elements

3–1. Education

a. Every member of the Army family has the potential to come in contact with a person who is at increased risk of suicide. Crucial steps in the suicide prevention process are an awareness of the variables and life stress events that put individuals at risk and the signs and symptoms of a person at risk. Therefore, as a first priority, leaders, managers, and supervisors at all levels will receive training in suicide risk identification and suicide prevention.

b. Ultimately, all members of the Army family should have a level of awareness that will enable them to identify problems and refer co-workers, friends, and family members who are in crisis to an appropriate source of help.

c. Training in stress management and coping skills is of great value in the overall prevention effort.

d. Inherent in sustaining a prevention program, is the continued use of judicious, low-key community awareness activities. Community awareness includes—

(1) Publication of existing military and civilian crisis hot line numbers in local media.

(2) Publication of articles on stress, depression, family violence and abuse, substance abuse, and the identification of agencies that can help.

(3) The amount and type of community awareness activities will be tailored to the needs of the community as evaluated by the SPTF. Units may coordinate with unit chaplains and the CMHS regarding appropriateness and content of this type of information in unit newsletters.

(4) Media items may need to be published prior to periods or events that are likely to produce a higher than normal incident of suicide (for example, the summer moving months of July and August have a higher incidence of suicide).

3–2. Identification and crisis intervention

a. Leaders and other individuals who are aware of suicide risk factors can facilitate early identification and intervention for persons in crisis. Early involvement is a critical factor in suicide risk reduction.

b. Leaders, supervisors, and other members of the Army community who are in frequent, close contact with others are often in the best position to identify persons at risk. Intervention may include listening, referring, and taking the person to a helping agency.

c. Persons who express suicidal thoughts will, at their request, be taken directly to a mental health professional. Law enforcement and medical personnel should be summoned to the scene if the individual declines assistance. It is important to understand that prevention is not solely accomplished by awareness and identification. Intervention includes alteration of the conditions which produced the current crisis, treatment of any underlying problem that contributed to suicidal thoughts, and long term follow-up to assure problem resolution.

d. Medical treatment facility (MTF) emergency rooms and urgent care rooms are the primary 24-hour crisis intervention facilities on most Army installations. Procedures for continuous crisis intervention services should be well defined by the MTF and included in the ASPP.

e. At installations that do not have 24-hour access to military emergency room care, the installation or community will provide for continuous crisis intervention services.

f. Maximum use should be made of crisis "hot" lines, which may exist in the civilian community. Publication of these numbers through military means should be coordinated with the civilian agency providing the service. Where available, data on military use of crisis hot lines should be collected and analyzed by the SPTF.

3–3. Suicide risk management team (SRMT)

a. Army divisions and other large activities with adequate support should consider establishing a suicide risk management team (SRMT). This is an optional element of the ASPP. The SRMT will actively monitor the progress of soldiers identified as suicidal and at high risk. The team is charged with the responsibility of addressing the medical and administrative needs presented by high risk cases.

b. The SRMT will convene immediately during a suicide crisis at the request of the battalion or separate company commander. Its function is to assist the commander in assessing the situation, determining appropriate courses of action, directing immediate interagency and interstaff actions, and advising the commander. Team intervention will include taking actions necessary to provide for the immediate welfare of families who have suffered a suicide or suicide attempt.

c. The SRMT will not become involved in rescue or emergency lifesaving operations with respect to suicide attempts. These activities will be left to military police and medical personnel who are trained in emergency procedures. It is the role of the SRMT to address those problems and issues that precipitated the suicide attempt and to deal expeditiously with them.

3–4. Objective of the suicide risk management team

a. Non-divisional installations and communities should substitute appropriate non-divisional or community staff officers.

b. The SRMT intervenes in suicide attempts with a goal of preventing suicides. The SRMT will be composed of—

(1) The division surgeon.

(2) The division psychiatrist.

(3) The battalion or separate company commander.

(4) A representative of the division chaplain.

(5) A representative of the Assistant Chief of Staff G1 (personnel) (G1/AG).

(6) A representative of the staff judge advocate.

(7) A representative of the provost marshal.

(8) A representative of the Alcohol and Drug Control Office (ADCO).

(9) A representative of the Army Community Services Office (ACS).

3–5. Functions of members of the SRMT

a. Battalion and separate company commanders—

(1) Convene, through the division surgeon, the SRMT when soldiers within the command are identified as a suicide risk.

(2) Institute procedures within the battalion or company to facilitate the identification, evaluation, and medical evacuation (if necessary), of soldiers at increased risk of suicide.

(3) Maintain an active and close liaison with other members of the SRMT on matters affecting members of the command.

(4) Coordinate any necessary administrative action required by members of the command who have attempted suicide.

b. The division surgeon—

(1) Assumes primary responsibility as the SRMT coordinator.

(2) Develops and manages case files on identified high risk individuals.

(3) Provides active multidisciplinary coordination for the medical, administrative, and legal needs of the suicidal individual, utilizing to the fullest extent possible the offices provided by other team members, medical treatment facilities, and existing human resource agencies.

(4) Serves as the primary point of contact during a suicide crisis for battalion and separate company commanders to convene the SRMT.

(5) Institutes all necessary management procedures internal to division and executes, as necessary, memorandums of understanding with medical treatment facilities to assure that an immediate and appropriate response to a suicide attempt is achieved.

(6) Provides for collection, evaluation, and dissemination of all data pertaining to attempted suicides or suicide related behavior. The release of information must adhere to the protection of the privacy rights of family members and the military interest. Although deceased persons have no right to privacy, their family members are protected under the Privacy Act.

(7) Coordinates the use of medical assets in the training of stress management, suicide prevention, and family advocacy subject matters.

c. The division psychiatrist

(1) Serves as the alternate coordinator in crisis situations in the absence of the division surgeon, and as the principal point of contact with medical treatment facilities as a member of the SRMT.

(2) Provides for the clinical evaluation, treatment and disposition of military personnel who may be at increased suicide risk.

(3) Provides for training in stress management, suicide prevention, and family advocacy subject matters.

(4) Provides battalion and separate company commanders information about soldiers who may be at increased risk of suicide, when it is necessary for the commander to take action to protect a soldier, and convene the SRMT if suicide is imminent.

(5) Develops and disseminates an epidemiologic profile that will serve as a standard by which members of the chain of command can identify potential suicides.

(6) Assists the division surgeon in the collection and analysis of suicide related behavioral data.

d. The division chaplain representative—

(1) Meets with the division surgeon during a suicide crisis upon request.

(2) Develops policies and procedures for unit chaplains to assure an active monitoring of high risk soldiers and provide for chaplain intervention during a suicide crisis.

(3) Provides immediate pastoral assistance to families who have suffered a suicide or suicide attempt.

(4) Assists the division surgeon in providing training to soldiers in stress management, suicide prevention, and family advocacy subject matters.

e. The G1/AG (personnel) representative—

(1) Meets during a suicide crisis when requested by the division surgeon.

(2) Supports the division surgeon in the collection, analysis, and dissemination of suicide related behavioral data.

(3) Formulates letters of instruction, regulations, etc., as required, to prescribe appropriate procedures and activities which foster suicide prevention and intervention.

(4) Advises other team members on career implications, courses of action, etc., regarding soldiers identified as potential suicides.

(5) Coordinates with the battalion or separate company commander concerned, and provides advice or administrative assistance as required.

f. The provost marshal representative—

(1) Meets during a suicide crisis when requested by the division surgeon.

(2) Ensures that procedures are established for immediate notification of the division operations center, the division surgeon, and the appropriate commander during instances when suicides or family members suicides are imminent or have occurred. Also coordinates directly with medical treatment facilities in crisis situations (emergency rooms) as appropriate or necessary.

(3) Provides for immediate protection and well being of soldiers or family members at high risk for suicide until unit or medical personnel are on the scene.

g. Representatives of the adjutant general, staff judge advocate, alcohol and drug control officer, and army community services officer.

(1) Meet during a suicide crisis when requested by the division surgeon.

(2) Provide advice and assistance to the division surgeon within their areas of administrative or professional expertise on matter pertaining to suicide risks or attempts.

3–6. Followup treatment

The permanent prevention of suicide for an individual at risk depends upon treatment of the underlying disorder (such as depression), and the alteration of conditions that produced the current crisis. Effective treatment depends on the availability of mental health professionals (psychiatrists, psychologists, psychiatric nurses, and social workers) who are properly trained for the population they serve.

3–7. Postvention activities

a. Postvention activities involve the therapeutic work with survivor victims of a dire event such as suicide. A suicide creates an adverse impact on the morale and readiness of a military unit. Often a great sense of guilt is experienced by leaders and others who may have known or felt they should have known that the victim was experiencing difficulty. In an attempt to continue "business as usual", such feelings may be ignored or submerged by both the organization and individuals. Such practices delay the healing process and prolong the impact on unit readiness.

b. ASPPs will make provisions for the concentration of mental health and chaplain resources to provide assistance as required to an organization and its members following a suicide of a soldier or civilian employee. Open discussion with a mental health officer allows survivors to express feelings of loss, grief, embarrassment, guilt, and anger over the possible suicide of a loved one.

c. The loss of a family member, especially the loss of a child due to suicide, is perhaps the most difficult form of death for survivors to accept. On top of their grief over the death of a loved one, families of suicide victims often experience shame, humiliation, and embarrassment. Other common reactions are fear, denial, anger, and guilt, all of which combine to produce one of the most difficult crisis a family will ever experience. At these times the complete resources of the military community must be mobilized to assist the family. The ASPP will make explicit provisions for assisting families who have experienced such a loss to the extent permitted by applicable laws and regulations.

d. The psychological autopsy required by AR 195–2 provides an excellent opportunity for postvention activities. This procedure brings a mental health officer into early and direct contact with the survivors of a suicide victim and facilitates bereavement counseling. This counseling not only speeds the recovery of survivors but may also prevent new suicides among the affected group.

Chapter 4
Family Member Suicide Prevention

4–1. Family Member Suicide Prevention Program

a. The Family Member Suicide Prevention Program (FMSPP) will be implemented by Army Community Services (ACS). This program includes suicide prevention education for Army family members and referral to other helping agencies as needed. Suicide prevention for family members is not a separate ACS mission or program. Suicide prevention is an integral and inherent part of the family violence prevention programs of the Family Advocacy Program (FAP) and other ACS programs.

b. ACS programs, which include suicide prevention will be coordinated with the overall suicide prevention efforts of the installation and the Army. It is inappropriate for ACS to provide crisis intervention services for suicidal individuals, except as it may surface under the provisions of ACS services. ACS crisis intervention will be limited to referral to the MTF or CMHS. ACS personnel will not provide counseling or clinical services to any individual or family where suicide may be a concern. Such individuals or families will be referred to the MTF or directly to the CMHS. Specific roles and functions for supporting installation suicide prevention programs are discussed in the following paragraphs.

4–2. Program development

a. Program development should be based on existing military and civilian family and social service resources. Personnel who are in contact with military families at particular stress points such as permanent change of station (PCS) moves, financial difficulties, significant losses, domestic violence, and who find services for exceptional family members can provide input on needs, available services, and target groups for community awareness efforts.

4–3. Education awareness

a. The FMSPP is designed to promote an understanding of the potential for suicide in the community. The installation ACS officer will conduct an education awareness program for Army family members to help them recognize the signs of increased suicide risk and to learn about referral sources for friends and family members. Educational programs will focus on three groups—parents, teens, and spouses.

b. Education awareness efforts will include the following:

(1) Distribution of information materials at strategic places such as hospital waiting rooms, schools, youth activity (YA) centers, commissaries, launderettes, snack bars, in-processing centers, civilian personnel centers, installation health fairs, and in welcome packets.

(2) Presentations about suicide prevention to interested community and military groups such as parent-teacher organization meetings, newcomers orientations, and mayors' program meetings.

(3) Production and distribution of guides to soldier and family support services available and how to use them.

4–4. Staff suicide prevention training

a. ACS professionals and volunteers who come in contact with soldiers and family members will receive training in suicide prevention. Training may be obtained through any or all of the following:

(1) The ACS course and the Family Advocacy Staff Training (FAST) course.

(2) In-service and contracted training.

(3) Review of professional books and journals, pamphlets, and video and audio cassette training programs.

b. Training for other community staff supporting the suicide prevention mission such as YA, child development services (CDS) as well as key family support group representatives and contact persons will be coordinated by the ACS Officer. Assistance in conducting this training may be sought from military mental health officers, chaplains, and other community assets.

4–5. Development of support groups

Family support groups should be developed as a part of the FMSPP. The best primary prevention is an informed community that demonstrates care and concern for its members by assuring that families are accepted into the mainstream of community life. This acceptance reduces the frustration and depression that can lead to suicidal thoughts, feelings, and plans. The degree of stress a family experiences with a problem is directly related to their belief that they can solve the problem or get help that they need. Support groups can reduce family isolation and provide the support, nurturing, and assistance the family needs in time of distress.

4–6. Focus on family life education

Family life education can improve family functioning and reduce potential problems by providing services such as—

a. Child development and parenting classes.

b. Communication skills workshops.

c. Assertiveness training.

d. Stress management training.

e. Financial management assistance.

Chapter 5
Psychological Autopsy

5–1. General

a. A psychological autopsy will be conducted according to the criteria and procedures specified by AR 600–63. The purpose of the psychological autopsy is to—

(1) Provide the victim's commander with information about the death.

(2) Enable the unit and the Army to develop future prevention programs and lessons learned so that soldiers and family members are better served.

b. It is not intended that the psychological autopsy be used to assign blame when a suicide occurs. Commanders should not take a fault finding approach to investigating suicides or suicide attempts. While understanding and publicizing the lessons learned is helpful, it is important that senior commanders are supportive towards unit commanders when a suicide occurs. Such an approach will speed the recovery of the unit following a suicide and will promote combat readiness.

c. The use of the psychological autopsy in the Army has grown beyond its original function—the clarification of equivocal deaths. The retrospective analysis of deaths serves to increase the accuracy of reports and will promote the epidemological study of suicide in the military population. A review of the status of the victim with those who had a special relationship with the victim prior to the act (that is, supervisors, coworkers, physician, relatives, and friends) will provide a source of information for future prevention actions.

d. Finally, the psychological autopsy brings a mental health officer into direct contact with survivors of a suicide victim, which facilitates bereavement counseling.

e. The intention of the victim determines whether a death is classified as suicide rather than an accident. In an equivocal case, it is difficult to evaluate the deceased's intentions, either because the factual circumstances of the death are incompletely known, or because the deceased's intentions were ambivalent, partial, inconsistent, or not clear.

f. The psychological autopsy is a thorough, retrospective investigation of the intention of the victim relating to his or her being dead. The information for the autopsy is obtained by interviewing individuals who knew the victims actions, behavior, and character well enough to report on them.

g. At present there are at least two distinct questions that the psychological autopsy can help to answer, as follows:

(1) Why did the individual do it? When the mode of death is clear and unequivocal, the psychological autopsy can serve to enhance our understanding of the factors that lead to the act. When the mode of death is clear, but the reasons for the manner of dying remain puzzling, the psychological autopsy is a reconstruction of the motivations, philosophy, psychodynamics, and existential crisis of the decedent.

(2) What is the most probable mode of death? When the cause of death can be clearly established but the mode of death is equivocal, the purpose of the psychological autopsy is to establish the mode of death with as much accuracy as possible.

5–2. Operational criteria for the classification of suicide (OCCS)

The OCCS that follows were developed to provide a standard definition of suicide for purposes of conducting a psychological autopsy.

a. Self-inflicted. There is evidence that death was self-inflicted. Pathological (autopsy), toxicological, investigatory, and psychological evidence, and statements of the decedent or witnesses may be used for this determination.

b. Intent. There is evidence (explicit and/or implicit) that at the time of injury the decedent intended to kill self or wished to die and that the decedent understood the probable consequences of his or her actions.

(1) Explicit verbal or nonverbal expressions of intent to kill self.

(2) Implicit or indirect evidence of intent to die such as the following:

(a) Preparations for death, inappropriate to or unexpected in the context of the decedent's life.

(b) Expressions of farewell or desire to die, or acknowledgment of impending death.

(c) Expressions of hopelessness.

(d) Efforts to procure or learn about means of death or rehearse fatal behavior.

(e) Precautions to avoid rescue.

(f) Evidence that decedent recognized high potential lethality of means of death.

(g) Previous suicide attempt.

(h) Previous suicide threat.

(i) Stressful events or significant losses (actual or threatened).

(j) Serious depression or mental disorder.

5–3. Motivation for suicide

a. The psychological autopsy should address the motivation for suicide. The reasons, motives, and psychological intentions of suicidal persons are quite complex. Some of the prominent mental trends in suicidal persons are—

(1) A wish to escape from mental or physical pain.

(2) A fantasy of eternal rest or life with a loved one.

(3) Anger, rage, revenge.

(4) Guilt, shame, atonement.

(5) A wish to be rescued, reborn, start over.

(6) A wish to make an important statement or communication.

b. Destructive ideas or impulses that are ordinarily well controlled or mostly unconscious can be activated or released under the influence of emotional stress, physical exhaustion, or alcohol.

5–4. Role of intent

a. Suicide implies a direct connection between the victim's intention, self-destructive action, and subsequent death. Uncertainty about the correct certification of death results when—

(1) The victim's intention was ambivalent, with coexisting wishes both to live and to die,

(2) The self-destructive action itself was inconclusive,

(3) death followed the action after a considerable delay.

b. Intention is variable in degree, not all or nothing. The concept of intention signifies that the individual understood, to some degree, his or her life situation and the nature and quality of the proposed self-destructive action.

5–5. Classification of suicides by intent

a. One classification system that incorporates the notion of degree of intention and that may be used in the autopsy is as follows:

(1) First-degree suicide: deliberate, planned, premeditated, self-murder.

(2) Second-degree suicide: Impulsive, unplanned, under great provocation or compromising circumstances.

(3) Third-degree suicide: victim placed his or her life in jeopardy by voluntary self-injury, but we infer the intention to die was relatively low because the method of self-injury was relatively harmless, or because provisions for rescue were made. The victim was "unlucky" enough to die.

b. The following are two other categories of self-inflicted death that are not typically classified as suicide because the intention to die cannot be established.

(1) Self-destruction when the victim was psychotic or highly intoxicated from the effects of drugs or alcohol. These circumstances suggest impaired capacity for intention.

(2) Self-destruction due to self-negligence. This last category of death has been described as subintentioned death. A subintentioned death is a death in which the decedent plays some partial, covert, or unconscious role in his or her own demise. Evidence for this ambivalence toward life may be found in a history of poor judgment, excessive risk-taking, abuse of alcohol, misuse of drugs, neglect of self, a self-destructive life-style, a disregard of prescribed life-saving medication, and in other actions where the individual fosters, facilitates, exacerbates, or hastens the process of his or her dying. In terms of the traditional classification of modes of death (natural, accident, suicide, and homicide), some instances of all four types can be subsumed under this category, depending on the particular details of each case.

5–6. Lethality

a. The psychological autopsy should also address the issue of the lethality of the suicidal behavior. Although the victim's intention to die is the factor used to classify his or her death as a suicide, the amount of lethality involved may be used to discriminate among the various degrees of suicide. Lethality is the probability that the suicidal behavior would result in death.

b. Consideration of the lethality involved permits an evaluation of the individual's drive to self-imposed death. All suicides threats, gestures, attempts, and completed suicides should be rated for their lethality.

c. The lethality of the victim's behavior, whether or not it results in death, may be judged to be in one of four classes: high, medium, low, or absent. This may be accomplished using the lethality of Suicide Behavior Rating Scale at table 5–1. The numerical scale will be used to rate the lethality of the suicidal behavior of the victim. The lethality rating will be the number of the statement that best characterizes the suicidal act. Lethality will then be characterized as being high, medium, low, or absent.

d. The lethality rating derived from the scale in table 5–1 relates to the classification system based on degree of intention (para 5–5) as follows:

(1) A first-degree suicide would require a high lethality rating. There is no doubt as to the victim's intention to die.

(2) A second-degree suicide may be either rated as high or medium in lethality. The victim knew that the suicidal behavior would likely result in death, however, the act was impulsive and unplanned.

(3) A third-degree suicide would be rated as being either medium or low in lethality.

(4) Suicidal behavior resulting in a subintentioned death would always be rated as low in lethality.

(5) Where the capacity for intention is absent or where the victim played no role in effecting his or her own death, it may be said that lethality was absent in the victim's behavior.

Table 5–1
Lethality of suicide behavior rating scale

Lethality: Absent
Rating: 0
Statement: Death is impossible result of the "suicidal behavior."

Lethality: Low
Rating: 1
Statement: Death is improbable. If it occurs it would be a result of secondary complications, an accident, or highly unusual circumstances.

Lethality: Low
Rating: 2
Statement: Death is improbable as an outcome of the act. If it occurs it is probably due to unforeseen secondary effects. Frequently the act is done in a public setting or reported by the individual involved or by others. While medical aid may be warranted, it is not required for survival.

Lethality: Low
Rating: 3
Statement: Death is improbable as long as first aid is administered by the victim or other agent. The victim usually makes a communication or commits the act in a public way or takes no measures to hide self or injury.

Lethality: Medium
Rating: 4
Statement: Death is a fifty-fifty probability directly or indirectly, or in the opinion of the average person, the chosen method has an equivocal outcome.

Lethality: Medium
Rating: 5
Statement: Death is the probable outcome unless there is "immediate" and "vigorous" first aid or medical attention by the victim or other agent. One or both of the following are true:

(a) Makes communication (directly or indirectly).

(b) Performs act in public where he or she is likely to be helped or discovered.

Lethality: High
Rating: 6
Statement: Death would ordinarily be considered the outcome to the suicidal act, unless saved by another agent in a "calculated" risk (for example, nursing rounds or expecting a roommate or spouse at a certain time). One or both of the following are true:

(a) Makes no direct communication

(b) Takes action in private

Lethality: High
Rating: 7
Statement: Death is the highly probable outcome. "Chance" intervention and/or unforeseen circumstances may save the victim. Two of the following conditions also exist.

(a) No communication is made

(b) Effort is put forth to obscure act from helper's attention.

(c) Precautions against being found are instituted.

Lethality: High
Rating: 8
Statement: Death is almost a certainty regardless of the circumstances or interventions by an outside agent. Most of the people at this level die quickly after the attempt. A very few survive through no fault of their own.

5–7. Death investigation team

a. In the Army, the psychological autopsy will be conducted by a mental health officer and provided to the commander of the local U.S. Army criminal investigation activity for inclusion in the report of investigation of the death. In difficult cases where the command desires a more extensive investigation, consideration will be given to forming a death investigation team. This is a multi-disciplinary approach involving the collaboration of a pathologist or other medical officer with mental health officers in the areas of psychiatry, psychology, psychiatric nursing, and social work, and a law enforcement officer.

b. The developers of the psychological autopsy procedure have emphasized that an outline or accumulation of postmortem data alone is not a psychological autopsy. The information must include the personal responses of each member of the death investigation team. Team members will report in their areas of expertise and participate in mutual exchanges of information. The completed report should represent a consensus of the views of the team members.

5–8. Procedure for psychological autopsy

a. Whether it is conducted by a single mental health officer, or by a complete death investigation team, the psychological autopsy typically consists of interviews of persons who knew the deceased (such as spouse, parents, children, neighbors, supervisor, coworkers, friends, and physicians) in an attempt to reconstruct the lifestyle of the deceased. This will usually be done jointly with a law enforcement officer to facilitate mutual access to persons and records. In the investigation, an attempt is made to obtain relevant information about any psychiatric idiosyncrasies or the presence of any suicide warning signs the victim may have voiced.

b. The following information should be gathered by the investigating officer or team:

(1) Life history.

(2) Psychiatric-psychological data.

(3) Clues to or communications of suicide intent.

(4) Recent life events.

(5) Miscellaneous data that may be relevant to the death, but not necessarily psychological in nature (for example, physical evidence from the scene of the death).

c. As a preliminary step in conducting a psychological autopsy, the mental health officer should review the following data:

(1) Inpatient and outpatient medical records.

(2) Physical autopsy (necropsy) report including toxicology results.

(3) Military police and Criminal Investigation Division investigation results.

(4) Line of duty investigation report.

(5) Any records existing in the Community Mental Health Service, hospital departments of psychiatry and social work, Alcohol and Drug Abuse Prevention and Control Program, Army Family Advocacy Program, or other Army programs.

5–9. Psychological autopsy report

The following is a guide for preparing psychological autopsy reports and should be used unless there are special considerations. The categories below should be included.

a. Identifying information.

(1) Name.

(2) Rank/Grade.

(3) SSN.

(4) Age/Date of Birth.

(5) Sex.

(6) Race.

(7) Marital Status (married, single, divorced, widowed, separated).

(8) MOS.

(9) Unit/Station.

(10) Level of Education

(11) Home Address (where victim was living at time of death).

b. Method. Method of gathering information and identification of sources contacted.

c. Details of death.

(1) Date/Time (provide date and time of suicidal act and death if different).

(2) Location (address and description, that is, friend's house, parents home, victim's off-post residence, motel, and so forth).

(3) Method.

(4) Details of discovery.

(5) Provisions for rescue (describe).

(6) Note (contents).

(7) Communication of suicidal intent.

(8) Acts of violence that accompanied the suicidal act.

(9) Other details.

d. History of prior suicide attempts.

(1) Dates and description of prior attempts and threats.

(2) Provisions for rescue.

(3) Circumstances surrounding suicide attempts.

e. Physical autopsy (necropsy) results.

(1) Cause of death.

(2) Blood alcohol and other toxicology results.

(3) Describe any evidence of disease process.

(4) List and explain significant abnormalities.

f. Personality and lifestyle.

(1) Basic personality (relaxed, intense, jovial, gregarious, withdrawn, outgoing, morose, bitter, suspicious, angry, hostile, combative, mild-mannered, other).

(2) Describe the victim's recent changes in mood or symptoms of mental illness.

(3) Describe the victim's recent changes in behavior such as eating, sleeping, sexual patterns, drinking, driving, taking pills, social relationships or hobbies.

(4) Stress reactions as follows:

(a) Describe the victim's normal reaction to stress.

(b) Describe the typical patterns of stress reactions.

(c) State recent losses, if any.

(5) Interpersonal relationships as follows:

(a) Describe the victim's interpersonal relationships (few, casual, or intense)

(b) State recent uncharacteristic behavior of the victim such as withdrawal from friends, gambling, spending, promiscuity, and fights.

(c) Describe the victim's friendship group.

(d) Describe the manner in which his or her time was spent.

g. Marital/dyadic relationship history.

(1) Marital status.

(2) Category of dyad trouble.

(3) Nature of dyad trouble.

(4) Number and length of marriages.

(5) Current living arrangements.

(6) Number, age, and sex of children.

(7) Where do children live.
(8) Changes in relationship with spouse or children.
(9) Threats of or actual divorce or separation.
(10) Recent deaths in family.
(11) History of abusive behavior
(12) Overall quality of current relationship
(13) Dating history.

h. Family of origin history.
(1) Describe parent's marital history.
(2) Family medical history.
(3) History of family member psychiatric hospitalizations and treatment.
(4) Family suicide history.
(5) Number, ages, and sex of siblings.
(6) Family history of sexual abuse or other forms of child abuse or family violence.
(7) Family history of alcoholism or other substance abuse.

i. Family history. Death history of victim's family (suicides, cancer, other fatal illnesses, accidents, ages of death, and other details).

j. Past problems. Describe any trouble, pressures, tensions, or anticipted problems during the past year.
(1) List and describe any observed or expressed symptoms of depression.
(2) List and describe any observed immediate danger signals.

k. Work history.
(1) State the victim's occupation.
(2) State the victim's level of satisfaction from work (excellent, good, fair, or poor)
(3) State the victim's employment history (job loss, promotion, or retirement)

l. Military history.
(1) Time in service.
(2) Time in grade.
(3) Months assigned to present unit.
(4) Date of last PCS.
(5) Date of pending PCS.
(6) Date of last DEROS.
(7) Awards.
(8) Uniform Code of Military Justice (UCMJ) actions (Article 15s, courts-martial).
(9) Pending unfavorable personnel actions (Bars to reenlistment, weight control program, other).

m. Medical history.
(1) Describe significant illnesses and treatment.
(2) Describe recent loss or change in health status.
(3) Describe any injuries, accidents, or hospitalizations.
(4) List current medications and history of compliance.
(5) HIV positive or not.

n. Psychiatric history.
(1) Hospitalizations, psychotherapy, or other therapy.
(2) If so, when and for how long.
(3) Describe the diagnosis and nature of treatment.
(4) Describe victim's use of psychotropic medications or sleeping pills.
(5) State evidence of a personality disorder or difficulties.

o. Alcohol history.
(1) Describe role of alcohol or drugs in the victim's overall life style and death.
(2) State the victim's usual alcohol consumption.
(3) Identify the victim's behavior changes when drinking and drunk.
(4) State the evidence of addiction to alcohol, and include the number and dates of detoxifications.
(5) State when and where the victim was enrolled in the Alcohol and Drug Abuse Prevention and Control Program.

p. Drug abuse history.
(1) Identify drugs the victim used, if any.
(2) State if the victim was addicted to drugs.
(3) State the number and dates of detoxifications.

q. Financial status. Describe the victim's financial situation (recent losses, business successes or failures).

r. Legal history.
(1) Describe the victim's legal actions, if any.
(2) State the victim's criminal record (number and length of jail or prison terms, nature of the offenses).
(3) State if the victim was absent without leave (AWOL) or a deserter at the time of the suicide. Provide dates of AWOL or desertion.
(4) State if the victim had been accused of sexual misconduct or other sexual deviations.

s. Recent agency contacts. List and describe all contacts with any of the following agencies during the past year.
(1) Mental health.
(2) Chaplain.
(3) Physician.
(4) Legal Assistance (to the extent no privileged information is involved).
(5) Army Emergency Relief (AER).
(6) Army Community Services.
(7) Family Advocacy Program.
(8) Alcohol and Drug Abuse Prevention and Control Program.
(9) Civilian agencies.

t. Indications of increased suicide risk.

(1) List and describe any observed or expressed symptoms of depression.

(2) List and describe any observed immediate danger signals. Describe the response of the observer to the danger signals.

u. Duty Performance if any.

(1) Work or assignment related problems.

(2) Problems in accepting Army life.

(3) Recent changes in duty performance

(4) Accidents.

(5) Problems with personal hygiene/appearance.

(6) Problems with being late, or missing work.

(7) Problems with the quality of work.

(8) Relationship problems with superiors, peers and/or subordinates.

(9) State the victim's display of emotional state as seen by others in the work environment.

v. Assessment of intention.

(1) State the role of the victim in his or her own demise.

(2) Determine the rating of lethality (see table 5–1 for lethality of Suicide Attempt Rating Scale.)

(3) State if the victim reasonably expected and wished to die as a result of his or her suicidal behavior.

w. Summary and conclusions.

(1) State whether in the opinion of the investigator or death investigation team, this death was a suicide.

(2) Estimate the victim's subjective state at the time of suicide.

(3) If this death was a suicide, determine classification (first, second, or third-degree suicide, subintentioned death).

(4) State the most probable reasons for the victim's decision to commit suicide (factors immediately contributing to the suicidal behavior, precipitating events).

(5) State if the victim's commander supervisor, or the medical system identified a problem before the suicide took place,

(6) State if the suicide was—

(a) A bad outcome following reasonable command attention and medical care, or

(b) The product of a system failure or inadequate medical care.

(7) State what actions, if any, could have been taken by those who had a special relationship with the victim (supervisors, coworkers, physician, family, and friends) that would have led to the anticipation and prevention of this suicide? State what could have been done to lower the risk of suicide in this case?

(8) Provide comments, special features, lessons learned, and usefulness, and relevance of available suicide prevention training materials in this case.

5–10. Special considerations

For each method of suicide explore the following:

a. Gun shot.

(1) The victim's knowledge, experience, and training with firearms.

(2) The victim's history of handling weapons recklessly or cautiously.

(3) The victim's prior firearms accidents.

(4) The victim's recent purchase of a firearm.

b. Overdose.

(1) State the victim's knowledge of drugs and their potential dangers (prescribed or street drugs and the amount).

(2) Were there premature refill requests?

(3) Was the victim ever seen under the influence of drugs?

(4) What was his or her behavior under the influence of drugs?

(5) Was there a history of prior overdoses and how were they treated?

(6) Was the victim careless in the use of medications, taking more than prescribed?

(7) How did the victim keep track of pill intake?

(8) What were other sources of pills?

c. Hangings or asphyxia.

(1) Explore for sexual involvement.

(2) How was the victim clothed?

(3) When found, state if pornographic material or sexual apparatus was nearby.

(4) State the victim's known sexual activity (deviance, reading material, interests, knowledge of asphyxia techniques and experience with rope).

d. Jumping, drowning, vehicular death.

(1) State the reason for the victim to be at the place of death.

(2) With respect to the specific method, state his or her habitual behavior.

Glossary

Section I
Abbreviations

ACS
Army Community Services

ADAPCP
Alcohol and Drug Abuse Prevention and Control Program

ADCO
Alcohol and Drug Control Officer

ADT
active duty for training

AER
Army Emergency Relief

AG
Adjutant General

ASPP
Army Suicide Prevention Program

AWOL
Absent Without Leave

CDS
Child Development Services

CID
Criminal Investigation Division

CMHS
Community Mental Health Service

CPO
civilian personnel officer

DEROS
Date Eligible for Return from Overseas

DHS
Director of Health Services

DPCA
Director of Personnel and Community Activities

DPT
Director of Plans and Training

FAP
Family Advocacy Program

FAST
Family Advocacy Staff Training

FMSPP
Family Member Suicide Prevention Program

MACOM
major Army command

MEDDAC
medical department activity

MTF
Medical Treatment facility

MOS
military occupational specialty

OCCS
operational criteria for the classification of suicide

PAO
public affairs officer

PCS
permanent change of station

RC
Reserve Component

ROI
report of investigation

SJA
staff judge advocate

SPTF
suicide prevention task force

SRMT
suicide risk management team

UCMJ
Uniform Code of Military Justice

USACIDC
U.S. Army Criminal Investigation Command

YA
youth activities

Section II
Terms

Equivocal death
Cases in which the available facts and circumstances do not immediately distinguish the mode of death are called "equivocal death." A death is equivocal when ambiguity or uncertainty exists between any two or more of the four modes.

Mental health officer
Those trained mental health professionals who are credentialed or licensed as psychiatrists, clinical or counseling psychologists, social workers, or psychiatric clinical nurse specialists.

Mode of death (also known as manner of death)
Four categories of death: natural, accident, suicide, and homocide; the initial letters of each make up the acronym NASH. The four modes of death have to be distinguished from the many causes of death such as gunshot wound or a disease process. When the mode of death is unknown, a fifth category, "undetermined," is often used.

Postvention
Those actions taken after an incident of suicidal behavior that serve to moderate the effects of the event on the survivors of a person who has committed or attempted suicide.

Psychological autopsy
Attempts to clarify the nature of death by focusing on the psychological aspects of the death. Its primary purpose is to understand the circumstances and state of mind of the victim at the time of death. The procedure involves the reconstruction of the life style and circumstances of the victim, together with details of behaviors and events lead to the death of the individual.

Suicide attempt
All overt act of self-destructive behavior that does not result in death.

UNITED STATES ARMY

SUICIDE

PREVENTION PLAN

PREPARED BY DIRECTORATE OF HUMAN RESOURCES DEVELOPMENT, OFFICE OF THE DEPUTY CHIEF OF STAFF FOR PERSONNEL

Pages 1-22 to 1-33 not included in this edition.

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SECTION I

BACKGROUND

A. Recent concern over the problem of suicide in the United States has prompted the Army Leadership to seek a proactive approach to suicide prevention for soldiers, family members and civilian employees.

B. Although the suicide rate for active duty Army males has been declining since the mid-1970's, any loss of life due to suicide is tragic and unacceptable. The Army total suicide rate for 1982 (the last year for which complete data exists) was 11.4. Suicide rates are expressed in cases per 100,000 persons at risk. The suicide rate for active duty females is half the rate for active duty males. The Army female suicide rate has been declining from a 1977 high of 15.2 to a rate of 5.5 for 1982, the last year for which complete data exists. The suicide rate for Army females appears to be more acceptable than the rate for Army males. However, comparisons of the suicide rates for males and females, both in the general population and in the Army, indicate that the rate for Army women should be even lower.

C. The suicide rates for military family members and civilian employees are essentially unknown. However, we do know that suicide rates for American teenagers have tripled since 1950. Currently, suicide is the third leading cause of death among teens following accidents and homocides. Suicide rates for persons under 25 years old have increased greatly while the rates for all other age groups has decreased. Suicide data for family members and civilian employees has not been compiled. Present data collection efforts are being hampered by the fact that many, if not a majority, of such deaths occur off post and do not come to military attention. It will be a goal of this plan to improve the data collection for military family members and civilian employees.

D. The active duty force is composed of a prescreened, healthy population from which severely impaired persons have been eliminated. Furthermore, it is a population of relatively young individuals who are all employed. In such a group a low suicide rate is to be expected. A coordinated program which provides for identification of and assistance for persons in crisis and conducted in an atmosphere of caring leadership should further reduce the rate of suicide in the military community.

E. The Army Suicide Prevention Plan is designed as a formal commitment by numerous Department of the Army Agencies to support the objective of reducing suicides within the Army Community through a variety of prevention initiatives and greater understanding of the causes of suicide in the Army. The plan

stresses that, through the exercise of concerned and caring leadership, the occurrence of suicide in the Army may be minimized. While the specific actions listed focus on the next two years, long term success in accomplishing the objective will require continuing emphasis from appropriate command and staff agencies.

F. The Action Plan consists of 26 separate initial actions to be accomplished by 14 different agencies. Milestones have been set to insure proponents implement assigned actions as appropriate. MACOMs are encouraged to use this plan. It provides a framework for prevention efforts at all levels and ensures that all available resources are focused on identifying and assisting soldiers, their families, and civilian employees who are in crisis.

SECTION II

A Strategy for Suicide Prevention

A. The BASIS:

1. In response to rising concern in the United States over the apparent increase in the number of young people attempting and completing suicide, the Army Chief of Staff directed that a panel of experts be formed to review existing suicide prevention efforts and determine what additional steps could be taken to reduce the rate of suicide among soldiers, military families and civilian employees. The panel was convened on 19 December 1984 and included experts from the civilian and military sectors as well as representatives from several DA agencies with responsibility for programs or policies affecting suicide prevention, reporting and investigation.

2. The review conducted during this and several subsequent meetings produced a number of observations regarding suicide and the status of suicide prevention efforts in the Army today. The following points constitute a philosophical context for policy initiatives and preventive actions and a summary of identified problem areas:

a. A significant reduction in the numbers of suicides within the Army will only occur if leaders at all levels exercise the greatest caring and concern for soldiers and their families as well as for civilian employees. Senior leaders must sensitize junior leaders as to the importance of this matter. The combat effectiveness of any soldier will be reduced if that soldier is concerned about the welfare of his or her family. Commanders and leaders must not fail to show concern for the well being of soldier's families and to ensure that appropriate assistance is provided when necessary. Leaders who care about soldiers must be ready to make tough decisions about interventions in order to prevent a tragedy.

b. Suicide is a low frequency event that mandates an explanation. Suicide is the end result of a complex interplay of individual, family, unit, community, and biologic variables. Alterations in unit cohesion and morale, family integrity and social supports as well as individual life stress events may result in an increased risk of suicide or suicide related behaviors. Suicide is but one type of deviant behavior affected by these variables. Excessive drinking, drug abuse, family violence, accidents, AWOLs, and all sorts of other disciplinary problems may stem from the same conditions that produce suicides. These behaviors should be considered as potential indicators of an individual in crisis.

c. A suicide may be an indicator of organizational stress. It must be emphasized, however, that it is only one indicator and, as such, must be understood in the context of other traditional indicators of unit readiness. Such things as accident rates, AWOL and reenlistment rates, sick call rates, and the rate of self referral to the mental health clinic should be considered in understanding if unit conditions may have contributed to an individual's decision to attempt suicide.

d. Suicide prevention education programs are of great value in identifying persons who are at increased risk of suicide and who need help. However, suicide prevention is not accomplished solely by identification. Suicide is prevented by altering the conditions and treating the underlying problem which produced the suicidal thoughts.

e. According to researchers from the Division of Neuropsychiatry, Walter Reed Army Institute of Research (WRAIR), the most frequent reason given for soldier suicides is difficulty with a love relationship (69 percent). Likewise, among children and adolescents, attempts at suicide are often associated with family discord. For active duty soldiers, prevention of suicide depends primarily upon caring leaders who are willing to listen to their problems and assist them in getting the necessary help. However, the prevention of suicide for a majority of family members who are at increased risk of self destructive behavior depends upon the availability of mental health professionals and chaplains who are trained in marital, family, child, and adolescent therapy. At present in the Army, there are both inadequate numbers and inadequate distribution of professionals trained in family, child, and adolescent therapy.

f. Perhaps the greatest impediment to understanding the true extent and causes of suicide within the Army is the lack of reliable data. The collection of accurate suicide data is complicated by the fact that many accidents may actually have been suicides. There are two independent sources of suicide statistics in the Army: the MILPERCEN casualty information system which includes Line of Duty (LOD) investigations, and the AMEDD Individual Patient Data System (IPDS). Both systems contain information on all deaths of active duty Army soldiers. A study conducted by William E. Datel, Ph.D., a research psychologist from WRAIR (Military Medicine, 1979) found that, of the 232 persons who were labeled as suicides during 1975 and 1976 by one or both of the two systems, only 72 (or 31 percent) were mutually labeled as suicides by the two systems. Furthermore, of the 132 persons labeled as suicides by IPDS, only 77 percent could be found in the Casualty Information System as having died at all. Datel concluded that, "the level of agreement in a two-year soldier mortality count between two parallel (and independent) electronic data processing systems in the US Army is unacceptable for epidemiologic purposes." There has been no

systematic collection of suicide statistics on Army family members. The addition of a third independent source of data, the Serious Incident Report (AR 190-40), to collect timely suicide statistics on family members, civilian employees and soldiers should begin to improve this situation. However, a potential for additional confusion exists unless efforts are made to share information among the data sources.

g. The focus of the suicide prevention program at the installation level should be on identification and treatment of depression and not on suicide per se. Because media and other publicity about suicide is known to produce short term increases in suicide rates, local prevention efforts should maintain a low profile. Suicide prevention is best accomplished by treating the causes of suicide. Delaying intervention until an individual has become suicidal may be too late.

B. PHILOSOPHY AND STRATEGY

1. Based on the conclusions of the review, a Suicide Prevention Strategy was developed. The Strategy is a two-pronged approach. First, the Action Plan has caused a formal commitment by numerous DA staff agencies to mutually support the Army's objective through a series of actions. Second, the Strategy provides the framework and philosophical guidance necessary for coordinated efforts at all levels within the Army.

2. The Strategy and supporting elements are based on the following premise: To the extent that suicide rates are modifiable within the Army, they will be modified by leadership through command policy and action. The key to the prevention of suicide is caring leadership and the early involvement of the chain of command. The exercise of such leadership should be assisted by the AMEDD, the Military Police, chaplains, and a broad base of other community support agencies.

C. THE SUICIDE PREVENTION ACTION PLAN:

1. The 26 initiatives contained within this plan are grouped into three major categories. The categories are: prevention, data collection, and analysis of the problem.

2. Of the initiatives contained in this plan, nearly 60 percent are prevention related actions. The remaining actions focus on increasing our understanding of the problem to include the causes of suicide and suicide related behavior in the Army so that future actions can be implemented as appropriate.

SECTION III

ACTIONS - AN OVERVIEW

A. This section outlines the significant points of the 26 actions contained in the plan. Many of these initiatives do not require additional resources in order to implement. Some initiatives, however would require substantial increases in funding and personnel. If approved, these actions would represent unfinanced requirements. Proponents for each program are responsible for the submission of necessary program and budget input for those actions that do require additional funding.

B. The actions described in this plan consist of short, mid, and long-term initiatives. The plan covers a two year period. In order to achieve the most timely and widespread impact, approximately 75 percent of the listed actions should be completed within the first six months of the plan and 90 percent within the first year.

C. All 26 actions have been grouped under one of three major categories: prevention, data collection, and analysis of the problem. Proponents and supporting agencies are designated for each action. A specific milestone date has been established to report on implementation and the results of analysis to the DCSPER, Department of the Army who will act as the overall proponent for this plan. It is anticipated that additional actions will be developed as a result of the implementation of this plan

D. Prevention:

1. Short-term actions (6 months) include:

a. Develop and publish a model installation suicide prevention plan to be promulgated through the MACOMs. The model would include a post-suicide intervention plan for units, families, and the community. The model would include additional requirements for funding, manpower, and resources.

b. Develop and publish a statement of the Army Leadership's philosophy on suicide prevention and stress management signed by the Chief of Staff of the Army.

c. Develop and publish a Commander's Guide for company and battalion commanders on suicide and suicide prevention listing specific factors which point to increased risk of suicide in soldiers.

d. Develop and publish an article on suicide prevention in "Commander's Call."

e. Make suicide prevention an item of interest for Medical Treatment Facility (MTF) commanders. MTF commanders will evaluate the status of suicide prevention resources within their communities and advise the installation commander on matters pertaining to suicide prevention. The scope of this evaluation should range from a review of emergency room procedures for handling suicide situations to a consideration of incorporating suicide prevention into Dependent Youth Activities (DYA) programs.

f. Evaluate the appropriateness and, if appropriate, the feasibility of operating a crisis hot line in all Army MTFs which maintain 24-hour emergency services.

g. Request a review through OASD-HA of commercially available anti-depression and suicide prevention programs for use in DODDS and other on-post and community schools attended by military children.

h. Review commercially available videotapes on suicide prevention in families for distribution through TASO.

i. Review the incentive package for the retention of mental health professionals who are qualified specialists in child and family mental health.

2. Mid-term actions (18 months) include:

a. Produce a training videotape for commanders focusing on suicide prevention for active duty service members.

b. Develop short-term training programs (short courses) in child and family counseling for mental health professionals.

c. Review the resources of the Community Mental Health Service (CMHS) and recommend changes to enable the provision of multidisciplinary counseling by fully qualified professionals for marital, family, child, and adolescent problems. The Surgeon General has estimated that this action would require an additional 150 mental health professionals, not including ancillary support personnel, at an approximate cost of $7.5 million.

d. Evaluate the feasibility of procuring telephone systems with conference call capability that would enable crisis line or emergency room staff to contact on-call professionals while remaining on the line with the person in crisis.

e. Review existing leadership training provided in the Army service schools to ensure that students gain a sensitivity to the problem of suicide prevention.

3. Long-term actions (2 years) include: Consider increasing the number of fellowship training opportunities in child psychiatry, child psychology, and child and family social work.

E. Data Collection:

1. Short-term actions include:

a. Continue to monitor, refine and report on AMEDD suicide data sources.

b. Report all suicides of active duty service members and, to the extent possible, those of family members and of civilian employees to DA via the Serious Incident Report (AR 190-40).

c. Investigate and report on all completed suicides of service members and their immediate families which occur on an Army installation and report the investigations of appropriate law enforcement agencies of completed suicides of service members and their immediate families which do not occur on an Army installation.

d. Coordinate the planning for a computerized data base for all suicides and suicide related behavior so that current trends in data may be analyzed, reconciled, and shared with other collection agencies. Consideration will be given to the requirements for patient confidentiality.

e. Explore the possibility of collecting suicide data on family members from CHAMPUS.

2. Long-term actions include: Utilizing the computerized data base, work toward a better reconciliation of data collected from MILPERCEN casualty, AMEDD, SIR, and CID sources.

F. Analysis of the problem:

1. Short-term actions include:

a. Formalize a DA Suicide Prevention Advisory Committee to be comprised of military and civilian subject matter experts to guide the development and implementation of the Army suicide prevention program.

b. Develop a standardized format for conducting a medical psychological investigation (psychological autopsy) of the probable causes of a suicide for Army use.

c. Require a psychological investigation (psychological autopsy) of the facts surrounding all suicides and attempted

suicides of service members which require hospitalization to be assisted by a mental health officer as a part of the Line of Duty (LOD) investigation in order to develop probable causes of the event.

d. Sponsor a small Tri-Service conference of military suicide investigators to share information and coordinate research efforts among the services.

e. Coordinate the preparation of a concept paper on a method of conducting an in-depth analysis of the probable causes of suicides occurring at selected Army installations. The analysis would be conducted for a limited period of time.

2. Long-term actions include: Investigation of the relationship between PCS moves and suicide; the lack of "protective effect" of Army membership on female suicide rates; and the role of unit, family, and Army community supports on suicide related stress behaviors.

PREVENTION

ACTION	RESPONSIBILITY	MILESTONES	REMARKS
P1 Review suicide prevention programs currently in use by the Army and develop a model installation suicide prevention plan to be promulgated through the MACOMs. The model will include all aspects of prevention to include suicide-related behaviors as well as a post-suicide intervention plan for units, families, and the community.	DAPE (PEDA)* DASG	Jun 85	Model distributed to MACOMs by this date. This plan will include a mechanism to establish a system for sharing information about persons who are at increased risk of self-destructive behavior.
P2 Prepare a statement of the Army Leadership's philosophy with regard to suicide prevention for the signature of the Chief of Staff and Secretary of the Army.	DAPE-HRL-A* DAPE (PEDA)	Feb 85	
P3 Using the concept of "Caring Leadership" as a guide, develop a Commander's Guide for company and battalion commanders on suicide and suicide prevention. This would include common danger signals and specific factors to consider in deciding who should be referred for help. The Guide will be provided to the MACOMs for use or tailoring to meet local needs.	DAPE (PEDA)* DASG	May 85	Guide to be distributed to the MACOMs by this date.
P4 Prepare an article on suicide prevention for unit commanders for "Commander's Call."	DASG* DAPE (PEDA)	Apr 85	

* Indicates lead responsibility

PREVENTION (CONTINUED)

ACTION	RESPONSIBILITY	MILESTONES	REMARKS
P5 Make suicide prevention an item of interest for Medical Treatment Facility (MTF) commanders. MTF Commanders will evaluate the status of suicide prevention resources within their communities, publicize those resources, and advise the installation commander on matters pertaining to suicide prevention.	DASG	Apr 85	Tasking forwarded to HSC and MEDCOMs by this date. Report of evaluation due to ODCSPER Oct 85.
P6 Evaluate the appropriateness and feasibility of operating a crisis hot line in all Army MTFs which maintain 24-hour emergency services.	DASG	May 85	Evaluation of concept and decision paper to DCSPER completed by this date.
P7 Evaluate the feasibility of procuring telephone systems that would enable crisis line workers to contact on-call professionals while remaining on the line with the person in crisis.	DASG	Jun 86	Action requires that the utility and desirability of system be evaluated. Report of evaluation due on this date. Procurement, if required, subject to availability of funds.
P8 Produce a training videotape for commanders focusing on suicide prevention for active duty members.	DASG	Jul 85	Videotape currently being produced by AHS.

PREVENTION (CONTINUED)

ACTION	RESPONSIBILITY	MILESTONES	REMARKS
P9 Request a review through OASD-HA of commercially available anti-depression and suicide prevention programs for use in the DODDS and other on-post and community schools. Prepare a list of acceptable programs and distribute the list to all military schools.	DAPE (PEDA)	Mar 85	Date for distribution of the lists is Sep 85.
P10 Review commercially available videotapes on suicide prevention for families for distribution through TASO.	DAPE (PEDA)	Jun 85	Review completed by this date. Procurement to be completed by Dec 85 subject to availability of funds.
P11 Develop and conduct short-term training programs (short-courses) in child and family counseling for mental health professionals.	DASC* HSC	Oct 85	Planning and coordination completed by this date. Implementation is dependent on availability of funds.
P12 Review the resources of the Community Mental Health Service (CMHS) and recommend changes to enable the provision of multidisciplinary counseling by fully qualified professionals for martial, family child, and adolescent problems.	DASC	Jan 86	Review of installation requirements completed by this date. Full implementation is dependent on funding and additional manpower authorizations. Lead time for recruitment and training of necessary mental health professionals could be several years.

* Indicates lead responsibility

PREVENTION (CONTINUED)

ACTION	RESPONSIBILITY	MILESTONES	REMARKS
P13 Investigate the feasibility of increasing the number of fellowship training opportunities in child psychiatry, child psychology, and child & family social work. Establish standards for the credentialing of child and family specialists in these professions.	DASG	Oct 86	Includes quantification of need assuming implementation of action P12. Recruitment and training opportunities will have to be examined as to how they impact on current career patterns of mental health professionals.
P14 Review the incentive package for the retention of qualified child mental health professionals.	DASG	May 85	Retention incentive packages will have to be examined as to how they will impact on current career patterns of mental health professionals.
P 15 Review existing leadership training provided in the Army service schools to ensure that students gain a sensitivity to the problem of suicide prevention.	TRADOC	Jul 85	Review to be completed by this date.

DATA COLLECTION

ACTION	RESPONSIBILITY	MILESTONES	REMARKS
D1 Continue to monitor, refine, and report out to appropriate agencies AMEDD suicide data sources.	DASG	Continuous	Ongoing by WRAIR.
D2 Require all suicides of service members and, to the extent possible, those of family members and civilian employees to be reported to DA via the Serious Incident Report (AR 190-40).	DAPE (PEMP)	Dec 84	
D3 Coordinate the planning for a computerized data base for all suicides and suicide-related behavior so that current trends in data may be analyzed, reconciled, and shared with other collection agencies.	DAPE (PEDA)* DAPE (PEMP) DAPC DASG	Apr 85	Date is for initial coordination meeting. Development of the data base will depend on the requirements generated by the agencies concerned.
D4 Explore the possibility of collecting suicide data on family members from CHAMPUS.	DASG	Jun 85	Report to ODCSPER (USADATA) on feasibility by this date.
D5 Investigate and report in accordance with AR 195-2 on all completed suicides of service members and their immediate families which occur on an Army installation and report the investigations of appropriate law enforcement agencies of completed suicides of service members and their immediate families which do not occur on an Army installation.	CIDC	Jan 85	

* Indicates lead responsibility

ANALYSIS OF THE PROBLEM

ACTION	RESPONSIBILITY	MILESTONES	REMARKS
A1 Formalize a DA Suicide Prevention Advisory Committee to be comprised of military and civilian subject matter experts to guide the development and implementation of the Army suicide prevention program.	DAPE (PEDA)	Mar 85	Committee to be constituted IAW appropriate Army Regulations by this date.
A2 Develop a standardized format for conducting medical psychological autopsies within the Army.	DASG* DAPE (PEDA)	Apr 85	Also identify appropriate method of publication of format (i.e., change to AR, etc,).
A3 Require a psychological investigation (psychological autopsy) of the facts surrounding all suicides and attempted suicides of service members which require hospitalization to be completed by a mental health officer as an assistance to the Line of Duty (LOD) Investigating Officer in order to develop probable causes of the event.	DAPC	May 85	To be included in the current revision of LOD regulation.
A4 Sponsor a small Tri-Service conference of military suicide investigators to share information and coordinate research efforts among the services.	DAPE (PEDA)*	May 85	First meeting to be held by this date.

* Indicates lead responsibility

ANALYSIS OF THE PROBLEM (CONTINUED)

ACTION	RESPONSIBILITY	MILESTONES	REMARKS
A5 Coordinate the preparation of a concept paper on a method of conducting an in-depth analysis of the probable causes of suicide and suicide related stress behaviors on selected Army installations.	DAPE (PEDA)* DASG	Jun 85	Concept paper due on this date.
A6 Coordinate the investigation of the relationship between PCS moves and suicide; the lack of "protective effect" of Army membership on female suicide rates; and the role of unit, family, and Army community supports on suicide-related stress behaviors.	DAPE (PEDA)* DASG	Jan 87	Date represents projected date of completion of study. Initial coordination efforts to include a concept paper due in Jan 85.

* Indicates lead responsibility.

SECTION V

RESPONSIBILITIES

A. The Office of the Deputy Chief of Staff for Personnel, HQDA, will maintain an oversight/stewardship role and report out on suicide prevention programs and initiatives. ODCSPER will also assist each Army staff office in identifying and supporting new prevention initiatives. ODCSPER will receive assistance in its stewardship task from the DA Suicide Prevention Advisory Committee which is composed of military and civilian subject matter experts, representatives from ARSTAF agencies with responsibilities or interest in the implementation of the action plan, and MACOM representatives.

B. The Leader Policy Division, Human Resource Development Directorate, Office of the Deputy Chief of Staff for Personnel (DAPE-HRL) is the ARSTAF proponent and coordinating agency. The United States Army Drug and Alcohol Technical Activity (USADATA) is the primary operator of the plan. Responsible agencies will coordinate with and receive technical assistance from USADATA.

C. Agencies and MACOMs identified in the action plan are responsible for implementing the suicide prevention initiatives within their areas of responsibility. As actions are completed, managers will submit in writing to the DCSPER an assessment of actions taken and expected impact. Responsible agencies are required to program for additional resources, if required, to accomplish action plan elements.

D. Listed below are the major players in the suicide prevention strategy who's involvement is critical to the success of this effort. Their general responsibilities include:

1. Office of the Surgeon General (DASG) will provide technical assistance in the areas of identification treatment, and other medical aspects of suicide prevention. OTSG will assist in the development of improved suicide data collection on soldiers and family members.

2. The Office of the Chief of Chaplains (DACH) will assist in developing programs for chaplain involvement in suicide prevention.

3. Army Public Affairs (SAPA) will coordinate and implement the public affairs plan for the strategy.

4. Office of Law Enforcement (DAPE-HRE) will coordinate the implementation of actions involving law enforcement agencies.

5. Leader Policy Division (DAPE-HRL) will incorporate suicide prevention into leadership goal initiatives.

6. Civilian Personnel Directorate (DAPE-CPL) will coordinate suicide prevention initiatives for the civilian personnel in the Army.

7. The US Army Community and Family Support Center (DACF-ZE) will assist in developing family programs and provide input on family member problems.

8. TRADOC (Soldier Support Center) will review existing leadership training provided in the Army service schools to insure that students gain a sensitivity to the problem of suicide prevention.

9. MACOMs will implement applicable elements of the strategy and develop complementary actions to support the philosophy.

SECTION VI

EVALUATION

A. The Army Suicide Prevention Strategy must be evaluated on three levels. First, Department of the Army must monitor the progress of implementation of the action plan. Second, there must be an evaluation of the impact of the actions on targeted populations in terms of their response to the initiatives. For example, it is expected that the publication of the Commander's Guide may result in increased referrals from commanders to mental health. Third, the evaluation must assess the effect of these initiatives on the suicide rates of the military community.

B. Evaluation of all of these levels should be conducted by agencies responsible for action plan implementation with input from the DA Suicide Prevention Advisory Committee, and similar groups at MACOM and installation level. Responsible agencies will develop their own measures of progress for evaluating the impact of their initiatives on the Army Community utilizing, wherever possible, existing data and reporting mechanisms.

C. In-process reviews (IPR) hosted by the Director of Human Resources Development will be the vehicle for conducting semi-annual and other reviews and evaluations of action plan implementation. All program managers will provide an update of listed actions during these meetings. MACOM representatives will be invited to attend these reviews and to present an overview of ongoing initiatives in support of the Strategy. In addition, MACOM representatives will be encouraged to recommend changes and additions to the action plan. (See Appendix A for details.)

D. The action plan represents a two-year effort to improve supportive services to service members, military families, and civilian employees and to increase understanding of the extent of the problem and causes of suicide and suicide-related behaviors so that appropriate preventative measures can be undertaken. The ultimate goal of the plan is to reduce the rate of suicide and suicide-related behaviors within the total Army Community. As short-term actions are accomplished, there will be a need to expand and modify intermediate and long-term actions. While the specific actions listed focus on the next two years, long-term success in accomplishing the objective will require continuing emphasis from appropriate command and staff agencies.

APPENDIX A

DESCRIPTION OF REVIEW PROCESS

1. An in-process review will be the primary vehicle for conducting semi-annual evaluations of the Army Suicide Prevention Strategy. Additional evaluations will be conducted as needed. Participation and content of these review sessions will be tailored to the particular need. A general description of the review process follows.

2. Semi-annual In-Process Review (IPR).

a. Participants will include members of DA agencies responsible for implementation of the action plan, MACOM representatives, and selected experts from the civilian sector. IPRs will be hosted by the Director of Human Resources Development.

b. Each agency will report on the status of implementation of each action to include:

(1) Actions completed in the past review period.

(2) Difficulties, if any, in meeting future milestones.

(3) Evaluation of the effectiveness of actions previously completed.

(4) Discussion of future actions (additions, deletions, modifications).

c. MACOM representatives may provide the following reports:

(1) Status of MACOM initiatives.

(2) MACOM recommendations for additional actions.

SECTION VII

MARKETING

A. The goal of the Suicide Prevention Strategy is to reduce the incidence of suicide in the Army. To accomplish this, the Army must sensitize various groups of people and cause them to take appropriate action. Leaders, soldiers, civilian employees, and family members must be made aware of the problem and come to understand its causes and contributing factors as well as what can be done to help.

B. Marketing is instrumental in raising awareness and providing the necessary information about the problem and resources available to assist in prevention of self destruction. Effective marketing must consider the target audience and appropriate information to be provided.

C. Suicide prevention efforts should be targeted basically on two groups: those who are susceptible to the myriad of factors that contribute to or cause self-destructive behavior, and those personnel who can intervene to prevent the incident from occurring.

1. The first group consists of essentially the entire Army community because no one is totally immune to the myriad of circumstances and pressures which contribute to the problem. The basic messages to be delivered to this population have to do with the factors which cause personal crises and the resources which are available for assistance. The messages should be geared to various segments of the population. As a minimum, one must consider the component (e.g. active duty, family member, civilian employee), grade, education, and maturity level of the target audience. The chosen media must be appropriate for the target audience.

2. The second major target group consists of people who can act to prevent a suicide. This group consists of Army leaders and civilian supervisors, helping professionals, concerned family members, and cohorts of possible suicide victims. The general messages are simple - create sensitivity and awareness of the problem and explain what can be done to prevent and intervene. However, because of the wide range in skills, life experiences, and emotional involvement, the messages sent to each of these segments must be carefully selected and presented. The use of mass media must be low key and emphasize depression, stress management, marriage and family problems rather than focusing on suicide.

D. The Office of the Deputy Chief of Staff for Personnel (ODCSPER) will be the overall proponent for the marketing of the

Suicide Prevention Strategy. ODCSPER, through the US Army Drug and Alcohol Technical Activity (USADATA), and the Office of the Chief, Public Affairs (OCPA) will prepare a public affairs plan to support the ODCSPER marketing strategy. ODCSPER will provide OCPA the necessary articles/input for publication and dissemination in accordance with the plan.

E. Agencies who are designated proponent for actions in Section IV of this plan are responsible for the implementation of an information campaign for each of the initiatives for which they are responsible. Information efforts may include items such as CSA Weekly Summary Articles, ARNEWS releases, and articles for professional journals. The object of this effort is to ensure that the ultimate "user" of the material/initiative developed is aware of its existence and encourages to put it to use. The Advertising and Marketing Office of ODCSPER (DAPE-ZXA) is available to assist in developing these campaigns. All articles released for publication must have been cleared through OCPA.

DEPARTMENT OF THE ARMY
OFFICE OF THE DEPUTY CHIEF OF STAFF FOR PERSONNEL
WASHINGTON, DC 20310

REPLY TO ATTENTION OF

13 NOV 1995

DAPE-HRL

SUBJECT: Model Army Community Suicide Prevention Program

SEE DISTRIBUTION

1. References.

a. Memorandum, HQDA, DAPE-HR, 27 Feb 85, subject: US Army Suicide Prevention Plan.

b. Memorandum, HQDA, DACS-ZA, 22 Feb 85, subject: SA and CSA Policy Statement on Suicide Prevention.

c. Message, HQDA, DAPE-HRL, 121305Z Apr 85, subject: Suicide Prevention.

2. Purpose. The US Army Suicide Prevention Plan (Reference a.) was published in response to the concern of the Army Leadership over the problem of suicide in the Army Community. The plan provides Army Staff policy guidance with respect to suicide prevention and directs that a series of initiatives designed to impact on the problem be accomplished. Among the initiatives is a requirement to publish a model installation suicide prevention plan. The enclosed draft of the Model Army Community Suicide Prevention Program is designed to assist commanders in the development of local programs.

3. Scope.

a. Army installations and communities are encouraged to develop local suicide prevention programs. The Model Army Community Suicide Prevention Program outlines elements of a comprehensive prevention program. Commanders at MACOM and installation level should tailor their programs to accommodate local needs.

b. It is important to understand that suicide prevention is as much proactive as it is reactive. The focus in the draft Model Army Community Suicide Prevention Program is primarily on the identification of the soldier most at risk and suggestions to provide help. However, if suicide events may be considered as an index of either low morale or high stress among soldiers and units, then suicide prevention also becomes a critical organization and systems issue. Taken as such, suicide

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SUBJECT: Model Army Community Suicide Prevention Plan

prevention would demand the use of positive leadership skills which include attitudes and behaviors which demonstrate caring concern by unit leaders for their soldiers. Caring leadership creates a reliance on and support of each other by fellow soldiers, a sense of unit belonging, provisions for quality family life, and training that effectively imparts a clear sense of unit mission and the importance of the individual to that mission.

c. No community suicide prevention effort will be completely successful without consideration of the impact of the tempo of operations (OPTEMPO) on the quality of individual and family life. Therefore, plans and operations staff officers should be included as members on the local Suicide Prevention Task Force.

4. Suggested Improvements. The Model Army Community Suicide Prevention Program is scheduled to be published as a DA Circular. This draft is being provided to facilitate planning and for comments if desired prior to publication. Users are invited to send comments and suggestions directly to HQDA (DAPE-HRL), Washington, DC 20310-0300. The POC at HQDA is CPT(P) R. W. Thomas, AUTOVON 289-2453.

FOR THE DEPUTY CHIEF OF STAFF FOR PERSONNEL:

GERALD H. PUTMAN
COL, GS
Chief, Leader Policy Division

Encl

DISTRIBUTION:

Installation DPCA/DCAS

MODEL ARMY COMMUNITY SUICIDE PREVENTION PROGRAM

1. PURPOSE. Suicide prevention must be the business of every leader, supervisor, soldier, and civilian employee in the Army. To facilitate this effort, coordinated suicide prevention program is needed at every Army installation and separate activity. This model is intended as a guide for the development of local programs. As such, the model may be modified to meet local needs. It is important that, whatever the form of the local program, responsibilities be clearly established and that commanders closely monitor and supervise the progress of the local suicide prevention program.

2. STRATEGY. The strategy and supporting elements of the Army Community Suicide Prevention Program are based on the premise that suicide prevention will be accomplished by leadership through command policy and action. The key to the prevention of suicide is caring leadership and the early involvement of the chain of command. The exercise of such leadership must receive broad based staff support. Installation commanders should emphasize the importance of this effort through the publication of a command letter on suicide prevention and through other directives and instructions as appropriate. Senior leaders must sensitize junior leaders as to the importance of this matter. Leaders at all levels must understand that, just as they have a duty to develop technical and tactical proficiency in themselves and their subordinates, they have a duty to care deeply and sincerely for their subordinates and their families. Leaders must know their subordinates and assure that timely assistance is provided when needed.

3. RESPONSIBILITIES.

a. The ultimate responsibility for the welfare of soldiers rests with the commander. Leaders at all levels must remain sensitive and responsive to the needs of soldiers, their families and civilian employees. They must also sensitize their subordinates as to their responsibilities to help soldiers, and Army employees and initiate proactive measures to prevent loss of lives within the Army family due to this tragic event.

b. A suggested listing of specific responsibilities for installation staff agencies is provided at Appendix A. This listing is provided for guidance only and should not be considered as directive. Assignment of specific staff responsibilities remains a command prerogative.

4. PROGRAM ELEMENTS.

a. Education - Awareness.

(1) Potentially, every member of the Army Family could come in contact with a person who is at increased risk of sui-

cide. Awareness of the variables and life stress events that put individuals at risk, coupled with awareness of the signs and symptoms of the person at risk, is crucial step in the suicide prevention process. As a first priority, leaders, managers, and supervisors at all levels must assure an increased awareness in themselves and their subordinates of facts important to suicide prevention. Ultimately, all members of the Army family should have a level of awareness that will enable them to identify problems and refer friends and family members in crisis.

(2) Specific groups to be targeted for training in suicide prevention and risk identification are as follows:

(a) Commanders, Leaders, Supervisors.

(b) Professionals (Mental Health, Physicians, Chaplains, Counselors, Teachers).

(c) Family Members (Parents, Teens, Spouses).

(d) Civilian Employees.

(e) Dependent Youth Activities Workers.

(f) Soldiers.

(3) Training in stress management and coping skills is of great value in the overall prevention effort. It should be emphasized that the military is an inherently stressful environment. Therefore, the goal is not stress reduction, but rather stress management.

(4) Training Opportunities.

(a) Officer and NCO calls.

(b) Officer, NCO and civilian professional development classes.

(c) Family member orientations which include stress management and information about agencies that help.

(d) Quarterly Company Commanders' and First Sergeants' Courses.

(e) Spouse orientations.

(f) Family Support Group meetings.

(g) Unit holiday safety briefings.

(h) Chaplain Training Conferences.

(5) Publicity. Inherent in sustaining a prevention program is the continued use of judicious, low-key publicity. Publicity includes:

(a) Publication in local media of crisis hot line numbers.

(b) Articles on stress, depression, family violence and abuse, and the identification of agencies that can help.

(c) The amount and type of publicity will be tailored to the needs of the program as evaluated by the Suicide Prevention Task Force. Units may coordinate with unit chaplains regarding appropriateness and content of this type of information in unit newsletters.

(d) Media items may need to be published prior to periods or events likely to produce a higher than normal incident of suicide (e.g., March, April, May and the summer moving months have a higher incidence of suicide).

b. Identification and Crisis Intervention.

(1) Caring leaders and individuals who are aware of suicide risk factors can facilitate early identification and intervention for persons in crisis. Early involvement is a critical factor in prevention. Leaders, supervisors, and other members of the Army community who are in frequent, close contact with others are often in the best position to identify persons at risk. Intervention may include listening, referring, and physically taking the person to helping agencies such as mental health professionals, chaplains, etc. It is important to understand that prevention is not solely accomplished by identification. Interventions include alteration of the conditions which produced the current crisis, and treatment of any underlying problem(s) which contributed to the suicidal thoughts.

(2) Medical Treatment Facility (MTF) emergency rooms and urgent care rooms are the primary 24-hour crisis intervention facility on most Army installations. Procedures for continuous crisis intervention services should be well defined in the Community Suicide Prevention Plan. MTFs should investigate the possibility of obtaining telephone services that would permit calls from persons in crisis to be routed to the mental health worker on call.

(3) Maximum use should be made of crisis "hot" lines which may exist in the civilian community. Publication of these numbers through military means should be coordinated with the civilian agency providing the service.

c. Suicide Risk Management Team (SRMT).

(1) Army divisions and other large activities with adequate support should consider establishing a Suicide Risk Management Team. The SRMT will actively monitor the cases of soldiers and family members identified as suicidal and at high risk. The team is charged with the responsibility of addressing the medical and administrative needs presented by high risk cases.

(2) The SRMT will convene immediately during a suicide crisis at the request of the battalion or separate company commander. Its function is to assist the commander in assessing the situation, determining appropriate courses of action directing immediate interagency and interstaff actions, and otherwise advising the commander. Team intervention will include taking those actions necessary to provide for the immediate welfare of families who have suffered a suicide attempt or who are at risk of injury. A suggested listing of specific responsibilities for members of the SRMT is provided at Appendix B.

∞ d. Long-Term Treatment. The permanent prevention of suicide for an individual at risk depends upon treatment of the underlying disorder (such as depression, etc), and the alteration of the conditions which produced the current crisis. Effective treatment depends on the availability of mental health professionals (psychiatrists, psychologists, and social workers) who are properly trained for the population they serve. Wherever military resources are inadequate for family members and retirees, publication of appropriately credentialed and licensed mental health care providers who will accept direct CHAMPUS payments should be considered. This is especially important when child, adolescent and family services are needed.

e. Post-suicide Interventions

(1) A suicide creates an adverse impact on the morale and readiness of a military unit. Often a great sense of guilt is experienced by leaders and others who may have known or felt they should have known that the victim was experiencing difficulty. In an attempt to continue "business as usual", such feelings may be ignored or submerged by both the organization and individuals. Such practices delay the healing process and prolong the impact on unit readiness. Community Suicide Prevention Programs shall make provisions for the concentration of mental health and chaplain resources to provide assistance as required to both the organization and its members following a suicide of a unit member.

(2) The loss of a family member, especially the loss of a child due to suicide, is perhaps the most difficult form of death for survivors to accept. On top of their grief over the death of a loved one, families of suicide victims often experience shame, humiliation, and embarrassment. Other common reactions are fear,

denial, anger, and guilt, all of which combine to produce one of the most difficult crisis a family will ever experience. It is at such times that the complete resources of the military community must be mobilized to assist the family. The Community Suicide Prevention Plan shall make explicit provisions for assisting families who have experienced such a loss to the extent permitted by applicable laws and regulations.

5. Program Coordination.

a. Suicide Prevention Task Force. Each installation will establish a committee to develop and manage local suicide prevention program. The membership of this committee will be tailored to meet local needs. Installation commanders may assign the suicide prevention mission to an existing committee or council such as the Human Resources Council, or may elect to establish a separate Suicide Prevention Task Force. When utilizing an existing committee, care must be taken so that suicide prevention does not take a second place to the other responsibilities of the committee. Responsibilities of the committee members, with respect to suicide prevention, must be clearly established. The Suicide Prevention Task Force or other appropriate committee or council should consist of the following: Assistant Chief of Staff (ACofS), G1 or the Director of Personnel and Community Activities (DPCA, Assistant Chief of Staff (ACofS) G3 or the Director of Plans and Training, Installation and/or Division Chaplain, Director of Health Services and/or Division Surgeon, Chief, Community Mental Health Service and/or Division Mental Health Officer, Public Affairs Officer, Civilian Personnel Officer, Provost Marshal, Staff Judge Advocate, Alcohol and Drug Control Officer (ADCO), and Army Community Services. The Task Force Chairman will be designated by the installation commander.

b. Responsibilities of Task Force.

(1) Coordinate program activities and the suicide prevention activities of the command and interested agencies and persons.

(2) Evaluate the needs of the installation with regard to this program and make appropriate recommendations to the commander.

(3) Review, refine, add, or delete items to the program based on an on-going evaluation of needs.

(4) Develop awareness training on suicide prevention of the installation and identify appropriate forums for this training to occur.

(5) Evaluate the impact of the tempo of operations (OPTEMPO) on the quality of individual and family life in the total military community. Develop policy guidance for the command on OPTEMPO issues to assure that soldiers and their leaders have sufficient opportunity for quality family life.

(6) Be aware of publicity generated with respect to suicides in the community and develop public awareness articles for publication.

(7) Meet at the discretion of the Task Force Chairman.

(8) If a suicide occurs, the Task Force, as soon as practicable, will review the possible causes of the suicide and, if necessary, evaluate the prevention effort and make recommendations to the commander.

(9) Coordinate with civilian support agencies as necessary.

c. Coordination of Helping Services. Community Suicide Prevention Programs shall make provisions for the coordination of services provided by military and civilian helping agencies such as the Community Mental Health Service (CMHS), Chaplains and the Family Life Center, Army Community Services and other agencies as appropriate. This coordination will include information about and planning for programs and services as well as information pertaining to specific clients when it is in the best interests of the client and when done with regard for requirements for client confidentiality.

APPENDIX A

RESPONSIBILITIES

1. ACofS, G1 or DPCA will:

a. Serve as chairman of the Suicide Prevention Task Force and coordinate efforts of Task Force members.

b. Serve as central focal point for program information and advice to the Commander and to the major subordinate commands.

c. Integrate suicide prevention into "people" programs as appropriate.

2. ACofS, G3 or DPT will:

a. Serve as a member of the Suicide Prevention Task Force and, in the absence of the G-1/DPCA as the Task Force chairman.

b. Inform the Task Force of the current training and operational requirements of the command and estimate the impact of their requirements on the quality of life within the area served by the Task Force.

c. Develop policy to assure that the impact of the tempo of operations (OPTEMPO) on individual and family quality of life be considered in planning for all training and operational requirements.

3. Division and Installation Chaplains will:

a. Serve as the base of training expertise that will assist the command in the sensitization and awareness training process. Unit chaplains will be the cornerstone of this effort and will include Family Support Group volunteers as they target their training objectives. Additionally, the chaplains will advise and assist other staff members and Task Force members in satisfying identified training needs in this area.

b. Monitor and assess the level of awareness in units and the stress factors which may be controllable by leaders and supervisors.

c. Advise, assist, and feed back information to the Suicide Prevention Task Force.

d. Coordinate with other support services and persons (including MEDDAC chaplain) as appropriate.

e. Serve as the specific Task Force participant responsible for the crisis hot line.

4. Division Surgeon or Director of Health Services will:

a. Participate on the Suicide Prevention Task Force.

b. In his responsibility for monitoring health and health care in the command, assess and advice on stress factors that may result in increased numbers of persons at risk.

c. Sensitize division health care providers via periodic in-service training and work with Commander, MEDDAC in training emergency medical treatment personnel in crisis intervention techniques.

d. Serve as liaison with MEDDAC Mental Health Service and Division Mental Service (Division Surgeon).

e. Coordinate training activities (as necessary) with Chaplains.

5. Directorate of Personnel and Community Activities (DPCA) (or Directorate of Community Activities and Services (DCAS) if applicable).

a. Continue operation of advocacy and outreach programs dealing in areas of stress and family violence.

b. In coordination with Suicide Prevention Task Force and Public Affairs Officer, enhance publicity and awareness of the support and helping mechanisms available within DPCA/DCAS.

c. Provide representation of the Suicide Prevention Task Force.

d. Conduct appropriate in-service training to maintain the level of awareness of staff members who routinely assist soldiers, civilian employees, and family members who might be at risk of suicide.

e. Emphasize support agencies and mechanisms during family member orientations and other appropriate briefings.

f. Serve as the specific task force participant responsible for coordinating with civilian support agencies.

6. Quality of Life Coordinator will:

a. Identify Quality of Life issues that could cause family members to be at risk of suicide.

b. Refer or assist family members at risk who are identified by mayor's programs and other outreach programs.

c. Assure that Quality of Life staff and volunteers are trained to identify suicide risk factors and made aware of referral methods.

d. Coordinate awareness training needs of the Quality of Life staff, volunteers, and others with the Chaplains. This includes needs within Family Support Group volunteers that may be identified.

7. Public Affairs Officers will:

a. Provide representation on the Suicide Prevention Task Force.

b. Coordinate the publicity needs of the Task Force.

8. Provost Marshal will:

a. Provide representation on the Suicide Prevention Task Force.

b. Provide sensitive and discreet responses to requests for assistance on calls with a potential suicide victim.

c. Provide feedback information to the Task Force, as appropriate, on any suicide related event which may have occurred on post.

d. Sensitize military police personnel by increasing their awareness that some of the actions they undertake may create a crisis event for some people and put them at an increased risk of suicide. Additionally, law enforcement personnel must be made aware of how to identify persons at risk and to notify the appropriate support person or agency. Awareness training, using the assistance and advice of chaplains and mental health professionals, may be conducted at in-service training and professional development classes.

e. Establish liaison with local civilian police agencies, as appropriate, to coordinate community suicide prevention programs and procedures.

9. Criminal Investigation Division Commander (or Special Agent in Charge) will:

a. Provide representation on the Suicide Prevention Task Force.

b. Establish liaison with local civilian police agencies, as appropriate, to obtain information regarding suicide related events involving military personnel, their families, or civilian employees, which may have occurred off-post, and provide such information to the Task Force.

10. Staff Judge Advocate will:

a. Using advice and assistance from the chaplains and/or mental health professionals, sensitize the Staff Judge Advocate staff and Trail Defense Service. Administrative and legal actions initiated against individuals may cause some persons to be at increased risk of suicide. Trail Defense personnel and legal assistance officers may assist soldiers, family members, and, in certain circumstances, civilian employees who are in crisis, not only from administrative and legal actions, but also from other causes. Identifying persons at risk of suicide and referring them to the proper support person or agency is crucial.

b. Provide representation to the Suicide Prevention Task Force.

11. Civilian Personnel Officer will:

a. Provide representation of the Suicide Prevention Task Force.

b. Assure that local programs take into consideration the needs of the civilian work force.

c. Serve as the specific Task Force participant responsible for identification and arranging for the training needs of civilian managers and supervisors.

12. Commanders:

a. Coordinate and conduct awareness training for subordinate leaders.

b. Assure that subordinates are aware of assistance agencies.

c. Refer individuals who are identified as having personal or emotional problems to an appropriate source of help. It is essential that commanders follow through to assure that the problem is either resolved or continuing help is being provided.

APPENDIX B

SUICIDE RISK MANAGEMENT TEAM

1. PURPOSE: To assign formal responsibilities and specific functions for the prevention of, and intervention in, suicide attempts. The Suicide Risk Management Team is composed of the Division Surgeon, Division Psychiatrist, Battalion or Separate Company Commander, Division Chaplain, ACofS, G1, Adjutant General, Staff Judge Advocate, Provost Marshal, Public Affairs Officer, Alcohol and Drug Control Officer (ADCO), and Army Community Services Officer (ACS). This appendix was written for use within a combat division. Non-divisional installations should substitute appropriate non-divisional staff officers.

2. RESPONSIBILITIES:

a. BATTALION AND SEPARATE COMPANY COMMANDERS:

(1) Convene, through the Division Surgeon, the Suicide Risk Management Team when soldiers or family members of soldiers within the command are identified as a suicide risk.

(2) Institute procedures within the battalion or company which shall facilitate the identification, evaluation and medical evacuation (if necessary) of soldiers or family members at increased risk of suicide.

(3) Maintain an active and close liaison with other members of the Suicide Risk Management Team on matters affecting members of the command.

(4) Coordinate any necessary administrative action required by members of the command who have attempted suicide.

b. DIVISION SURGEON: Assumes primary responsibility as the Suicide Prevention/Intervention coordinator. In addition:

(1) Develops and manages case files on identified high risk individuals.

(2) Provides active multidisciplinary coordination for the medical, administrative and legal needs of the suicidal individual, utilizing to the fullest extent possible the offices provided by other team members, medical treatment facilities, and existing human resource agencies.

(3) Serves as the primary point of contact during a suicide crisis for battalion and separate company commanders to convene the Suicide Risk Management Team. The team will convene at the request of a commander or within 12 hours of suicide attempts.

(4) Institutes all necessary management procedures internal to division and executes as necessary, memorandums of understanding with medical treatment facilities to guarantee that an immediate and appropriate response to a suicide attempt is achieved.

(5) Provides for the collection, evaluation, and dissemination of all data pertaining to attempted suicides or suicide related behavior.

(6) Coordinates the use of medical assets in the training of stress management/suicide prevention and family advocacy subject matters.

c. DIVISION PSYCHIATRIST:

(1) In the absence of the Division Surgeon, serves as the alternate coordinator in crisis situations and as the principal point of contact with medical treatment facilities as a member of the Suicide Risk Management Team.

(2) Provides for the clinical evaluation, treatment and disposition of suicide risk cases.

(3) Provides for training in stress management/suicide prevention and family advocacy subject matters.

(4) Provides battalion and separate company commander pertinent information on high risk suicide cases and may convene the Suicide Risk Management Team if suicide is imminent.

(5) Develops and disseminates an epidemiologic profile that will serve as a standard by which members of the chain of command can identify potential suicides.

(6) Assists the Division Surgeon in the collection and analysis of suicide related behavioral data.

d. DIVISION CHAPLAIN:

(1) Serves as a member of the Suicide Risk Management Team, and is prepared to meet during instances of a suicide crisis when so requested by the Division Surgeon.

(2) Develops policies and procedures for unit chaplains that shall assure an active monitoring of high risk soldiers or family members, as well as chaplain intervention during a suicide crisis.

(3) Provides immediate assistance to families who have suffered a suicide attempt.

(4) Assists the Division Surgeon in providing training to soldiers and family member in stress management/suicide prevention and family advocacy subject matters.

e. ACofS, G1:

(1) Serves as a member of the Suicide Risk Management Team, and is prepared to meet during instance of a suicide crisis when so requested by the Division Surgeon.

(2) Assists the Division Surgeon in the collection, analysis, and dissemination of suicide related behavioral data.

(3) Promulgates letters of instruction, regulations, etc., as required to prescribe appropriate procedures and activities which foster suicide prevention and intervention.

(4) Advises other team members on career implications, courses of action, etc., regarding soldiers identified as potential suicides.

f. ADJUTANT GENERAL, STAFF JUDGE ADVOCATE, PUBLIC AFFAIRS OFFICER ALCOHOL AND DRUG CONTROL OFFICER, ARMY COMMUNITY SERVICES OFFICER:

(1) Serve as members of the Suicide Risk Management Team and are prepared to meet during instance of a suicide crisis when so requested by the Division Surgeon.

(2) Provide advice and assistance to the Division Surgeon within their areas of administrative or professional expertise on matter pertaining to suicide risks or attempts.

(3) Coordinate with the Battalion/separate Company Commander concerned, and provide advice or administrative assistance as required.

g. PROVOST MARSHAL:

(1) Serves as a member of the Suicide Risk Management Team, and is prepared to meet during instances of a suicide crisis when so requested by the Division Surgeon.

(2) Ensures that procedures are established for <u>immediately</u> notifying the Division Operations Center, the Division Surgeon, and the appropriate commander during instances when suicides or family members suicides are imminent or have occurred. Also coordinates directly with medical treatment facilities in crisis situations (Emergency Rooms) as appropriate or necessary.

(3) Provides for the immediate protection and well being of soldiers or family members at high risk for suicide until unit/medical personnel are on scene.

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY TRAINING AND DOCTRINE COMMAND
Fort Monroe, Virginia 23651-5000

TRADOC Pamphlet
No. 600-22

30 October 1985

TRADOC Suicide Prevention Planning Guide

1. The Secretary of the Army and the Chief of Staff, U.S. Army, recently emphasized the responsibilities of leaders for suicide prevention. Therefore, TRADOC has made a formal commitment to create a command climate which is sensitive and responsive to factors which contribute to suicide throughout our military community. The enclosed TRADOC guide is provided for leaders to use as a framework in establishing proactive measures against this disturbing problem.

2. This guide is not intended to eliminate all stress situations from the military environment. Personal strength and integrity are developed and tempered through the experience in dealing with stressful events in our lives. However, occasionally individuals become overwhelmed by a combination of events that lead the person to believe that suicide is the only way out. We must create and maintain an optimal social environment through the expansion of caring leadership at all echelons. This is the signal our leaders must send to all service and family members immediately. Emphasis is placed on the following:

a. Caring leadership and early involvement of the chain of command and professional agencies.

b. Sensitization of junior leaders by senior leaders.

c. A formal commitment to mutually support the Army's objective through a series of actions which treat the causes of suicide rather than suicide itself.

3. Each TRADOC installation and activity is expected to utilize its Human Resources Council, or other similarly constituted council assisted by the AMEDD, Provost Marshal, chaplains and a broad base of other community support agencies. Its function is to identify and develop an installation plan, institutionalize the initiatives and enhance the positive social and physical environment of its installation.

4. TRADOC's Suicide Prevention Planning Guide provides installations with recommendations and training materials to use in developing their program as follows:

Part I	Training the People
Part II	Training in the Schoolhouse
Part III	Training Human Services Providers
Part IV	Assessing the Physical and Social Environment for Potential Negative and Positive Stressors

Part I - Training the People

1. The goal of the Suicide Prevention Strategy is to reduce the incidence of suicide in the Army. To accomplish this, the Army must sensitize various groups of people and cause them to take appropriate action. Suicide prevention efforts should be targeted basically on two groups: those who are susceptible to the myriad of factors that contribute to or cause self-destructive behavior, and those personnel who can intervene to prevent the incident from occurring.

a. The first group consists of essentially the entire Army community because no one is totally immune to the myriad of circumstances and pressures which contribute to the problem.

b. The second major target group consists of people who can act to prevent a suicide. This group consists of Army leaders, civilian supervisors and helping professionals. The general message to this group is simple--create sensitivity and awareness of suicide and explain what can be done to intervene and prevent.

2. "The United States Army Guide to Prevention of Suicide and Self-destructive Behavior" (Appendix B) provides for training Army leaders, supervisors and helping professionals. Also available through the local Training and Audiovisual Support Centers (TASCs) is an 18-minute video tape produced by the Academy of Health Sciences, entitled "Suicide Prevention." It is recommended that these two teaching aids be used in training leaders, from NCOs to senior commanders and supervisors. In addition, each installation should prepare a local SOP handout identifying specific options and POCs for leaders who identify individuals with potential suicide behavior who may require professional assistance.

Part II - Training in the Schoolhouse

1. Suicide Prevention training will be provided in all TRADOC officer and NCO development courses to ensure Army leaders are sensitized to the suicidal dangers for soldiers and family members. Suicide Prevention will be included in the Duties, Responsibilities and Administration (DRA) block of leadership instruction.

2. Suicide Prevention training will be augmented by "The United States Army Guide to Prevention of Suicide and Self-destructive Behavior" and the 18-minute video tape produced by the Academy of Health Sciences, entitled "Suicide Prevention."

Part III - Training Human Services Providers

1. Human services providers are often in a unique position to observe symptomatic self-destructive behavior or to deal with family members or close friends of such people.

2. Chaplains, military police, ADAPCP counselors, ACS financial assistance counselors and other functional area personnel need to be familiar with the following:

a. To become sensitive to the signals that could identify a potential suicide.

b. To become familiar with the appropriate network of professional help available to active duty, civilian employees and family members.

c. To have a clear understanding of how to deal with a perceived situation when it presents itself.

3. It is recommended that this training be provided by a qualified professional.

4. Specialized training initiatives for health care professions are being implemented through The Surgeon General channels.

Part IV - Assessing the Physical and Social Environment for potential Negative and Positive Stressors

1. Suicide prevention is not accomplished solely by identification of the suicide prone individual. Suicide is prevented by altering the conditions and treating the underlying problem which produced the suicidal thoughts.

2. Suicide is the end result of a complex interplay of individual, family, unit, community, and biologic variables. Alterations in unit cohesion and morale and family integrity, as well as individual life stress events, may result in an increased risk of suicide or suicide related behaviors. Suicide is but one type of deviant behavior affected by those variables. Excessive drinking, drug abuse, family violence, accidents, AWOLs, and all sorts of other disciplinary problems may stem from the same conditions that produce suicides. These behaviors should be considered as potential indicators of an individual in crisis.

3. A suicide may be an indicator of organizational stress. It must be emphasized, however, that it is only one indicator and, as such, must be understood in the context of other traditional indicators of unit readiness.

4. Suicide prevention also requires the assessing of the social environment and activities which foster primary relationships. The individuals who isolate themselves, who have not developed close friendships, are most likely to internalize problems and dwell on them in irrational terms. The individuals who may be overwhelmed by circumstances but who have close friends with whom to verbalize their problems will likely sort out those problems in a more rational manner. A workable strategy for the prevention of suicide is to enhance the social environment and those activities which foster primary relationships (home, chapel, family, etc.) for our TRADOC personnel.

Appendix B

THE UNITED STATES ARMY GUIDE TO PREVENTION OF SUICIDE AND SELF-DESTRUCTIVE BEHAVIOR

Suicide among young adults is a serious and growing problem. In the past 25 years, there has been a 300 percent increase in the adolescent suicide rate. More than 6,500 young Americans kill themselves each year. Taking all age groups into account, nearly 30,000 Americans die by their own hand each year. There are over 1000 suicide attempts in the United States daily or one every minute of every day. Nationally, suicide is the tenth leading cause of death. In persons 14 to 25 years of age, it is the third leading cause of death and, among college students, it is second.

WHY SUICIDE?

There is no simple answer as to why people choose to kill themselves. Usually, the emotional upset is so great that the person "just wants to stop the pain." The suicidal person feels a tremendous sense of loneliness and isolation. They feel helpless, hopeless, and worthless. Often they believe that it does not matter if they live or die and that no one would miss them. Suicidal people feel that they cannot cope with their problems and that suicide is the only possible way to escape unbearable pain.

WHAT CAUSES SUICIDE?

In trying to understand why people kill themselves, it is tempting to look at the source of stress in their lives. An analysis of life stressors is not, however, the answer. Stress is a normal part of life and people are usually able to cope. Actually, most people think about suicide at sometime during their lives. Usually they find that these thoughts are temporary and that things do get better. Generally, it is a combination of events that lead a person to believe that suicide is the only way out. One common thread is that the person feels hopeless about life. Feelings of hopelessness and low self-esteem can have many causes:

o Break up of a close relationship with a loved one or difficulties in interpersonal relationships with family or close friends.

o Death of a loved one: spouse, child, parent, sibling, friend, or pet.

o Worry about job or school performance and concerns about failure or doing less well than one hoped or expected.

o Loss of "support systems" or "emotional safety" which comes from moving to a new environment.

o Loss of social or financial status of the family.

o The compounding and disorienting effects of drugs and/or alcohol.

DEPARTMENT OF THE ARMY
HEADQUARTERS US ARMY GARRISON
2837 BOYD AVENUE
FORT HUACHUCA ARIZONA 85613-7001

REPLY TO
ATTENTION OF

ATZS-CDR (600)

26 November 2003

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: POLICY--Suicide Prevention

1. References:

a. AR 600-85, Army Substance Abuse Program (ASAP), 01 October 2001.

b. Chapter 5, Suicide Prevention and Psychological Autopsy, to AR 600-63, Army Health Promotion, 28 April 1996.

c. DA Pamphlet 600-24, Suicide Prevention and Psychological Autopsy, 30 September 1988.

d. Memorandum, TRADOC, ATBO-F, 6 Mar 00, subject: TRADOC Suicide Prevention Program (TSPP).

e. Memorandum, US Army Intelligence Center and Fort Huachuca, ATZS-CG, 9 August 2001, subject: Applied Suicide Intervention Skills Training (ASIST).

f. Memorandum, TRADOC, ATBO-ZI, 21 Mar 03, subject: The Tragedy of Suicide – TRADOC Prevention Efforts.

2. Suicide prevention is a Commander's program and responsibility. It is accomplished through caring; a positive leadership presence; strong policy and direction; sensitive awareness and training in timely suicide risk identification and suicide prevention; effective intervention; and concerned and responsive follow-on care.

a. Leaders at all echelons must be alert to discern and train their subordinates to recognize potential suicide danger signals such as apparent feelings of worthlessness, hopelessness or helplessness, withdrawal from family and friends, increased time spent alone, alcohol or drug abuse, loss of interest or pleasure in usual activities, changes in appetite or weight, talk about

suicide, giving away possessions, obsession with death, and changes in sleep habits. Also important is listening to an individual as cues and clues are often in his or her words. Established with this policy is the new requirement for all privately owned weapons on post to be registered with Directorate of Public Safety (DPS). This will improve the capability of commanders to quickly identify at-risk soldiers who have such weapons in their possession. Additionally, all commanders and leaders are strongly encouraged to obtain ASIST for all first-line supervisors, cadre, and drill sergeants. The ASIST is mandatory for units in which suicide behavior and other high rates of Risk Reduction problems occur.

b. Leaders will make every effort to widely disseminate information on helping agencies and sources of support. They are:

(1) the Raymond W. Bliss Army Health Clinic, Behavioral Health Services, 0730-1630, 533-5161/7030; Sierra Vista Regional Health Center, Emergency Room (ER), 417-3060. (Provide suicide assessment and counseling. First point of contact for suicide assessment, treatment, and referral, if necessary)

(2) the Office of the Family Life Chaplain, 533-4748; After-hours, 533-2624/2291. (Provide suicide awareness and prevention training to assist commanders with identification of at-risk personnel and conduct quarterly ASIST training.)

(3) and the Army Substance Abuse Program/Risk Management & Employee Assistance Services, 538-1286/1397 (oversee the incorporation of the Installation Prevention Team and ensure the Installation Suicide Prevention Committee meets at least biannually.) Also report statistical information on the ASAP Risk Reduction Program to Mr. Vern Hunter, Alcohol and Drug Control Officer (ADCO), vern.hunter@us.army.mil.

3. Disseminate and encourage the use of TRADOC suggested websites and phone numbers, i.e., The National Hopeline Network 1-800-SUICIDE , www.HOPELINE.com , www.SAVE.org ; American Association of Suicidology, WWW.SUICIDOLOGY.ORG , www.QPRINSTITUTE.com .

4. Every commander, soldier, family member, supervisor, and civilian plays an important part in suicide prevention. Every member of the Fort Huachuca family has the potential to come in contact with a person who is at an increased risk of suicide and, therefore, must be part of the solution.

5. The proponent for this policy is the US Army Garrison, Army Substance Abuse Program, extension 538-1286.

ATZS-CDR
SUBJECT: POLICY—Suicide Prevention

6. This memorandum supersedes policy memorandum, ATZS-CDR, 17 June 2003, subject as above.

//original signed//
LAWRENCE J. PORTOUW
COL, MI
Commander, US Army Garrison

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Commander,
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AMC LAO

DEPARTMENT OF THE ARMY
U.S. ARMY DRUG AND ALCOHOL TECHNICAL ACTIVITY
5600 COLUMBIA PIKE, SUITE 300
FALLS CHURCH, VIRGINIA 22041

REPLY TO ATTENTION OF

March 28, 1985

Mr. Meyer Moldeven
P.O. Box 19644
Las Vegas, Nevada 89132-06444

Dear Mr. Moldeven:

I have been asked by the Army Public Affairs Office to review your booklet, "Civilian Community -- Military Installation Teamwork in Suicide Prevention: A Handbook for Collaboration" and respond to your request for comments and suggestions. I am the project officer for the Department of the Army's Suicide Prevention Program. The Army leadership has given suicide prevention a very high priority. The Army Chief of Staff and the Secretary of the Army have issued a memorandum on suicide prevention (Enclosure) and approved an Army plan for suicide prevention (Enclosure). This plan will serve as the guide for all suicide prevention efforts in the Army. The action plan calls for the publication of a commander's guide for suicide prevention and a model installation suicide prevention plan. It is in the context of the model installation plan, that I see your work to be the most helpful.

In response to your request for comments, we found the factual data presented in your handbook to be essentially correct and consistent with information we have gathered. Your basic approach to the problem, with its emphasis on Leadership and Command involvement, is highly consistent with the Army philosophy on suicide prevention. The concept of close cooperation between Army professional and paraprofessional mental health workers and civilian community suicide prevention agencies will be an integral part of the Army model installation suicide prevention plan.

It would appear that your handbook and in particular the "Procedures and Resources Guide" would be most helpful to civilian mental health and crisis intervention agencies operating near military installations. It gives the layman a basic understanding of military resources and how to obtain assistance from the military.

I would be very interested in obtaining a copy of your final product. Please inform us specifically of what parts (if any) of this copyrighted material may be used in official Army publications.

Sincerely,

Robert W. Thomas

ROBERT W. THOMAS, Ph.D.
Captain, M.S.C.
Clinical Psychologist

Enclosures

1-82

(Prepared originally in 1971 by Meyer (Mike) Moldeven (IG Office, McClellan AFB)

Procedures and Resources Guide

This sample guide may be useful to community suicide prevention agencies (or to other crisis intervention resources) seeking understandings with nearby military installations in handling distress calls from members of the active or retired military, their families, or others who have an entitlements relationship with the military services.

The experience of the writer is that a specific community-base procedural guide requires discussions among the community's crisis intervention/suicide prevention agencies to reach a consensus, and then, between the community and the area's military installations to arrive at mutually acceptable procedures. The resulting guide forms the basis for teamwork.

NOTE

The original of this guide was prepared to be used by Suicide Prevention Service (SPS) telephone workers within a specific geographic area when responding to calls from members of the active duty military or their families and it became necessary to get information from nearby military installations, at all times with the prior permission of the caller.

At the time the guide was in use the procedures were appropriate to the times and the place, and acceptable, with some reservations, to the Director of the SPS and to the potential contacts at nearby military installations. The times were the late 1960s-early 1970s, and [illegible] tumultuous.

Preparing a usable guide for a specific community-military installation relationship requires an evaluation of resources available to both sides, a methodology common to several community resources, and an understanding (possibly a Memorandum of Agreement) between the community and the commanders of the military installations who chose to participate in the process. For example: an installation commander may prefer a single point of contact on the base.

Before an approved guide is placed into actual use the staffs of the community suicide prevention agencies and the supervisors of the installations' contact points should consider testing them in an exercise so that each side has an understanding of what may develop when trying to prevent a suicide or reduce a person's lethality. The experience is mutually beneficial.

Material no longer relevant has been deleted to the extent possible to simplify the presentation.

TEXT OF GUIDE

PREFACE

This guide supplements established suicide prevention procedures, and may apply when a caller is a member of the active military forces, a military family member, a military retiree, the spouse of a military retiree, or anyone ~~else~~ who indicates he or she has a formal connection to the military services. Normally, these procedures would not apply to the general public or to members of the Federal Civil Service unless the call is perceived to be more than moderately lethal, AND the call is originating on the military installation itself.

Although this guide is primarily intended for use within community resources, copies are furnished to supervisors of the organizations identified herein as contacts so that they may be better prepared to respond to an urgent call from the community.

Readers and users of this guide are encouraged to propose changes, update telephone numbers, and offer ideas to improve and increase its usefulness.

Comments should be sent to: (Name/Organization/Address).

GENERAL

(Identify by name) County, (State) has a large military population, made up of active duty members, their families, retired military, and others who have formal ties to the military services. Although most of the active duty military are stationed at the major installations in the area (--- Air Force Base, --- Army Base, --- Naval Base, --- Marine Corps Base) the area is also the hub of a transportation network and is (a major gateway to and from overseas areas and/or central to numerous military and military service installations in this part of the State). As a result, our community provides for both a constant military population and a variable flow of military transients passing through on their way to and from overseas and local area stations.

Certain former members of the military services, and their families, are normally entitled to medical and specified other services on a military installation. Among these former members are retired military, spouses of retired military, and widows and dependent children of deceased active-duty-status military personnel and retirees. This should be ~~checked~~ determined on a case by case basis.

PROCEDURES

Circumstances in taking a call from a person in distress may, at times, dictate a need for information or assistance from one of the military bases in the area. This may occur when a caller identifies himself or herself as an active duty member of the military services, a military dependent, a retired military person, or, in some other way establishes a relationship to the ~~services~~ U.S. Armed Forces.

If you feel that contacting the base will serve a useful purpose, discuss it with the caller.

Because of the large number of active duty military, military families, and retired military in the area consider, during the interview, inquiring whether the caller has a connection with the military services. (Sometimes the caller will hint at it.) If the response is in the affirmative, this may open potential resources for assistance.

# # #

CAUTION

The caller may object to the military services being made aware that he or she contacted a community crisis intervention or suicide prevention resource.

Disclosing the identity of the person calling the community resource for help is prohibited unless the caller is in an immediate life risk situation, has initiated a self-destructive act, or, in your judgment, is about to cause physical harm to another person.

In such circumstances, and if time permits, contact your agency shift supervisor or director. If there is no time for such contacts and the situation is extreme, make the decision yourself.

Other than in the most extreme cases, when contacting a base official for information, the proper response to the official who insists on knowing the identity of the person in distress (the client) is:

-the identity of the person calling the agency is not known, or

-the identity of the person is privileged in the same manner as in a doctor-patient or attorney-client relationship.

The fragmentation of functions and responsibilities on the typical military installation may make it necessary, at times, to contact several people to get the required information or action. Nevertheless, there are a lot of concerned and capable people on the base who care, and who, almost without exception, will try to help in any way they can. Your job, when calling the base, is to explain what information or assistance you need, and how quickly, considering the circumstances of the person in distress.

When faced with an extreme and urgent situation which demands immediate action by a base official try to state, specifically, what the emergency is about. It is not enough to merely use the term "emergency" as the word has been misused so often it has lost its effectiveness.

Also, in most instances, the initial recipient of the call at the base is usually a secretary or subordinate who will not be in a position to give authoritative information or assistance. Normally, they are buffers between callers and decision-makers.

To get to the source of authoritative information, or to the decision-maker, should action be needed immediately:

-- ask the base telephone operator to remain on-line;

-- when you are connected to the office you're calling, say something like:

"This is the (identify your agency, i.e. Suicide Prevention Center, Police Department, Emergency Rescue Unit, School Crisis Center, Hospital Crisis Clinic, Social Service, etc) calling. I have a (military member/military family member/a military person who is assigned to your base) on my other line and (he/she) is threatening to commit suicide. I need (information/assistance) right now from your office to help this person through a suicidal crisis. Get your supervisor on the line immediately. I mean right now."

When the supervisor comes on, get his/her name and write it down. If they know you know who they are, it ~~helps the action.~~ accelerates the process.

Give the supervisor as many facts as you think is necessary to get you what you need. This may not be easy when you are also trying to protect the identity of the caller.

Be sure the supervisor understands. Here the fragmentation problem comes up: if the person being talked to disclaims responsibility or is otherwise evasive, try to find out from him/her who does have the ball, and get their telephone extension. Ask the base telephone operator to switch you over or help in other ways to make the next contact.

In cases where a highly-lethal, or otherwise deeply disturbed caller, who identifies himself/herself as being on active duty with the military services or as a military family member, or anyone calling directly from a military base, states (directly or indirectly), that he or she is about to engage in, or is planning an act that will be dangerous to others, you must give this threat credence.

Bring such calls to the attention of the agency shift supervisor or director immediately. If they are not available, and you are unable to dissuade the caller, reassess the indicators.

If the conclusion is reached that civilian or military law enforcement authorities should be notified, do not delay. Call them immediately. If they are not responsive phone the FBI. Write down the name of the police officer/FBI agent to whom you give the information. Be responsive to their

requests, especially if you are still on-line with the person making the threats.

The types of situations that fall into this category include:

-- Using an airplane, boat or other equipment to commit suicide;

-- Stealing weapons, explosives or other destructive devices from a military base, or anywhere else for that matter, and "taking others with me;"

-- Committing an act of arson or terrorism against government property as part of the suicide, or

-- Assassinating a government official and getting killed in the process.

Except for Hospital and Police, the base management staff is, ordinarily, on a 40-hour work week (8 to 5; Monday through Friday). However, in case of emergency, contacts can be quickly established with responsible officials through the Police Emergency Desk. Also, in some cases, the base telephone operator can provide assistance in reaching people during non-duty hours.

Following are the telephone extensions of contacts on the primary military installations in this area, and a brief description of how they can be useful for suicide prevention.

BASE CONTACTS AND HOW THEY CAN HELP

BASE TELEPHONE OPERATOR

--- Base (Telephone numbers)
--- Base
--- Base

The Base Telephone Service at all -- installations is manned round-the-clock.

If a call comes in to the base telephone operator from a person who states he or she is planning, or has started to, suicide, the operator will try to hold that person on-line until a connection can be made with the Base Hospital, the Chaplain, or the County Suicide Prevention Center.

When you phone the base telephone operator as part of the suicide prevention process, ask him/her to:

-- assist you in establishing contacts with the persons, or offices, needed to act in the situation, and

-- stand by on-line until the entire call has been completed and you go off-line from the Base. (This is important because you may have to switch back and forth among several contacts on base in order to get the needed information or assistance. There may be a need for a quickly-arranged conference call: The base telephone operator is in the best position to do this. Write down the name and/or number of the telephone operator for use in follow-on contacts.)

BASE MEDICAL EMERGENCY SERVICE

--- Base (Telephone numbers)
--- Base
--- Base

The Base Medical Services at --- Base and --- Base are manned round-the-clock. --- Base has a hospital and a staff psychiatrist. If the --- Base does not answer, call --- Base.

The Base Medical Emergency Service can provide:

-- emergency medical treatment, and

-- consultant services in psychiatry for military members and their families. (These include service by on-base and off-base professional resources.)

The Base Medical Service is not authorized to act where a suicidal person is a Federal Civil Service employee or a member of his or her family unless, and only if, the act of suicide is about to occur on the installation. (This may also apply if the person is not associated with the federal military or civilian services. If it's happening on base, base officials are usually very concerned.) If the call from a Federal Civil Service employee comes from off-base, deal with the community services.

If a military services caller agrees to seek professional help, remind him/her to take along their ID cards to show eligibility for military medical care.

Limitations: Active and retired military members and their families; all others if the attempted suicide is taking place on the military installation or in a place under the jurisdiction of the military services (military vehicle or aircraft, military ship or boat, etc).

MILITARY POLICE EMERGENCY DESK

--- Base Telephone Numbers
--- Base
--- Base

If the call comes in directly from the installation, and the caller has initiated the suicidal act, the Base Police can expedite locating the person and getting help to him or her. The fact that the person called the Center after starting to suicide is a strong indication that help will be accepted. Insist that the base telephone operator remain on-line to help in locating the individual.

During non-duty hours the Base Police can contact base officials who can, in turn, provide information or assistance.

Limitations: None, if the action is taking place on the installation.

INSPECTOR GENERAL

--- Base Telephone Numbers
--- Base
--- Base

Because of their general knowledge of overall base organization and resources, the Inspector General can be useful in getting information and assistance, or in getting cooperation and support from base organizations.

Limitations: None, if the action is taking place on the installation.

#

CHAPLAIN

--- Base Telephone Numbers
--- Base
--- Base

Contact the Chaplain in cases where the caller indicates that help through the clergy might be acceptable.

If the call is from on-base, and has such high-lethality that the Base Police have been brought in, get word to the Chaplain as quickly as possible.

Limitations: Active duty military members and their families.

FAMILY SUPPORT SERVICES

--- Base Telephone Numbers
--- Base
--- Base

Family Support Services provides information and assistance to members of the military services and their families in meeting and overcoming family problems beyond member/family resources. This, depending on circumstances, includes limited help in finances, relocation, transportation, how to get medical, mental health, and dental care, coping with "abuse" within the family, and many other problems. Family Services gives orientation talks to new military wives, and assists them in getting settled in their new surroundings. They give advice to military family members in cases where family routines have been unexpectedly disrupted.

Family Support Services is an excellent resource. Often, they are the focal point on the installation for dealing with family crises, and are trained paraprofessionals in crisis intervention work. The Family Support Services function usually has a professional staff, and volunteer workers who are highly motivated. If a problem has family implications, and the caller does not reject them, get Family Services into the act.

Limitations: Active and retired military and their families, and survivors of deceased military personnel.

(SERVICE) MILITARY AID SOCIETY:

--- Base Telephone Numbers
--- Base
--- Base

The (Service) Aid Society can provide rapid financial assistance to a military person in the event of emergency. Such assistance may be either in the form of a grant or a non-interest bearing loan. This resource should be used as a referral only. Give the caller the telephone number of the Aid Society. Do not call the Aid Society for the party calling for help. The Aid Society works closely with Family Services; if you must contact the Aid Society, do it through Family Services.

Limitations: Active duty military members only.

LEGAL SERVICES (STAFF JUDGE ADVOCATE)

--- Base Telephone Numbers
--- Base
--- Base

May be consulted when factors contributing to the caller's problems include violation of law, desertion, AWOL, violation of public trust, or other "legal" aspects of life in the military services. CAUTION: Do not disclose the identity of the person that called, even if it's a third party. That's the responsibility of the caller.

During the bases' non-duty hours call the base telephone operator at --- Base and ask for the telephone number of the Staff Judge Advocate attorney on emergency standby.

Limitations: All active duty military and their families; members of allied military services serving in the United States or its possessions; retired regular or reserve personnel and their families, and survivors of retired military on matters relating to benefits, entitlements, and insurance related to the military members' service.

MILITARY PERSONNEL RECORDS

--- Base Telephone Numbers
--- Base
--- Base

Can furnish name and telephone number of a military member's next of kin. Asking for this type of information should be confined to extreme situations, and only where the next of kin can provide assurance-type support to reduce lethality. First explore with the caller whether the next of kin can really help, and judge the situation accordingly.

Before contacting the next of kin, and if time permits, consult the base Chaplain. If the base Chaplain wants to make the contact with the next of kin, don't dispute his/her right to do so. However, follow-up is in order.

Limitations: Active duty military members only.

#

Other Functions Which May Contribute:

Ground/Sea/Air Safety

Explosive Ordnance Safety

Social Actions

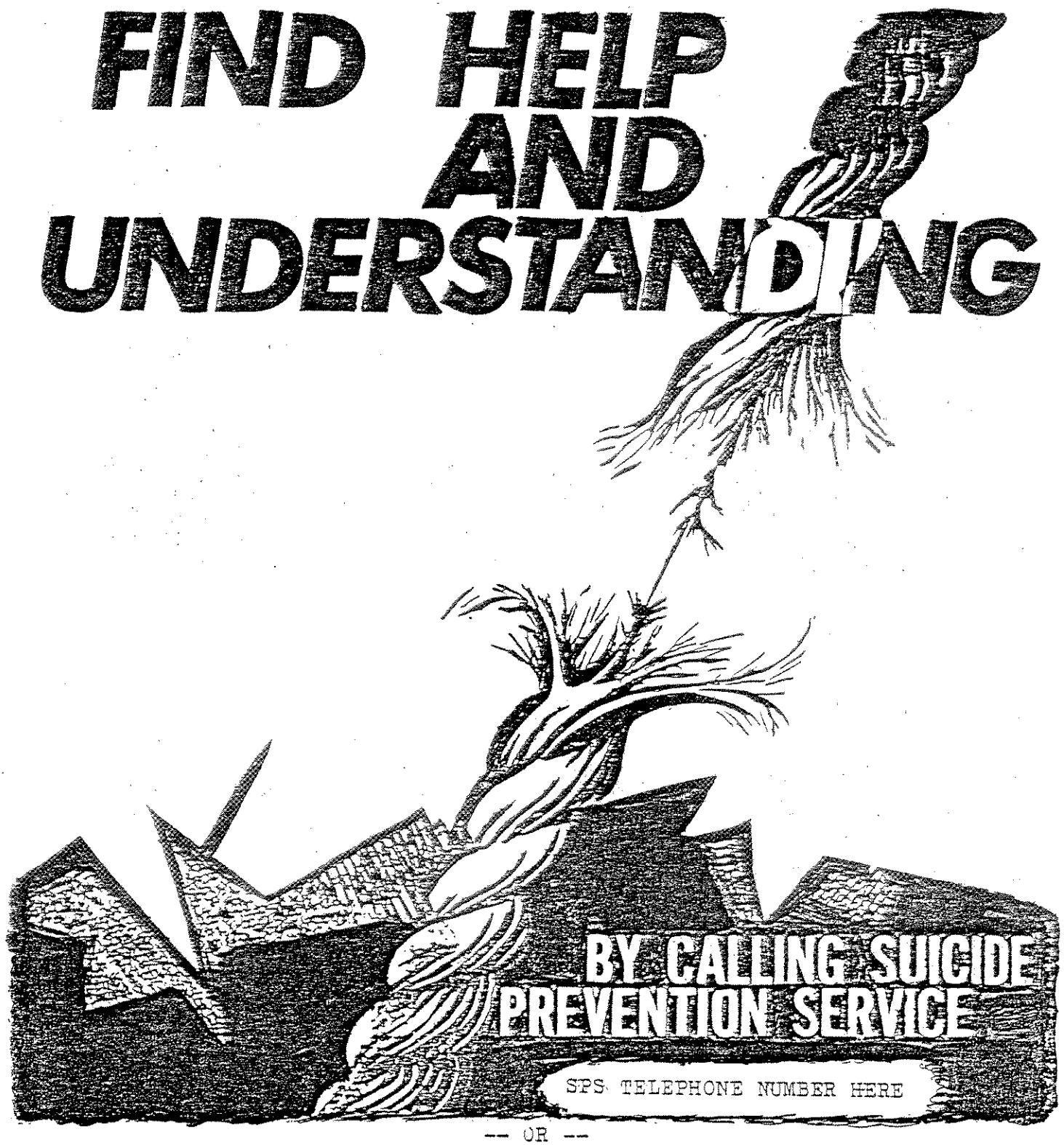
Mental Health

Payroll

Flight Operations

#

FIND HELP AND UNDERSTANDING



-- OR --

CALL ON-BASE PRIMARY RESOURCES

-- AFB -- ARMY BASE -- NAVAL BASE CAMP (MC) --

(Telephone Numbers)

MEDICAL EMERGENCY
* CHAPLAIN
* FAMILY SUPPORT

* DURING NON-DUTY HOURS CALL BASE OPERATOR AND ASK FOR OFFICER ON DUTY

1-98