

ANNEX D

REVIEW OF SOLDIER SUICIDES

**Operation Iraqi Freedom (OIF)
Mental Health Advisory Team (MHAT)**

16 December 2003

**Chartered by:
U.S. Army Surgeon General**

This is an annex to the OIF MHAT Report addressing suicide among Soldiers deployed to OIF, including Kuwait and Iraq.

This report is redacted to remove unit identifications, unit locations, and personal identity information in accordance with Army Regulation 25-55, *Department of the Army Freedom of Information Act Program*, and Army Regulation 340-21, *The Army Privacy Program*. Redacted information appears throughout this report blacked out, such as below.



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ANNEX D to OIF MHAT REPORT

INTRODUCTION

The objectives of this review were to identify factors impacting on suicide risk for Operation Iraqi Freedom (OIF) Soldiers and make recommendations to assist with suicide prevention efforts. Within the first 17 days of July 2003, five suicides occurred in Iraq and alerted the leadership of Combined Joint Task Force-7 (CJTF-7), Coalition Forces Land Component Command (CFLCC), Army Medical Department (AMEDD), and Department of Army (DA) to a potential suicide outbreak. Also within this same time period, a Soldier who had left OIF via psychiatric medevac committed suicide within days of returning to CONUS. As part of its charter, the OIF MHAT was directed to determine whether the July suicides represented a burgeoning suicide rate among OIF Soldiers.

This review provides an analysis of Army suicides occurring in Iraq and Kuwait between January and October 2003 by male and female Active and Reserve Component Soldiers. Although OIF did not commence until mid-March, Soldiers who deployed to Kuwait between January and March are included. The suicide rates for Soldiers deployed to OIF January – October 2003 were compared to other relevant suicide rates, and the characteristics of OIF suicides were studied to determine whether there are increased risks for suicide associated with OIF deployment. Findings and recommendations are presented first, followed by tables, summary of methods, and references.

This review provides a highly proactive suicide risk assessment for a deployed military force, conducted during an on-going military operation. There is no known precedent for this type of assessment. By its nature, suicide is a low frequency event and occurs for highly individualistic reasons. These characteristics present enormous challenges for detecting reliable trends among a population that will lead to effective prevention actions. The data analyzed for this review are time-sensitive and should be interpreted in this context.

FINDINGS

1. The suicide rate for Soldiers deployed to OIF January – October 2003 was higher than recent Army historical rates.

The OIF suicide rate was 15.6 suicides per 100,000 Soldiers per year for suicides occurring between January-October, and compares to the average annual rate of 11.9 per 100,000 for the eight-year period 1995-2002 (range 9.1 - 14.8).

2. There was a high incidence of OIF suicide during July when compared to other months but it did not signify an escalating rate of suicide. The July OIF suicides may be viewed as a spike when compared to the months before and after July, but

there was no continuing trend and no indication that any of the suicides were related to each other.

3. Firearms were the predominant method of suicide for OIF Soldiers.

Most suicides were committed by young males, a group that is typically high risk for suicide. The frequency of firearm suicide during OIF was much higher when compared to firearm suicide for the Army and U.S. populations in previous years. The deployed force is comprised of a large number of young males who are a group with high suicide risk in the U.S. population.

4. Compared to historical Army suicide rates, OIF suicide rates were higher for Soldiers located in Iraq and lower for Soldiers in Kuwait; higher for Active Component Soldiers and lower for Reserve Component Soldiers; and higher for both males and females. Compared to the average Army suicide rate of 11.9 per 100,000, the rates for OIF Soldiers assigned in Iraq, females, Active Component Soldiers, and males, were 21.2, 19.0, 17.2, and 15.2 respectively. The rates for Reserve Component Soldiers and Soldiers assigned in Kuwait were 9.2 and 3.0 respectively.

5. Deployment length varied widely for Soldiers who committed suicide.

One fourth of Soldiers who committed suicide did so within the first thirty days of arriving in theater. Transition to deployment may be a contributing stressor for some suicides, but vigilance for suicide risk should be maintained throughout a Soldier's deployment.

6. In the absence of a standing Army suicide prevention program for tactical environments, CJTF-7 and CFLCC created suicide prevention programs.

The Army Suicide Prevention Program (ASPP) was developed for a garrison-based force and provides little guidance for tactical application. The ASPP strategies for minimizing suicide risk can be readily adapted to a deployed force engaged in combat operations.

7. OIF behavioral health personnel have utilized traditional but passive suicide monitoring that provides limited visibility of suicide risk factors.

Suicide prevention programs are increasingly using active medical surveillance methods to expand the scope of suicide monitoring. New tools are available that monitor serious suicide behaviors to improve detection and management of population suicide risk.

RECOMMENDATIONS

1. Immediate: CFLCC & CJTF-7 should adapt the existing (community-based) objectives of the Army Suicide Prevention Program for OIF Soldiers and units.

Strategies of the ASPP can be applied to a forward deployed force through actions in the following five areas:

- Designate proponents to manage the CFLCC and CJTF-7 suicide prevention programs
- Maintain vigilance by leaders and Soldier-peers to ensure Soldiers at risk for suicide receive appropriate support
- Conduct training that provides crisis intervention skills to designated Soldiers with a goal of one trained Soldier per company
- Implement surveillance of completed suicides and serious suicide attempts with standardized suicide event reporting by behavioral health personnel
- Establish a command climate that encourages appropriate help-seeking behavior by distressed Soldiers. Behavioral health care should be delivered as far forward as possible to maximize the likelihood of successfully returning Soldiers to duty.

2. Future: Implement monitoring of serious suicide attempts within Army medical surveillance systems. Task CHPPM and the OTSG behavioral health consultants to develop monitoring of serious suicide attempts at the installation, operational, and Army-wide levels. Enough precedence exists to support the strategy of reducing suicide occurrence by reducing occurrence of serious suicide attempts (leading to hospitalizations and evacuations). A critical component of this strategy would be to monitor suicide attempts as a metric for suicide prevention actions. The pilot version of the AMEDD Suicide Events Report (ASER) is a promising tool for reporting suicide attempts.

DISCUSSION OF THE FINDINGS

DATA FINDING #1: The suicide rate for Soldiers deployed to OIF January – October 2003 was higher than recent Army historical rates.

Army historical rates. There were 53 suicides within the U.S. Army between January and October 2003 which represent an annualized rate of 12.5 suicides per 100,000 Soldiers per year. The Army suicide rate for the eight-year period 1995-2002 averaged 11.9 per 100,000 and ranged from a low of 9.1 in 2001 to a high of 14.8 in 1995 (Appendix 1, Tab A). The Army suicide rate, January – October 2003 is consistent with Army suicide rates from previous years.

OIF suicides. As of 5 December 2003, the Office of the Armed Forces Medical Examiner (OAFME) has classified 17 Army deaths occurring within Iraq or Kuwait as suicide for Soldiers deployed in support of OIF between January – October 2003 (Appendix 1, Tab B). In addition, there were two known suicides among Army OIF veterans, however they are not included as OIF suicides since their fatal self-inflicted injuries occurred after they departed the OIF Theater.

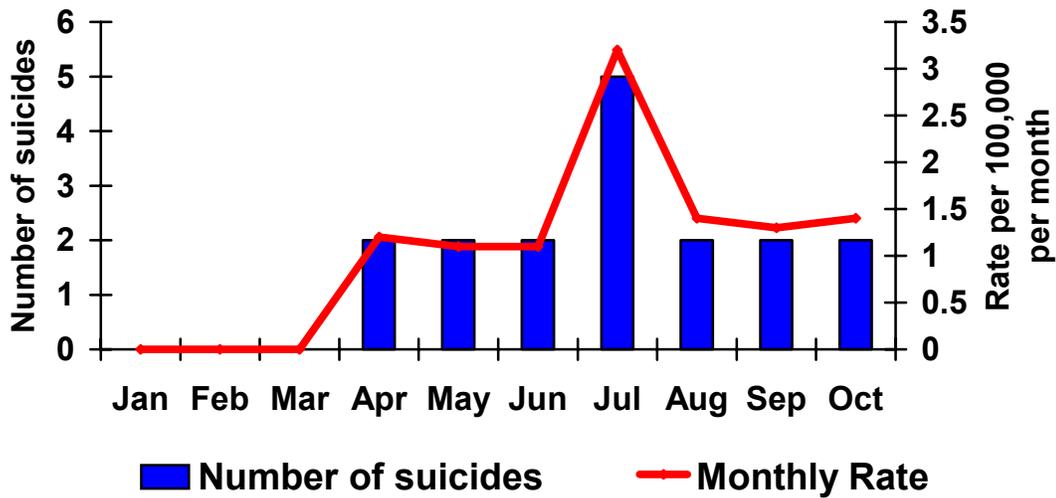
OIF suicide rate. The seventeen OIF suicides represent an annualized rate of 15.6 per 100,000 per year. The current OIF suicide rate is higher than the average annual Army rate of 11.9 per 100,000 (range 9.1-14.8).

Previous military operations. The Army does not calculate suicide rates for specific deployments. A review of the professional literature found few references to suicide rates during combat or other military operations. One author (Adams, et al, 1998) reported an aggregated rate of 15.6 suicides per 100,000 for U.S. military personnel during their tour of duty in Vietnam. Other authors (Writer et al, 1996) found a rate of 3.8 self-inflicted injury deaths per 100,000 personnel from all military branches during deployment to Operations Desert Shield and Desert Storm. This wide variation in rates serves as a poor baseline against which to compare the current OIF suicide rates.

DATA FINDING #2: There was a high incidence of OIF suicide during July when compared to other months but it did not signify an escalating rate of suicide.

In July, the monthly incidence of suicides increased nearly threefold from previous months, raising concern about a possible outbreak of suicide. Figure 1 displays the number of OIF suicides by month along with the monthly rate per 100,000 persons. The five OIF suicides in July may be viewed as a spike, but did not signify an escalating rate of suicide. When the months before and after July are compared, they are found to be highly similar for rate and number of suicide. Although the suicides in July were closely associated in time, there was no indication of a contagion effect whereby one suicide served as a trigger for another. None of the suicides occurred in the same battalion, and they occurred in geographically dispersed locations. However, a suicide did occur in late June, eight days prior to the suicide on 2 July at the same base camp and within the same Armored Cavalry Regiment (different squadrons). It is possible but unknown whether the Soldier who committed suicide on 2 July knew about the suicide on 24 June. Contributing stressors for the 24 June suicide are cited as financial and personal problems while stressors for the 2 July suicide were considered due to marital problems.

Figure 1: Number and Rate of OIF Suicides: Jan-Oct 03



DATA FINDING #3: Firearms were the predominant method of suicide for OIF Soldiers. Most suicides were committed by young males, a group that is typically high risk for suicide.

Sixteen of the 17 suicides (94%) were the result of self-inflicted gunshot wounds, the predominant method of suicide for male and female Soldiers. The high frequency of firearm suicide stands in contrast to 57% of Army suicides in 2002, and 55.1% of U.S. suicides in 2001. Access to firearms is a well-established risk factor for suicide. According to the American Association of Suicidology (2003), 85% of U.S. suicide attempts by firearms result in a fatality, and the risk for suicide of a household member increases nearly five times in homes with guns vs. those without. During deployment to OIF, Soldiers routinely have access to loaded weapons and thus a highly lethal means for suicide is readily accessible.

Criminal Investigation Detachment (CID) reports were reviewed to obtain information about possible motive for suicide but were incomplete for information about stressors contributing to the suicides. Seven of the 17 reports refer to stressors that may have contributed to the suicide. Reports for the other ten suicides did not include information about possible motives, but were often described as unexpected to fellow Soldiers. The stressors that were described are summarized as: Two (2) with marital problems, two (2) with legal problems, one (1) with non-specified personal problems, one (1) with multiple adjustment problems, and one (1) with financial and personal problems. These are the same stressors most often found among Soldier-suicides historically. To the extent that these suicides are representative of the other OIF suicides, it appears that suicide among OIF deployed Soldiers is occurring for the same reasons typically found among Soldier-suicides. It is not clear how many suicides were preceded with the warning signs that are typically taught in Army suicide awareness briefings. One Soldier clearly communicated specific thoughts of shooting himself to a fellow Soldier,

but no actions were taken to secure the Soldier's weapon and he shot himself fatally a short time later. Given the wider access to weapons however, it would seem that a higher number of Soldiers are acting on their thoughts or impulse for suicide before an intervention occurs. This indicates a need to emphasize that Soldiers and supervisors need to act more aggressively to intervene when are suspected to be at risk for suicide or display obvious warning signs.

Table 3 compares demographic characteristics of OIF Soldier-suicides to Army suicides in 2002. The OIF suicide cohort is primarily comprised of young males, a group that according to the National Vital Statistics report (2002) is high risk for suicide in the United States with twice the rate of suicide in the year 2000 (21.5/100,000 for males ages 20-34 vs. 10.7/100,000 national rate). The OIF cohort is more junior in rank with fewer married Soldiers but more racial/ethnic minority Soldiers.

Table 3: Summary Profiles of OIF and Army 2002 Suicides

<i>As of 5 Dec 03</i>	2003 Army OIF Suicides	2002 Army Suicides
Suicide by firearm/gunshot	94%	59%
Male	88%	98%
Age 30 or younger	82%	63%
E-4 or below	71%	48%
Married	35%	48%
Minority (non-white)	47%	20%

DATA FINDING #4: Compared to historical Army suicide rates, OIF suicide rates were higher for Soldiers located in Iraq and lower for Soldiers in Kuwait; higher for Active Component Soldiers and lower for Reserve Component Soldiers; and higher for both males and females.

Duty location. Sixteen of the 17 suicides occurred in Iraq. The annualized rate for suicide occurring in Iraq is 21.2 per 100,000, and 3.0 for suicide occurring in Kuwait. Compared to the Army historical rate, the rate for Iraq is higher and the rate for Kuwait is lower. This could be related to wider access to loaded weapons among Soldiers assigned in Iraq, and stressors associated with the operational environment in Iraq.

Component. Fifteen of the 17 suicides were Active Component Soldiers. Compared to the historical Army rate of 11.9 per 100,000, the rate for Active Component (AC) is higher at 17.2, and the rate for Reserve Component (RC) is lower at 9.2 per 100,000. The higher AC rate may largely reflect duty location as discussed above since the majority of AC Soldiers are assigned in Iraq. However, there may be protective factors

inherent among USAR and National Guard units such as older age of RC Soldiers or stronger social support relationships among unit members.

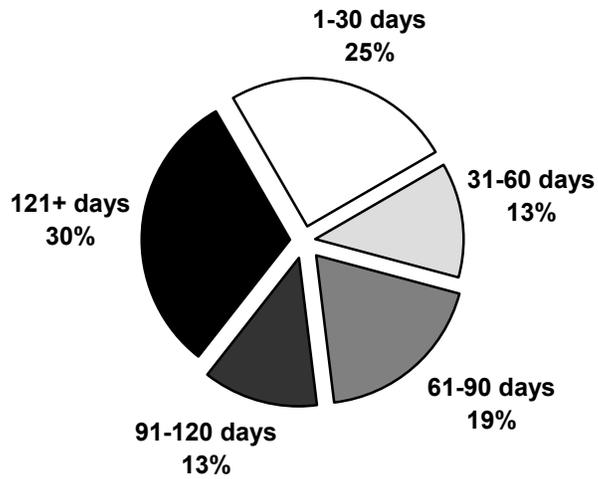
Gender. In addition to higher rates among Soldiers deployed to Iraq and Active Component Soldiers, a high rate was also documented among female Soldiers. Two of the 17 OIF suicides were female and represent an annualized rate of 19.0 per 100,000. This rate is higher than the Army historical rate of 11.9 per 100,000, and higher than the 4.1 per 100,000 rate of suicide among U.S. females in 2001. However, this rate is based on only two deaths which does not establish a trend, and should not be interpreted as suggesting that there is a particular problem of suicides involving women. The annualized rate for the 15 male suicides is 15.2 per 100,000 and although higher than the historical Army rate, is lower than the rate of 17.6 per 100,000 for U.S. males in 2001 (American Association of Suicidology, 2003).

Risk analysis. It should be noted that suicide rates for small populations are very unstable. A small increase in the number of suicides can appear as a disproportionately large increase in the rate of suicide. Although it is difficult to compare suicide rates between different population groups in OIF, the data suggest that there may be a higher risk of suicide for Soldiers assigned in Iraq and for Active Component Soldiers. Further surveillance of suicides is essential to determine there are different risk factors for subgroups of deployed Soldiers.

DATA FINDING #5: Deployment length varied widely for Soldiers who committed suicide.

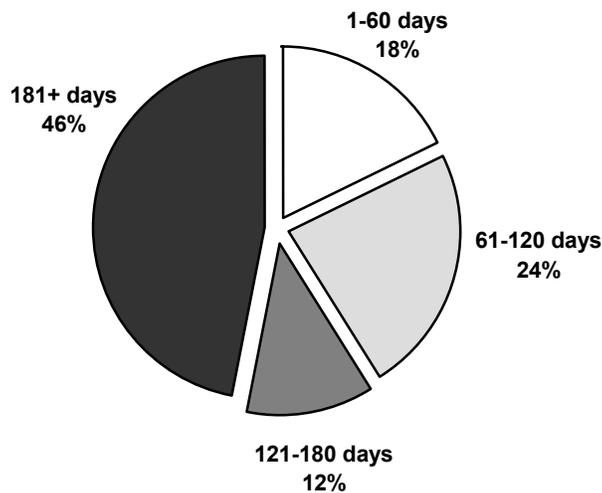
One fourth of Soldiers (25%) who committed suicide did so within the first thirty days of arriving in theater but nearly one third (30%) had been deployed more than 120 days (Figure 2). Transition to deployment may be a contributing stressor for some suicides, but suicides occurred with longer deployment lengths as well. Vigilance for suicide risk should be maintained throughout a Soldier's deployment.

Figure 2: Days in Theater Before Suicide



The majority of Soldiers (58%) had been assigned to their unit more than 120 days before committing suicide (Figure 3). Over three-fourths (82%) of the Soldiers had been assigned more than 60 days.

Figure 3: Days in Unit Before Suicide



DATA FINDING #6: In the absence of a standing Army suicide prevention program for tactical environments, CJTF-7 and CFLCC created suicide prevention programs.

The Army Suicide Prevention Program (ASPP) was developed for a garrison-based force and provides little guidance for tactical application. However, the five broad strategies of the ASPP for minimizing suicide risk remain relevant and can be adapted to a deployed force engaged in combat operations. The five strategies are:

- Develop positive life-coping skills
- Encourage help-seeking behavior
- Raising awareness and vigilance
- Synchronizing, integrating and managing a unit's suicide prevention program
- Conduct suicide surveillance, analysis and reporting

The supporting objectives and tasks to accomplish these strategies need to be tailored for a deployed force operating in a hostile environment without normal installation support. These objectives can be divided into three main areas, prevention, intervention and post-vention.

Prevention. Suicide prevention strategies are those that help prevent Soldiers from considering suicide. They include suicide prevention training, traditionally equated with awareness briefings conducted by unit ministry team members, and various resiliency programs that help Soldiers deal with the stresses of life. Suicide prevention training should continue, although at a smaller unit level than for a garrison force. Training should also give first line supervisors skills to recognize symptoms of combat-related stress and problems coping in a combat environment. Deployed combat stress control teams are ideally suited to accomplish this training.

Intervention. Regrettably, despite our best efforts, some Soldiers will reach a point where they consider suicide. Intervention programs are directed at recognizing these Soldiers and protecting them from self-harm until they are referred to a behavioral health professional. Applied Suicide Intervention Skills Training (ASIST) is a suicide first-aid program that enables Soldiers to recognize when a fellow Soldier is at risk for suicide, and employ an intervention model to reduce the immediate risk. The Army has targeted those individuals that are most likely to come in contact with a person at risk and provide them ASIST. However, for a deployed force, especially in an environment where the forces are isolated from mainstream helping agencies, it is recommended that every company have a "trusted agent" (a Soldier well respected by others) trained in ASIST. This training should be accomplished at the home station prior to deployment. However, there are current ASIST trainers deployed with the [REDACTED] Detachment that are sponsoring a condensed version of ASIST in a one-day workshop.

Post-vention. Post-prevention strategies include those policies and programs that help survivors of attempted suicide, or provide grief counseling within units where there has been a completed suicide. Those who have attempted suicide should receive immediate behavioral health treatment to ensure they are protected from further self-harm. Every division or major subordinate command should have a critical event response team that can rapidly assist a company/battery level unit cope with loss of a

Soldier to suicide. Suicide can have a devastating impact on unit readiness and morale. Critical event response teams, comprised of chaplains and behavioral health personnel can provide fellow Soldiers with an opportunity to deal with their emotions in a healing and helpful way.

DATA FINDING #7: OIF behavioral health personnel have utilized traditional but passive suicide monitoring that provides limited visibility of suicide risk factors.

When suspected suicides occur in Iraq, the [REDACTED] Medical Brigade is notified. Information about the Soldier and circumstances of the death are then gathered through informal means, generally by requesting information from the behavioral health unit closest to where the death occurred. The OIF MHAT found that Division Mental Health and Combat Stress personnel generally had limited information about suicides that occurred within their supported units except when they had been involved in a post-vention response. None of the Soldiers who committed suicide had been in treatment with OIF behavioral health providers prior to their suicide. The Army does not require systematic review of a completed suicide by a behavioral health officer, but following the high incidence of July suicides, the [REDACTED] Medical Brigade implemented a new reporting process for suicide attempts to better monitor trends and identify potential risk factors. This is consistent with the trend among suicide prevention programs to increase use of active medical surveillance methods to expand the scope of suicide monitoring. New tools are available that monitor serious suicide behaviors to improve detection and management of population suicide risk and are discussed below.

Constellation of suicide behaviors. In addition to the 17 suicides that occurred in Iraq or Kuwait, there have been two known suicides among OIF veterans. One of these suicides occurred at the CONUS treatment facility where the Soldier was medically evacuated for psychiatric treatment. The other suicide occurred nearly four months after the Soldier redeployed from OIF. The Soldier allegedly shot and killed a man who was vandalizing his vehicle and committed suicide soon thereafter. Both Soldiers had a history of psychiatric treatment. Although neither of these two suicides occurred while the Soldiers were deployed to Iraq or Kuwait, they are mentioned here due to the possibility that OIF-related factors influenced their suicide behaviors. In order to better understand and mitigate deployment factors that impact on suicide, the larger constellation of suicide behaviors should be considered. This point was made persuasively in a recent article by Ritchie et al (2003) that studied psychological correlates to suicidal behavior among U.S. military personnel admitted for inpatient psychiatric treatment. Persons who commit suicide may communicate warning signs prior to committing suicide, or may have a history of suicide attempts, threats, or gestures. Several psychiatric disorders are associated with increased risk for suicide including depression, post-traumatic stress disorder, and alcohol abuse.

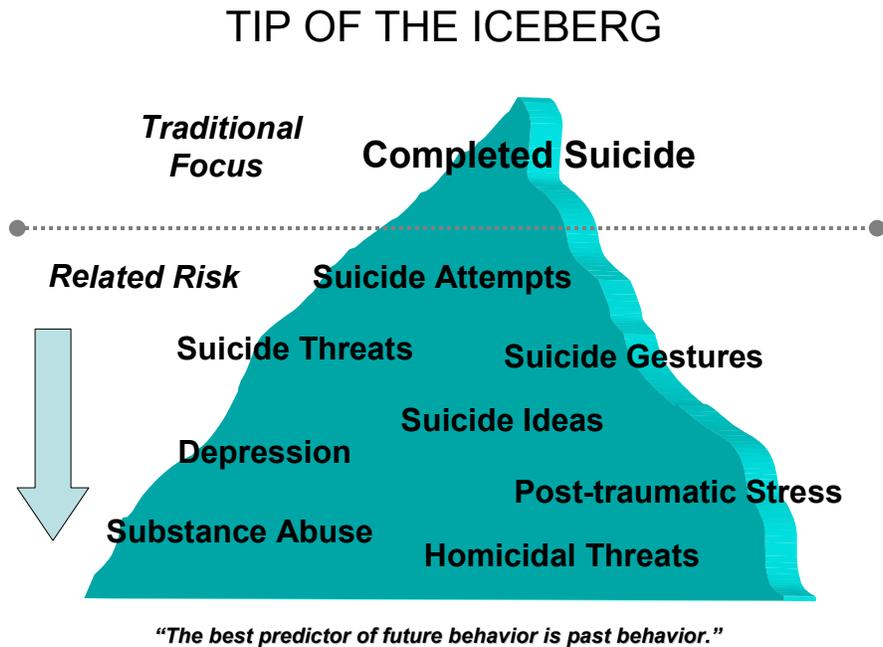
Suicide motive. A review of the CID reports and OAFME autopsy files for the OIF suicides provided limited information about motive for suicide. Only a few of the reports or files referenced potential contributing problems that included relationship, financial, and legal problems. Historically, the majority of Army suicides have been associated

with relationship problems. Army psychological autopsies from previous years reflect that 75% of Soldier suicides are due to failed intimate relationships, followed in frequency by recent or pending UCMJ action (50%) and financial problems (42%).

Suicide attempts. Attempted suicide increases risk for completed suicide. Nationally, the American Association of Suicidology estimates 25 suicide attempts for every completed suicide. A potential estimate of the number of suicide attempts among OIF deployed Soldiers is available from the OIF MHAT psychiatric medevac data. Ninety-five (95) of the 527 (18%) Soldiers medically evacuated with a psychiatric diagnosis had displayed self-injurious behaviors believed to be suicide attempts or gestures. If it is assumed that this number approximates the number of suicide attempts, the ratio for OIF is about six suicide attempts for every completed suicide (95 attempts:17 suicides). This is lower than the AAS estimate, but occurs in a population that has liberal access to health care and a high degree of behavioral supervision. It may also represent a higher likelihood that Soldiers who attempt suicide will succeed due to availability of loaded weapons as discussed above. The cohort of Soldiers who attempt suicide represent “suicide near misses”, and if studied, may provide insight into better prevention measures.

Suicide-related behaviors. Completed suicides may be viewed as the “tip of the iceberg” (Figure 4). The MHAT medevac data also provide some indication of magnitude of suicide-related behaviors among OIF Soldiers. About 32% of the 527 Soldiers evacuated from OIF for behavioral health reasons were evacuated with elevated suicide risk, and 9% were evacuated with elevated homicide risk. Accounting for overlap, about one-third of this group is estimated to have departed theater with suicide-related behaviors as part of their clinical presentation. This group constitutes a population that should be included in a comprehensive plan to mitigate suicide risk. A case in point was the completed suicide by one Soldier who had presented with symptoms of suicidal ideation prior to psychiatric medical evacuation.

Figure 4: Suicide-related Behaviors



Psychiatric Disorder. Depression is the psychiatric disorder most closely associated with suicide; the National Institute of Mental Health (2003) estimates that 60% of those who commit suicide in the U.S. are depressed. Combat related post-traumatic stress disorder is also linked to increased suicidality (Freeman et al, 2000). The Soldier Well-being survey identified higher than expected levels of post-traumatic stress among OIF Soldiers and significant levels of depression and anxiety. As the prevalence for these disorders increase within a population, presumably the risk for suicide behaviors also increases and would warrant more aggressive suicide prevention measures. This underscores the importance of active outreach efforts by OIF behavioral health personnel.

Suicide monitoring. Multiple Department of Defense (DoD) and DA agencies monitor suicide occurrence within the scope of their missions. None of the current monitoring processes is suitable as a health surveillance program for detecting trends and patterns of suicide behaviors. A comprehensive suicide prevention program should actively monitor serious suicide behaviors that have significant impact on health status or duty availability. Monitoring serious suicide attempts, for example, in addition to completed suicides could improve management and prevention of the constellation of suicide behaviors.

U.S. Army Criminal Investigation Command (USACIC). The USACIC investigates Soldier deaths to exclude other causes of death before making a determination of suicide. Criminal Investigation Detachment (CID) field agents conduct the investigations by analyzing crime scene evidence, reviewing autopsy findings, forensic medical tests, and conducting interviews with informants to determine the Soldier's state

of mind at time of death. It often takes several months to complete the investigation and make a final ruling of suicide. Although locally maintained CID case files can contain useful information about suicide motive, it would not be practical to utilize CID case files for health surveillance purposes.

Office of the Armed Forces Medical Examiner (OAFME). The OAFME is a division of the Armed Forces Institute of Pathology (AFIP) and maintains an archive of DoD completed suicides. For military deaths, a forensic pathologist renders an opinion about the manner of death based on autopsy results and USACIC case information. Once a medical examiner determines manner of death to be suicide, OAFME tracks the suicide through its Mortality Surveillance Division. Mortality reporting such as this does not include suicide behaviors nor does it “push” information about suicide occurrence to other agencies. Similar to USACIC investigations, OAFME medical examiner investigations can require several weeks or months to complete. The mortality surveillance system is not conducive to monitoring suicide behaviors or conducting population health surveillance for suicide risk.

U.S. Army Human Resources Directorate. The Human Resources Directorate, (a division of the Army G-1) monitors Army suicide numbers and rates by coordinating with the Office of the Armed Forces Medical Examiner, USACIC and Human Resources Command. Through its Suicide Prevention Program Manager, Army suicide rates and numbers are shared through MACOM Suicide Prevention Program Managers and an informal network of various contacts including Army ASIST trainers, and those trained at the Army Suicide Prevention Training Program. These rates are also reported to various DA leaders through the Army G-1 and Director of the Army Staff. The program manager does not classify manner of death, and will rely on one of the sources mentioned above for inclusion as either a “pending” (which is monitored until the status is determined) or confirmed as suicide.

U.S. Army Medical Command (MEDCOM). MEDCOM’s Center for Health Promotion and Preventive Medicine (CHPPM) is the DoD proponent for health surveillance. Army medical surveillance is conducted as a CHPPM function, utilizing the Reportable Medical Event System (RMES). This system primarily monitors communicable disease, however it includes other types of reporting such as heat and cold injury. Suicide behaviors are not considered reportable events; there are no behavioral or psychiatric disorders currently defined as reportable medical events.

Including suicide attempts that result in hospitalization or suicide attempts that result in air evacuation from the operational theater in medical surveillance would dramatically increase their visibility and lead to greater emphasis on their prevention. Better coordination between agencies is also needed, given that it sometimes takes considerable time to resolve manner of death determinations. Improved suicide prevention efforts will require Army health surveillance to develop accurate population denominators to assure that rates can be systematically monitored over time in subpopulations, such as by gender, and among reserve and active component Soldiers.

U.S. Air Force. In 1994, the Air Force implemented reporting of non-fatal self-injurious events and in 2002 reconfigured their database to improve suicide monitoring. The Air Force report form served as a model for a similar Army Medical Department (AMEDD) form discussed below. According to the USAF Suicide Prevention Program manager, it took several years to build the database that now provides monthly reports to major commands for comparing current suicide occurrence with previous years. A three-year university contract was recently awarded to study risk factors from the database.

AMEDD Suicide Event Report (ASER). In June 2001, DoD policy changed requirements for psychological autopsy from a routine report for all suicides, to a forensic investigation when manner of death is equivocal. To preserve surveillance of suicidal behavior the AMEDD, in conjunction with the Army G-1, developed the ASER (Appendix 5) to record demographic data and psychological correlates from Soldiers with suicide behaviors. The ASER is envisioned to feed a database that will permit analysis of trends and risk factors for suicide. Although not yet released for Army-wide implementation, it has been used locally at selected installations to improve management of Soldiers with suicide-related behaviors. The ASER promises to increase understanding of Soldier motives for suicide and elucidate contributing stressors, if it is used consistently to track completed suicides and serious suicide attempts (those that result in evacuation or hospitalization).

The OIF MHAT was only able to obtain limited information about psychosocial factors related to the OIF suicides, gleaned from initial CID reports and medical autopsy files. Consistent with current Army policy, there were no psychological autopsies or other reviews conducted by behavioral health personnel following OIF suicides. Likewise, there is no systematic tracking of OIF suicide attempts through medical channels. The ASER is a reporting tool that has already been developed and is the pilot version is available for immediate use. This is a tool that seems to offer OIF behavioral health personnel a useful means to monitor trends among Soldiers with suicide behaviors.

DISCUSSION OF RECOMMENDATIONS

RECOMMENDATION #1: Immediate: CFLCC & CJTF-7 should adapt the existing (community-based) objectives of the Army Suicide Prevention Program to OIF Soldiers and units. Strategies of the ASPP can be applied to the OIF force through actions in the following five areas:

Proponency. One key component of a deployed force's suicide prevention program is to assign a proponent that manages, coordinates and synchronizes the program for the commander within their theater of operations. Suicide prevention involves many professions and staffs (behavioral health professionals, chaplains and chaplain assistants, human resource officers, civilian helping agencies, emergency first

responders, trial defense lawyers, public affairs), many of whom are operating within the OIF areas of operation. The proponent should host periodic working group meetings involving responsible agents and staff members to focus attention towards achieving the Army's goal of minimizing the risk of suicide for their Soldiers. Each division or separate brigade should have its own suicide prevention proponent that coordinates the efforts within their respective units and ensure their plan is nested within the theater's suicide prevention plan. All managers should report on a routine basis to their commander on their estimated risk level for suicide.

Awareness. Maintaining awareness and vigilance is especially crucial for a deployed force. All leaders and first line supervisors must maintain awareness and vigilance towards their suicide prevention efforts. Major subordinate command senior leaders should emphasize their suicide prevention programs throughout their respective leadership channels. Junior leaders should be equipped with the skills to help them identify when one of their Soldiers is having difficulty adjusting to the stresses of an extended deployment within a combat zone. Combat Stress Control teams are located throughout the region and are available to conduct such training. First-line supervisors should also be vigilant for stressors their Soldiers are receiving from home. Personal relationship problems, financial problems and legal actions have been some of the common triggers for Soldiers contemplating suicide.

Training. Commanders should also ensure that they have sufficient ASIST trained personnel within their units. ASIST is very similar to the Army's combat lifesaving program, with the focus on identifying whether or not someone is at risk for suicide, and then if warranted, applying a proven intervention model that protects the individual until the chain of command or a behavioral help professional can assist. One of the objectives of the Army Suicide Prevention Campaign Plan is to target those who are most likely to come in contact with a person at risk for suicide to receive the ASIST training. In a deployed force, those who should have the training include all unit ministry team (UMT) members, selected defense trial lawyers, and any civilian-helping agency such as the American Red Cross. Given the isolation of the deployed forces, it would be ideal to identify additional trusted individuals, at least one per company/battery, to receive the training and assist with identifying Soldiers at risk for suicide. Normally ASIST is taught in a two-day workshop. However, the US Army has received permission from Living Works Education (LWE), the proprietor that developed ASIST, to condense the training into one day for OIF. There are certified Army trainers currently serving with the [REDACTED] in Iraq that are able to conduct the training.

Surveillance. Commanders should maintain situational awareness towards suicides and suicidal behaviors within their force. This awareness should include more than just a numeric count, but also include an understanding of suicidal risk factors that might influence behavior within their commands. This includes those factors that minimize the risk (available support and helping agencies) and those that increase risk (access to lethal means). As with other fatalities, commanders should ensure that all completed suicides and serious suicide attempts are reviewed to determine if there are "lessons learned" to prevent similar events from occurring in the future. These lessons learned

should be shared throughout the command. By maintaining awareness, the various staffs can also determine if there are possible trends or related factors for the causes or reasons behind the suicide or suicide attempt. If such trends are identified, appropriate counter-measures can be explored to mitigate the risk.

Commanders should also be informed when the rate of serious suicidal behavior among their Soldiers exceeds normal Army rates. Although every suicide is a tragic and unnecessary loss, it is unrealistic to expect that any commander of a large force can completely eliminate suicide behavior from their ranks. Therefore, suicide rates presented to the commanders should be presented in the context of other Army rates (based upon similar demographics) for comparison.

Help-Seeking Behavior. Encouraging help-seeking behavior is a leader responsibility at all levels and is especially important for a force deployed away from normal support agencies and systems (family, church, civilian health care, etc). Leaders should encourage help seeking behavior as a sign of individual strength and maturity. The first step is for leaders to understand themselves what services are available within their area of operations and the protocols for their use. Commanders of helping units/agencies or personnel who provide counseling and or assistance to Soldiers should strive to make their units/personnel available within the constraints of the force-protection plan. All first line supervisors should maintain a positive influence and presence within the lives of their Soldiers and anticipate when a Soldier needs assistance by knowing when the Soldiers is facing a crisis from home, or is not handling the stresses of the deployment well. The goal is to refer the Soldier for assistance before crisis becomes overwhelming. Soldiers should be informed that most problems can be handled in either an informal (meeting with unit chaplain) or even formal (meeting with a behavioral health professional) without any impact on their Army career.

RECOMMENDATION #2: Future: Implement monitoring of serious suicide attempts within Army medical surveillance systems. Recommend tasking CHPPM and the behavioral health consultants to develop capability for monitoring serious suicide attempts at the installation, operational, and Army-wide levels.

There is little precedent for actively monitoring suicide behaviors as part of population health surveillance, however enough precedence exists to support the strategy of reducing suicide occurrence by reducing the occurrence of serious suicide attempts (leading to hospitalizations and evacuations). A critical component of this strategy is the monitoring of suicide attempts an outcome metric for suicide prevention actions. It is impractical to monitor all suicide attempts for several reasons. First of all, many attempts are very minor (scratching skin, taking a few additional tablets of a medication, etc.). It is often difficult to distinguish gestures that did not include the intention to die from true attempts. It would overly burden behavioral health providers to report every attempt or gesture. However, a reasonable approach would be to document severe attempts defined as those that result in hospitalization or evacuation. The Air Force has led the way in developing a suicide event reporting system that includes non-fatal self-injurious behavior. However, this is a passive surveillance system that relies on clinician reporting and likely significantly underestimates the true rate of attempts. FORSCOM monitors suicide attempts and gestures on a quarterly basis as part of its Risk Reduction Program. This generally also relies on clinician reporting at the military treatment facility. At the installation level, Ft. Lewis has utilized the pilot version of the ASER to develop baseline rates for suicide attempts and help monitor suicide prevention efforts (Crow, 2003).

Several obstacles need to be overcome for monitoring suicide behaviors. Army-wide medical surveillance requires ICD-9 coded events which are not specific for suicide attempt. The ASER is poised for wider utilization but will require publicity and training to implement. There is currently no provision for creating and maintaining a database to archive ASER results, and no provision for developing capability to analyze ASER data for trends and risk factors. A monitoring system will need to push information to the behavioral health, medical, and Command leadership as a metric for suicide prevention actions.

The Army behavioral health consultants should collaborate with CHPPM to develop capability for this type of monitoring. Serious suicide attempts (that result in hospitalizations or evacuations) should be included within Army medical surveillance as reportable medical events analogous to communicable disease and other reportable events. The lessons learned from Air Force, FORSCOM, Ft. Lewis, and other local efforts should be harnessed to create installation level and Army-wide systematic monitoring of these suicide behaviors.

APPENDIX 1 (Tables) to ANNEX D to OIF MHAT REPORT

TAB A: U.S. Army Suicide Rates: 1995-2002

Calendar Year	Rate per 100,000
1995	14.8
1996	12.4
1997	10.6
1998	12.0
1999	13.1
2000	12.1
2001	9.1
2002	11.1
Average all years	11.9

TAB B: Profile of Confirmed OIF Suicides (as of 5 Dec 03)

Date of suicide	Age	Rank	MOS	Comp	Gender	Race/Ethnicity	Married	Method
██████	██	E-4	92G	AC	M	H	█	██████
██████	██	E-4	95B	AC	M	B	█	██████
██████	██	E-5	11B	AC	M	W	█	██████
██████	██	E-2	11B	AC	M	W	█	██████
██████	██	E-4	77F	AC	M	B	█	██████
██████	██	E-4	92G	AC	M	B	█	██████
██████	██	E-3	98C	AC	M	W	█	██████
██████	██	E-6	92A	AC	M	B	█	██████
██████	██	E-5	92A	AC	F	O	█	██████
██████	██	O-3	38A	RC	M	W	█	██████
██████	██	E-5	93C	AC	M	W	█	██████
██████	██	E-3	12B	AC	M	W	█	██████
██████	██	E-3	12B	AC	M	H	█	██████
██████	██	E-4	97E	AC	F	W	█	██████
██████	██	E-4	13D	AC	M	W	█	██████
██████	██	E-3	92Y	AC	M	W	█	██████
██████	██	E-2	12B	RC	M	B	█	██████

APPENDIX 2 (Methods and Procedures) to ANNEX D to OIF MHAT REPORT

1. OIF suicides were defined as those Army Active or Reserve Component deaths for which the fatal self-inflicted injury occurred in Iraq or Kuwait between 1 January 2003 and 31 October 2003, and for which the Office of the Armed Forces medical examiner has determined the manner of death to be suicide.
2. Information about the Soldiers from the suicide cohort was obtained from casualty reports, personnel records, CID reports, and the medical examiner records. There were no psychological autopsies or other reports from behavioral health personnel for the suicides occurring in Iraq or Kuwait. Behavioral health records were reviewed for the two OIF veterans who committed Soldiers after they left the OIF theater.
3. Suicide rates are reported by convention as the number of suicides per 100,000 persons. Monthly suicide rates were calculated by multiplying the number of suicides each month by 100,000 and dividing by the number of Soldiers in the OIF theater. The denominators used were force strength numbers at the end of each month, January through October 2003, for male and female active and reserve component Soldiers assigned to Kuwait and Iraq. In order to compare OIF rates to other annual rates, year-to-date rates were annualized by dividing the cumulative number of suicides by total person-years (cumulative person-months over the 10 month period divided by 12). Poisson analyses were conducted to determine if the number of OIF suicides statistically differed from historical rates (probability <.05).

APPENDIX 3 (References) to ANNEX D to OIF MHAT REPORT

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**APPENDIX 4 (Army Suicide Prevention-A Guide For Installations and Units-Draft
2002 Version) to ANNEX D to OIF MHAT REPORT**

Headquarters, Department of the Army, G-1

Army Suicide Prevention – A Guide for Installations and Units

Army Suicide Prevention – A Guide for Installations and Units

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

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

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

Lieutenant General, GS
Deputy Chief of Staff, G-1

Headquarters
Department of the Army
Washington, DC

Army Suicide Prevention – A Guide for Installations and Units

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

risk of suicidal behavior within the Army.

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

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Chapter One – Introduction

*“A leader is a dealer in hope”
Napoleon*

1-1. Magnitude of the Problem

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

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

1-2. Army Suicide Prevention Program Goal

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

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

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

1-3. CSA Statement

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

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

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

2-1. A Model for Explaining Dysfunctional Behavior

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

A Model for Understanding Dysfunctional Health-Risk Behaviors

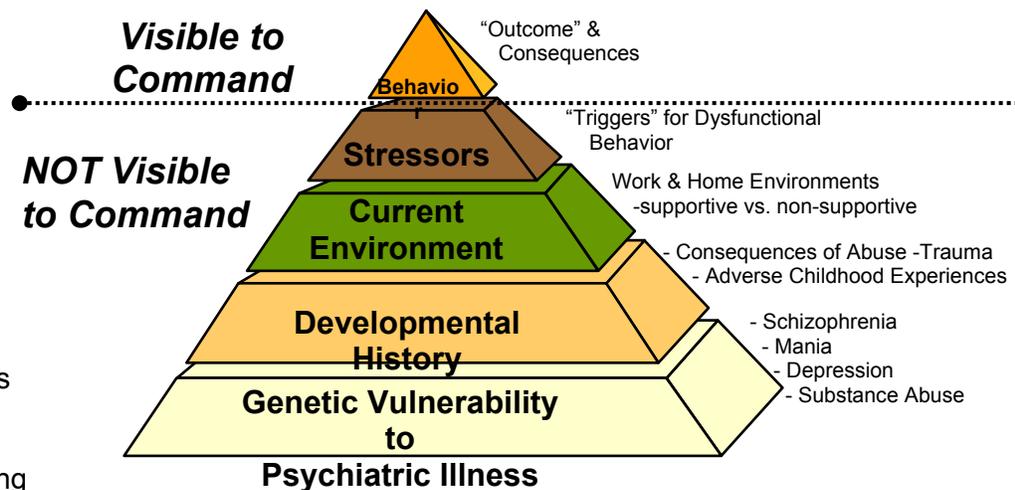


FIGURE 1

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

2-2. Mental Disorders.

Mental disorders "are health conditions that are characterized by alterations in thinking, mood, or behavior, which are associated with distress and/or impaired functioning and spawn a host of human problems that may include disability, pain, or death."¹ Mental disorders occur throughout society affecting all population demographics including age, gender, ethnic groups, educational

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

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

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

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

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

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

2-3. Developmental History

Developmentally, the home/family environment where reared will influence one's behavior. Unfortunately, many of today's youth are growing up in "non-traditional" homes, without two consistent parenting figures. This can be detrimental to the development of "well-adjusted" individuals capable of handling life's general stresses and potentially lead to dysfunctional behavior, including suicide. According to Tondo and Baldessarini,³ the suicide rate for America's youth is higher in single-parent families, especially when the father is not present.

This is particularly alarming considering that over 40% of the youth today are from “non-traditional” homes,⁴ which could explain why the suicide rate among America’s youth is rising.

Childhood abuse or neglect might also adversely affect the positive development of life-coping skills and lead to dysfunctional behavior. A research article released in 1998 by the American Journal of Preventive Medicine commonly referred to as “The ACE Study,” (adverse childhood experiences) stated that there was a “strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death.”⁵ These adverse childhood experiences include psychological, physical or sexual abuse, and exposure to dysfunctional behaviors including living with a substance abuser, someone with a mental illness, domestic abuse, or criminal activity. As exposures to ACEs increased, so did the risk of several health-related problems including smoking, obesity, depression, use of illegal drugs, promiscuity, and even suicide. According to Legree⁶ in a report published in 1997, the consequences of these adverse childhood experiences could cause friction within the Army as those recruits that have been abused can:

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

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

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

2-4. Influence of the Current Environment

The Army’s opportunity for intervention and influencing behavior begins when the Soldier or civilian reports to initial entry training (IET) (or equivalent) and lasts beyond their term of service. This intervention can either have a positive or negative influence on their behavior. Small unit leaders should strive to positively impact constructive life coping skills and create an environment filled with support, respect and acceptance, where individuals feel they are an integral part of a team. This supportive environment can potentially block certain types of dysfunctional behavior by providing Soldiers and civilians a support system and adequately equipping them to properly handle life’s stressors. The results or reward of a supportive environment (represented in the top left “output” box in Figure 2) will be a better-adjusted individual. Conversely, if the small unit leader creates an environment where negative life

coping skills are reinforced or positive life coping skills are ignored, such an environment could then possibly contribute to dysfunctional behavior (represented in the top right “output” box in Figure 2).

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

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

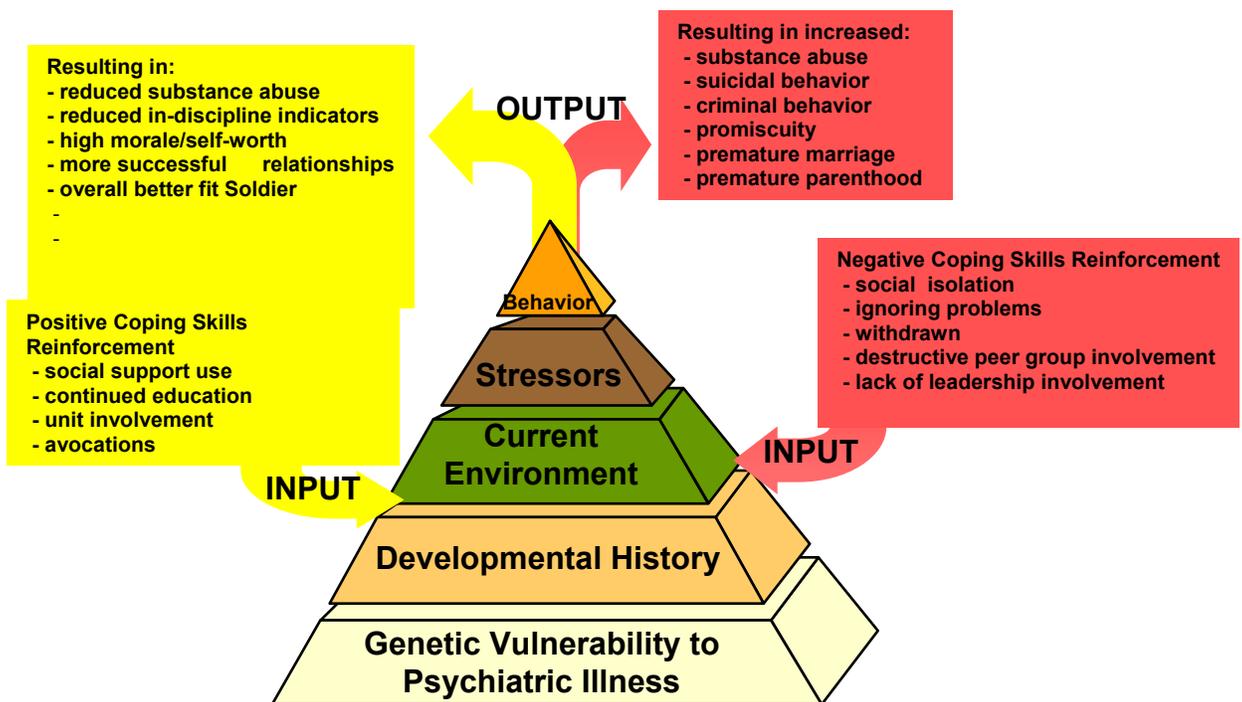


FIGURE 2

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

2-5. Suicide “Triggers”

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

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

Provided below is a list of potential triggers for suicide.

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

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

2-6. Reasons for Dying

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

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

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

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

Jobes and Mann⁹ examined Suicide Status Forms from various counseling centers and determined that they could categorize suicidal patient’s reasons for dying and that these categories vary with responses. They then listed the most frequent categories or reasons for dying which are listed below in descending order beginning with the most frequent.

- Escape – general. General attitudes of giving up or needing a “rest.”
- General descriptors of self. References to self such as “I feel awful” or “I’m not worth anything.”
- Others/relationships. References to other people such as “I want to stop hurting others” or “retribution.”

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

2-7. Suicide Danger Signs

The list below contains immediate danger signs that suicide behavior is imminent.

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

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

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

2-8. Suicide Warning Signs

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

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

These signs signal that the person might be experiencing a life-crisis and requires assistance. It is the responsibility of all leaders and the duty of all Soldiers and civilians to watch for these

danger and warning signs and realize that they might not be capable of helping themselves and therefore, require immediate action.

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

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

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

2-9. Resources for Living.

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

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

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

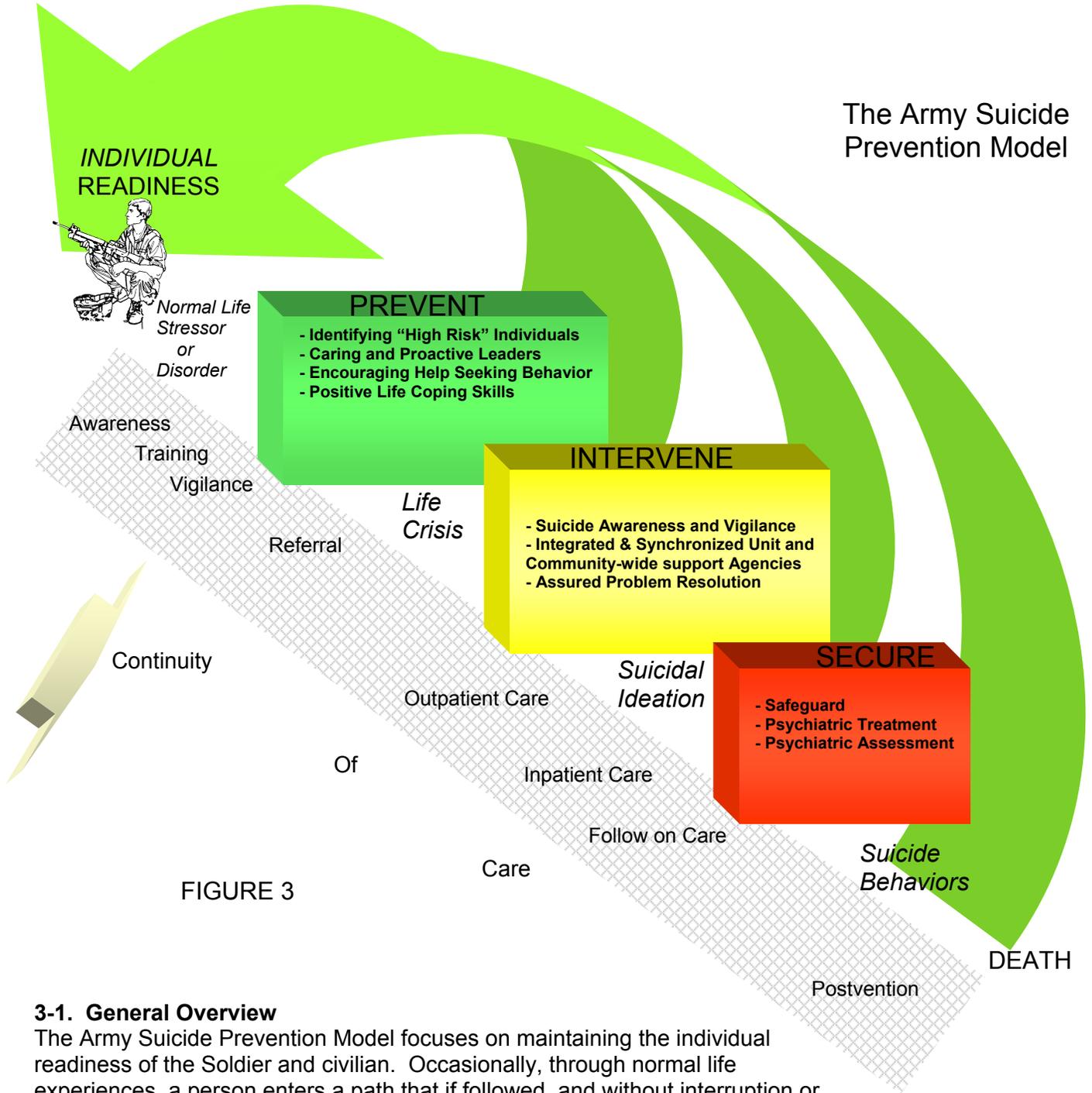
- Family. Any mention of a family member’s love.
- Future. Statements that express hope for the future.
- Specific plans and goals. Future oriented plans.
- Enjoyable things. Activities or objects that are enjoyed.
- Friends. Any mention of friends.
- Self. Statements about qualities of self such as “ I don’t want to let myself down.”
- Responsibilities to others. Any mention of obligations owed to others or the thought of protecting others.

- Religion. Statements referring to religion.

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

Chapter Three – The Army Suicide Prevention Model

**“Knowing is not enough, we must apply.
Willing is not enough, we must do.”
Goethe**



3-1. General Overview

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

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

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

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

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

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

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

Chapter Four – Prevention

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

4-1. Identifying “High Risk” Individuals

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

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

4-2. Caring and Proactive Leaders

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

PREVENT

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

TABLE 1

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

4-3. Encouraging Help Seeking Behavior

All leaders should encourage help seeking behavior within their subordinates, without fear of repercussions. Many senior Soldiers and civilians fail to seek professional assistance from a MHO for fear of reprisals, embarrassment, guilt, or shame. According to a 1998 DoD Survey of Health Related Behaviors Among Military Personnel, only 24 percent of Soldiers surveyed believed that receiving mental health counseling would not hurt their career. It is therefore easy

DoD Survey of Health Related Behavior		
	<u>ARMY</u>	<u>DOD</u>
Perceived Need for Mental Health Counseling		17.8%
		17.6%
Receipt of Mental Health counseling from military mental health professional	5.6%	5.2%
Perceived Damage to Career		
Definitely Will	17.7%	20.7%
May or May Not	58.1%	59.8%
Definitely Will Not	24.2%	19.5%

to understand that although 17.8 percent of Soldiers feel that they have needed mental health counseling in the past, only 5.6 percent actually sought and received help.

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

procedures.

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

- when the patient has given their consent, or
- when the mental health professional believes that a patient's mental or emotional condition makes the patient a danger to himself or herself, or to any other person, or
- when the mental disorder indicates a degree of impairment otherwise suggesting unsuitability for retention in military service, or
- in the case of an adjustment disorder of a military member during the member's initial 180 days of military service, or
- military necessity to ensure the safety and security of military personnel, family members, or government property.

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

4-4. Teach Positive Life Coping Skills Development

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

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

Chapter Five – Intervention

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

5-1. Suicide Awareness and Vigilance

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

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

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

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

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

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

ASIST T4T’s. Each major installation should have at least two ASIST T4T qualified trainers that could conduct the ASIST T-2 workshops on their installations or within their geographical region. One of these two should be the installation Family Life Chaplain. Family Life Chaplains work closely with allied helping professionals within the installation and local community. In addition,

part of their responsibilities include training Chaplains and their assistants assigned to Unit Ministry Teams. Family Life Chaplains have also received additional training that would enhance the ASIST training and would therefore be excellent candidates to sponsor and conduct the training. To become an ASIST “T4T” qualified trainer requires attendance of the five day trainers course taught by Living Works Education.

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

ASIST Workshops. Each installation T4T team must conduct at least three ASIST workshops in the first year following the T4T qualification training. Priority candidates for this training are the primary and secondary installation gatekeepers as specified in para 5.3c.

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

5-3. Five Tiered Training Strategy

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

Army Suicide Awareness Training Model

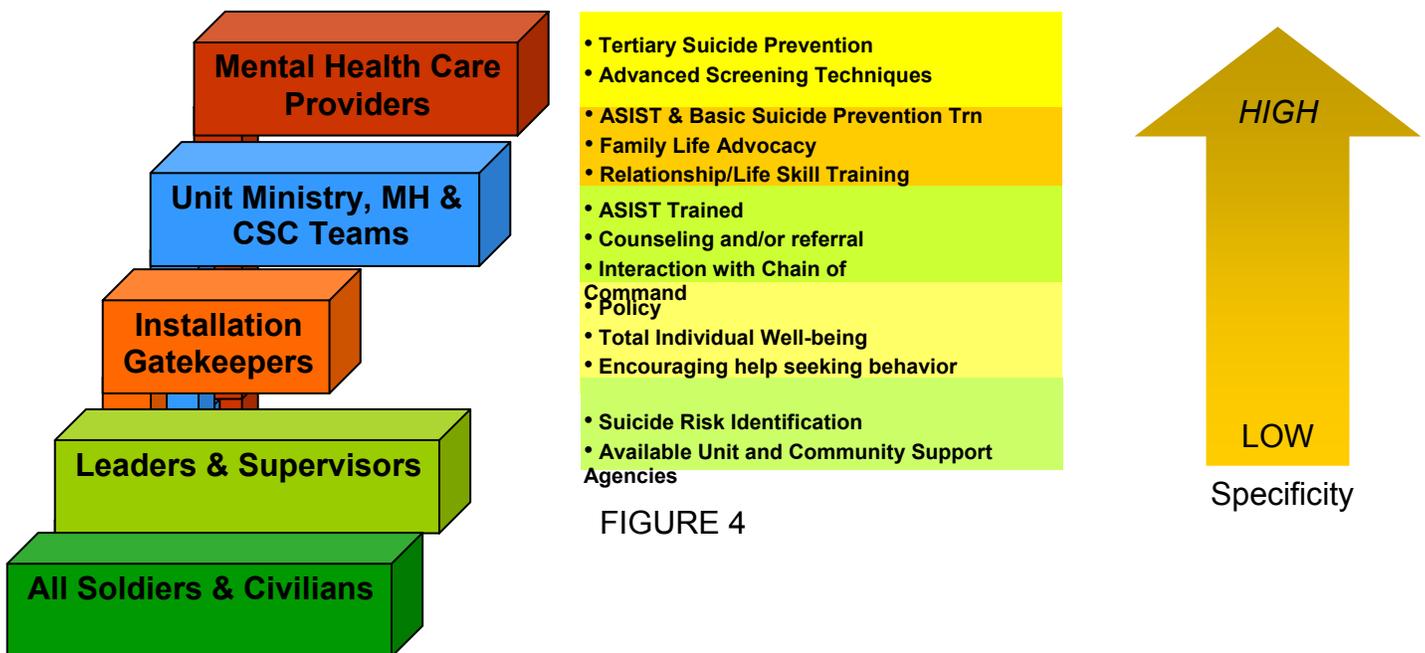


FIGURE 4

5-3a. Soldiers & Army Employees. All Army Soldiers and civilian employees shall receive basic training stressing the importance of mental health, stress reduction, and life coping skills.

They will also learn how to recognize suicide behavior and mental disorders that place individuals at elevated risk of suicide and how to react when they spot these issues. Most suicidal individuals give definite warnings of their suicidal intentions, but others are either unaware of the significance of these warnings or do not know how to respond to them. All Soldiers and civilians should receive training on how to properly identify these warning signs and know what action to take.

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

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

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

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

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

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

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

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

5-4. USACHPPM Suicide Prevention Resource Manual

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

5-5. Integration and Synchronization – The Installation Suicide Prevention Committee

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

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

The intent of establishing an Installation Suicide Prevention Committee is to focus installation and community assets towards assisting in suicide awareness and prevention. Involvement of local agencies and unit training will have a synergistic affect, which will result in minimizing suicidal behavior. Although the exact composition will depend on the specific local requirements, the garrison or installation commander should chair the standing committee and might involve representatives from the agencies listed below. Members could serve as either permanent or “ad hoc” members as the situation dictates.

Chair: Installation or Garrison Commander

Possible Members:

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

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

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

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

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

5-6. Commander's Involvement/Responsibilities

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

Once a Soldier or civilian experiencing a "life crisis," is identified, it is the responsibility of the commander to ensure that that individual not only receives the proper crisis intervention, but that the problem has been fully resolved. The referral doesn't end the commander's intervention responsibility, but only initiates the involvement which continues until the

commander is completely assured that the particular crisis or disorder has been resolved. This includes properly safeguarding the person at risk while they are receiving the required, professional assistance from mental health care providers.

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

Chapter Six – Secure

6-1. Safeguard

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

SECURE

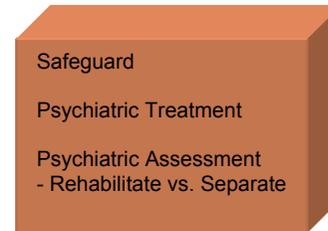


TABLE 4

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

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

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

6-2. Behavioral Health Treatment

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

6-3. Behavioral Health Assessment

Once admittance of a person to a hospital, it is the responsibility of the MHO to make an assessment the severity of the problem and a diagnosis on possible treatment and prognosis for recovery. The MHO will make every effort to successfully rehabilitate the person and return

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

Chapter Seven – Post-intervention Measures

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

7-1. Installation Suicide Response Team

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

7-2. Completed Suicide Reporting Procedures

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

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

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

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

7.2.a. Department of the Army Completed Suicide Report (CSR):

The purpose of the CSSR will be to capture the epidemiological data regarding the Army suicide population. Beginning 1 January 2003, the CSR will be mandatory following every confirmed or

suspected suicide of active duty Soldiers, including ARNG and USAR Soldier serving on active duty at the time of death.

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

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

7.2.b. Army Suicide Analysis Report (SAR):

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

1) a narrative analysis which details both the developmental/historical events that predisposed the victim to suicide as well as a narrative description of the more current preceding antecedent precipitants.

2) a "lessons-learned" & recommendations section.

3) address any specific questions posed by the chain of command.

7.2.c. Army Psychological Autopsy (PA):

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

Annex A – Strategy Matrixes

STRATEGY 1: Develop Positive Life Coping Skills

OBJECTIVE	KEY ACTIONS
<p>Instruct the “Understanding Dysfunctional Behavior Model” (as provided in Chapter 3) to officers and NCO’s assigned to leadership positions</p>	<ol style="list-style-type: none"> 1. Local MHO’s develop a standardized briefing for ISPC’s approval 2. ISPC’s publishes briefing on local web site or announces POC for scheduling the briefing 3. Local commanders coordinate with local MHOs and conduct the training
<p>Encourage and support various life coping skills programs</p>	<ol style="list-style-type: none"> 1. Identify pre-existing and emerging programs that focus on developing individual life coping skills such as: stress reduction, relationship building, financial management, preventing alcohol abuse 2. Ensure that these programs are publicized and promoted throughout the installation and made available to Soldiers (both active, reserves and retired), family members and Army civilian employees 3. Evaluate successfulness of such programs. Share recommendations for improvements or information concerning new programs to HQDA for dissemination to other MACOMs & installations
<p>Build life resiliencies for those who respond to, counsel or treat suicidal patients or those exposed to suicides</p>	<p>Develop services and programs, including training and education tailored for those who respond to suicides (emergency medical technicians, MP’s, firefighters) or counsel those at risk (chaplains, counselors) that addresses their own exposure and potential risk. Include training/instruction on the unique requirements of providing initial assistance/counseling to surviving family members.</p>

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

STRATEGY 3: Raising Awareness and Vigilance Towards Suicide Prevention

OBJECTIVE	KEY ACTIONS
Render assistance to those known or suspected of experiencing a major life crisis	<ol style="list-style-type: none"> 1. Develop systems that recognize when Soldiers and civilian employees are experiencing a potential life crisis in an effort to anticipate potential dysfunctional behavior. 2. Develop programs that can provide varying levels of supervision to Soldiers recognized as experiencing a potential life crisis. Such programs can vary between assigning a “battle buddy” to help the individual through the crisis, to suicide watch if the individual has actual suicide ideations
Educate all Soldiers and Army civilian employees on basic suicide prevention, which at a minimum, will cover recognizing warning and danger signs and what action to take if they suspect someone is at risk for suicide	<ol style="list-style-type: none"> 1. Utilizing the USACHPPM Resource Manual on Suicide Prevention as a guide, educate all Soldiers and Army civilian employees on basic suicide prevention. Although not mandatory, offer such training to family members. 2. Ensure newly assigned Soldiers and Army civilian employees have previously received the basic suicide prevention education. If not, provide training within 60 days upon reporting date. 3. Incorporate basic suicide prevention in all IET training and OBC courses
Instruct all NCO's, officers and Army civilian supervisors on recognizing symptoms of mental health disorder and potential “triggers” or causes of dysfunctional behavior	<ol style="list-style-type: none"> 1. Instruction will focus on educating leadership on the common symptoms of depression, substance abuse or other forms of mental disorder 2. Incorporate formal education on 3.2 at all basic leadership courses (OBS, PLDC)
Maintain Vigilance toward suicide prevention and awareness	As required, conduct periodic “refresher” training or discussions on suicide prevention in preparation for an upcoming extended deployment or redeployment, or another highly stressful event, or as designated by commanders. Maintain vigilance by either formal training including presentations, small unit discussions or even through varying local and Army wide news services and media formats. ISPC can also promote various national programs such as National Suicide Prevention Week (normally in May) and National Mental Health Month (normally in October).
Educate married Soldiers and Army civilian employees on how to appropriately store and secure lethal means of self-harm	Conduct public information campaign(s) or instruction designed to educate Army parents how to appropriately store and secure lethal means of self-harm including medications, poisons and firearms
Educate all Army health care providers in suicide risk surveillance	Educate all health care providers to identify potential suicidal danger and warning signs and what actions to take if they suspect one of their patients to be at risk
Educate installation gatekeepers on recognizing behavioral patterns that place individuals at risk for suicide and equip them with effective intervention skills to effectively reduce the immediate risk	<p>Train and maintain at least 90% of all “primary gatekeepers” (as defined in para 6-3c) in ASIST (or similar professional training).</p> <p>Train and maintain at least 50% of all “secondary gatekeepers” (as defined in para 6-3c) in ASIST (or similar professional training)</p>
Educate all UMT and Family Life Chaplains suicide awareness and prevention	Provide formal basic and advanced suicide prevention training for all UMT members. Training will include recognizing potential danger and warning signs, suicidal risk estimation, confidentiality requirements, how to reduce the immediate risk of suicide and how to conduct various suicide prevention training at the unit level

<p>Educate Soldiers, Army civilian employees and spouses on the safe storage of privately owned firearms</p>	<ol style="list-style-type: none"> 1. Determine which Soldiers within a command has a privately owned firearm. 2. Ensure those Soldiers and Army civilian employees and their spouses that own personal firearms understand the importance of responsible firearm storage in preventing suicide and accidental homicide. 3. Ensure Soldiers seeking permission to purchase a firearm are not at risk for suicidal behavior or other dangerous behavior. 4. Encourage those Soldiers who own personal firearms stored off-post and are determined to be at risk for suicidal behavior or a danger to someone else, to store their weapon in the unit arms room or with a close friend until the crises has been resolved and the risk of suicide has been eliminated.
<p>Incorporate screening in medical treatment facilities</p>	<p>Incorporate screening for depression, substance abuse and suicide risk as a minimum standard of care for assessment in primary care settings for all MEDCOM supported healthcare programs – as part of the clinical practice guidelines initiative being implemented in the AMEDD</p>

OBJECTIVE	KEY ACTIONS
<p>Synchronize and integrate local community and installation suicide prevention programs</p>	<ol style="list-style-type: none"> 1. Each ISPC will develop its own charter, which addresses formal and “ad hoc” membership of the committee. 2. Each ISPC will develop and publish its own suicide prevention program plan. Forward a copy through the respective MACOM HQ to DAPE-HR-PR (ODCSPER)
<p>Reduce risk of contagion, provide counseling to surviving family members and expedite the unit personnel recovery</p>	<p>Establish policies and procedures for the implementation of an Installation Suicide Response Team</p>

STRATEGY 5: Conduct Suicide Surveillance, Analysis and Reporting

OBJECTIVE	KEY ACTIONS
<p>Capture data on the number of non-fatal suicide events such as attempts and gestures</p>	<ol style="list-style-type: none"> 1. Determine pertinent data fields and develop the actual reporting format and procedures. Ensure format and procedures do not violate Federal, State or DoD regulatory or directives 2. Implement reporting procedures 3. Include statistics in monthly suicide surveillance update. Provide information to DCSPER and post information on the Army Suicide Prevention Web Site
<p>Conduct suicide surveillance in all Army MTF emergency rooms</p>	<p>Ensure that health care providers that work in Army MTF emergency rooms receive proper training in identifying those individuals whose injuries might have been self-inflicted</p>
<p>Increase percentage of Soldiers keeping follow-up mental health appointments</p>	<p>Establish procedures and guidelines that ensure Soldiers keep their mental health care appointments, especially when considered at risk for suicide</p>
<p>Identify and share effective suicide prevention programs</p>	<p>Identify those proven programs and initiatives effective in reducing the risk of suicide and share those programs and initiatives with the various MACOMs. Programs will range from the installation level to MACOMs and also include “best-science methodology” as determined by the Surgeon General or other branches of the service.</p>
<p>Assess availability of mental health and substance abuse treatment services for youth and DoD Schools</p>	<p>Assess availability of mental health and substance abuse treatment services for youth to determine the need for school-based clinical services for DoD schools</p>
<p>Improve reporting of suicidal behavior in news media</p>	<ol style="list-style-type: none"> 1. All Army news services/media divisions will adopt recommendations/guidelines concerning reporting suicides as provided by the 1989 Health Resources and Services Administration workshop sponsored by the New Jersey Department of Health, or AAS, NIMH, CDC, or other established suicide prevention organization. The design of these recommendations is not to restrict the reporting of suicides, but change the manner in which the suicide is reported. These recommendations will minimize suicide contagion. 2. Installation PAOs should be familiar with such guidelines and recommend that local news media adopt such guidelines when reporting about suicides within the installation or local community.

Annex B - Checklists

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

All Soldiers.

As the first line of defense and perhaps the most important person in suicide prevention:

- ✓ Know suicidal danger & warning signs and the leading causes for suicides. Remain vigilant!
- ✓ Take immediate action when suspecting someone is suicidal or if someone admits that they are contemplating suicide.
- ✓ Become aware of local helping services and protocols for use.

First Line Supervisors/Leaders.

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

Commanders

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

Unit Ministry Teams (UMTs)

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

Installation Suicide Prevention Standing Committee

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

Annex C – Suicide Risk Comparison of Age Cohorts

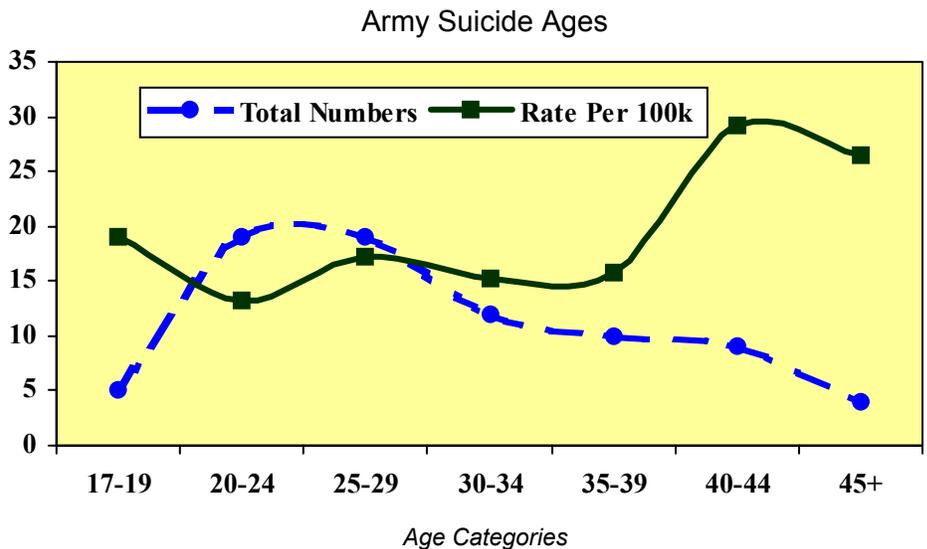
Almost half of all suicides within the Army occur with Soldiers 25 years of age or younger. However, maturity doesn't necessarily protect against suicidal behavior. In fact, older Soldiers have a higher suicide rate than younger Soldiers. As can be seen on Graph 1, although the greater incidence of suicides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

By examining psychological autopsies, we find that younger Soldiers are generally committing suicide as a result from insufficient or underdeveloped life coping skills. Suicides among older Soldiers reveal a different profile of causes. These suicides often result from one or more clinical psychiatric disorders with associated problems that have accumulated over time. Many are facing a major life transition, such as a failed marriage or a promotion pass over. Others suffer from chronic substance abuse or a mood disorder.

Unfortunately, many of these Soldiers don't seek professional help, in part because of the perceived cultural and organization stigma associated with receiving mental health treatment.

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

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



GRAPH 1

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

Annex D – Definitions

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

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

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

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

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

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

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

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

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

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

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

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

Gatekeepers – those individuals within a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate. Identified as either a “primary” or a “secondary” gatekeeper as defined in para 6-2b.

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

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

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

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

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

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

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

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

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

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

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

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

Mental illness – see mental disorder.

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

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

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

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

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

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

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

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

Psychiatric disorder – see mental disorder.

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

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

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

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

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

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

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

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

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

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

Self-injury – see self-harm.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Annex E – Abbreviations/Acronyms

AAFES – Army Air Force Exchange Service
AAS – American Association of Suicidology
ACE – Adverse Childhood Experiences
ACS – Army Community Service
ADAPCP – Alcohol and Drug Abuse Prevention and Control Program
AIT – Advanced Individual Training
AMEDD – Army Medical Departments
ASIST – Applied Suicide Intervention Skills Training
ASPP – Army Suicide Prevention Program
BSRF – Building Strong and Ready Families
CDC – Center for Disease Control and Prevention
CFSC – Community & Family Support Center
CID – Central Investigative Division
CCH – Chief of Chaplains
CPO – Civilian Personnel Office
CSA – Chief of Staff, Army
CSSR – Completed Suicide Surveillance Report
CY – Calendar Year
DCSPER – Deputy Chief of Staff for Personnel
DoD – Department of Defense
ETOH – Ethyl Alcohol
FAP – Family Advocacy Program
GSW – Gunshot Wound
IET – Initial Entry Training
IG – Inspector General
IO – Investigating Officer
ISRT – Installation Suicide Response Team
ISPC – Installation Suicide Prevention Committee
MACOMs – Major Army Commands
MEDCOM – Medical Command
MH – Mental Health
MHO – Mental Health Officer

MP – Military Police
MTF – Medical Treatment Facility
MUSARC/RSC – Major United States Army Reserve Command/Regional Support Command
MWR – Morale, Welfare, and Recreation
NAMI – National Alliance for the Mentally Ill
NCHS – National Center for Health Statistics
NGB – National Guard Bureau
OCCH – Office of the Chief of Chaplains
ODCSPER – Office of the Deputy Chief of Staff for Personnel
ODPHP – Office of Disease Prevention and Health Promotion
OTSG – Office of the Surgeon General
PA – Psychological Autopsy
PAO – Public Affairs Office
RAP – Recruit Assessment Program
SAR – Suicide Analysis Report
SMA – Sergeants Major of the Army
SPRRC – Suicide Prevention Risk Reduction Committee
TJAG – The Judge Advocate General
TSG – The Surgeon General (Army)
TRADOC – Training and Doctrine Command
UCMJ – Uniform Code of Military Justice
UMT – Unit Ministry Team
USACHPPM – US Army Center for Health Promotion and Preventive Medicine
USACIC – US Army Central Investigation Command
USARC – US Army Reserve Command
USC – United States Code
VA – Veterans Administration
VCSA – Vice Chief of Staff, Army
WRAIR – Walter Reed Army Institute of Research
WRAMC – Walter Reed Army Medical Center

Annex F - References

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6. Legree, Generation X: Motivation, Morals, and Values, Army Research Institute Special Report, June 1997
7. Naval Health Research Center Report #95-26, Pre-enlistment Maltreatment Histories of U.S. Navy Basic Trainees: Prevalance of Abusive Behaviors, 1995
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9. Jobes D, Mann R, Reasons for Living versus Reasons for Dying: Examining the Internal Debate of Suicide, Suicide and Life-Threatening Behavior, Vol. 29(2), Summer 1999

Other References

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

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

Military

DA PAM 600-24, Suicide Prevention and Psychological Autopsy

AR 600-5, Health Promotion

AR 190-40, Serious Incident Report

DoD Suicide Prevention and Risk Reduction Committee Charter

Annex G – Useful Web Sites/Contacts

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

Phone Numbers:

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

Army Suicide Demographics

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

Suicide Methods

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

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

APPENDIX 5 (AMEDD Suicide Event Report (ASER), Pilot Version-V.31 January 2003) to ANNEX D to OIF MHAT REPORT

AMEDD Suicide Event Report

ASER

Version: 2.01 (04-Mar-2004)
Previous editions are obsolete.

- This form is to be completed for suicide behaviors that result in death, hospitalization, and/or evacuation.
- Complete all information as it applied at the time of event.
- Select only one box per question unless directed otherwise.

I. Event Information

1. Event date:	_____ (dd-mmm-yy, can be entered mm.dd.yy or mm/dd/yy)
2. Type of event: (check all that apply)	<input type="checkbox"/> Completed suicide <input type="checkbox"/> Hospitalized <input type="checkbox"/> Evacuated <input type="checkbox"/> Other: _____
3. Severity of event:	<input type="checkbox"/> "Medical" intervention not required <input type="checkbox"/> Required "medical" intervention but was <u>not life-threatening</u> <input type="checkbox"/> Required "medical" intervention and <u>likely fatal without treatment</u> <input type="checkbox"/> Was fatal
4. Did event result in hospitalization?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<p>If yes, what type of facility?</p> <input type="checkbox"/> MTF <input type="checkbox"/> Civilian facility <input type="checkbox"/> VA Hospital What was the name of the facility? _____ Admission date? _____ (dd-mmm-yy) Discharge date? _____ (dd-mmm-yy)	
5. Was the event related to a deployment?	<input type="checkbox"/> Yes, anticipated deployment <input type="checkbox"/> Yes, current deployment <input type="checkbox"/> Yes, post-deployment <input type="checkbox"/> No

If yes,

Start date of deployment? _____ (dd-mmm-yy)

End date of deployment? _____ (dd-mmm-yy)

Deployment location?

Afghanistan Kosovo

Iraq Kuwait

Korea Other: _____

I. Event Information (continued)

6. Did patient/decendent communicate intent to others?

- Yes
- No

If yes, to whom? (check all that apply)

- Supervisor
- Chaplain
- Friend
- Mental Health staff
- Spouse or significant other
- Other: _____

7. Primary method used:

- Overdose

If overdose, select method:

- Prescription medication
- Over-the-counter medication
- Illicit drugs

- Poisoning by solid or liquid substance (not medication)
- Firearm / gun
- Jumping from high place
- Motor vehicle crash
- Hanging, strangulation, or suffocation
- Cutting or piercing instrument
- Poisoning by vehicle exhaust
- Poisoning by utility gas
- Submersion (drowning)
- Other: _____
- Don't know

8. During the event, were drugs used?

- Yes
- No
- Don't know

9. During the event, was alcohol used?

- Yes
- No
- Don't know

10. Was event committed in public place where it would likely be observed and intervened in by others?

- Yes
- No
- Don't know

11. The event was...

- Planned, deliberate, and/or premeditated
- Impulsive and/or unplanned
- Don't know

II. Patient/Decedent Personal Information

12. Last name: _____

First name & middle initial: _____, _____

Social Security Number: _____

13. Date of birth: _____ (dd-mmm-yy)

14. Sex: Male
 Female

15. Residence: Barracks
 BEQ / BOQ
 On-post family housing
 Off-post housing

16. Resides alone: Yes
 No
 Don't know

17. Education: Did not complete high school
 GED
 High school graduate
 Two-year college degree
 Four-year college degree or greater

18. Race/population: American Indian
 Asian
 Black
 White
 Other: _____
 Don't know

19. Ethnic group: Mexican Japanese
 Puerto Rican Korean
 Cuban Indian
 Latin American Filipino
 Other Spanish Vietnamese
 Aleut Other Asian
 Eskimo Melanesian
 U.S./Canadian Indian Tribes Polynesian
 Chinese Other Pacific Islands
 Other: _____
 Don't know

20. Marital status:
(check only one)

- Married, resides with spouse
 - Married, geographically separated
 - Widowed
 - Divorced
 - Separated, legally or due to relationship problems
 - Don't know
-

II. Patient/Decedent Personal Information (continued)

21. Minor children? Yes
 No
 Don't know

If yes, were the children residing with him/her?

- Yes
 No
 Don't know

III. Sponsor's Military Information

22. Service: Army
 Navy
 Air Force
 Marines
 Coast Guard
 Other: _____

23. Component: Regular (e.g. Army, Air Force)
 Reserve
 National Guard
 DOD civilian / contractor

24. Duty status:
(check all that apply) Active Duty
 AGR
 IET (Basic and Advanced Individualized Training)
 Mobilized RC (Reserve and National Guard)
 ADT (Active Duty for Training)
 IDT (Weekend Reserve Drill)
 Retired
 Other: _____

25. Rank: Enlisted 1 6
 Warrant Officer 2 7
 Officer 3 8
 Cadet / Midshipman 4 9
 5 10

26. Relationship to sponsor: Sponsor
 Spouse
 Child
 Other: _____

27. MOS:
(Military Occupation Specialty Code) _____

28. Division: _____
Brigade: _____

Battalion:

Company:

III. Sponsor's Military Information (continued)

29. UIC:
(Unit Identification Code) _____

30. Permanent duty station / installation: _____
 City: _____
 State: _____
 Country: _____

31. Length of time in unit: ___ years, ___ months Check if unknown

32. Duty environment/status at time of event:
(check all that apply)

<input type="checkbox"/> Garrison	<input type="checkbox"/> Psychiatric hospitalization
<input type="checkbox"/> Leave	<input type="checkbox"/> Medical hold
<input type="checkbox"/> TDY	<input type="checkbox"/> In evacuation chain
<input type="checkbox"/> AWOL	<input type="checkbox"/> Under command observation (e.g. CIP)
<input type="checkbox"/> Deployed	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Training	

IV. Combat

Did the patient/decedent recently...

	Yes	No	Don't know
33. experience direct combat operations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. have a close friend or unit member killed or seriously wounded in combat operations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. witness others (civilians, enemy combatants, unknown Soldiers) killed or seriously wounded while participating in combat operations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

V. Use of Medical and Helping Services Prior to the Event

In the past year was the patient/decedent seen by...	Yes within 30 days before event	Yes 31-365 days before event	No	Don't know
36. Medical Treatment Facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Substance Abuse Services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. Family Advocacy Program?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Out-Patient Mental Health? (including deployment mental health services)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. In-Patient Mental Health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VI. Risk Factors

Had the patient/decedent...	Yes	No	Don't know	If yes, is there a pending, related...	
				MEB?	admin. separation?
41. been diagnosed with any Mood Disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. been diagnosed with Bipolar Disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. been diagnosed with Major Depression?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. been diagnosed with Psychotic Disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. been diagnosed with PTSD?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46. been diagnosed with Anxiety Disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. been diagnosed with Personality Disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. had a history with Substance Abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, select all that apply:					
				Dependence	Abuse
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				(e.g. OTC medication)	
49. been taking psychotropic medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
50. had a family history of mental illness or suicide?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
51. had prior self-injurious events?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
If yes,					
<input type="checkbox"/> One prior event					
<input type="checkbox"/> More than one prior event					
Was this event similar to prior event(s)?					
<input type="checkbox"/> Yes					
<input type="checkbox"/> No					
<input type="checkbox"/> Don't know					
52. Was there a gun in the home or immediate environment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

VII. Relationships

	Yes	No	Don't know
53. Was the patient/decendent involved in a failed/failing intimate relationship?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
54. Was there a recent spousal or family death?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
55. Is there an ongoing spousal or family severe illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VIII. Motivation

56. What was the patient/decendent's <u>primary</u> motivation for committing suicide? (as judged by the clinician)	<input type="checkbox"/>	A wish to escape from mental or physical pain	
	<input type="checkbox"/>	A fantasy of eternal rest or life with a loved one	
	<input type="checkbox"/>	Anger, rage, revenge	
	<input type="checkbox"/>	Guilt, shame, atonement	
	<input type="checkbox"/>	A wish to be rescued, reborn, start over	
	<input type="checkbox"/>	A wish to make an important statement or communication	
	<input type="checkbox"/>	Other: _____	
<input type="checkbox"/>	Don't know		

IX. Abuse and Trauma History

Was the patient/decendent a recent victim of...

	Yes	No	Don't know
57. physical, sexual, or emotional abuse/assault? (e.g. FAP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
58. sexual harassment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

X. Military, Legal, and Administrative History

Was the patient/decendent an alleged or confirmed perpetrator of recent...

	Yes	No	Don't know
59. physical, sexual, emotional, or verbal abuse (e.g. FAP)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
60. sexual harassment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Was the patient/decendent recently involved in...

	Yes	No	Don't know
61. Courts Martial proceedings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62. Article 15 proceedings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63. Administrative Separation proceedings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64. AWOL or desertion proceedings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
65. non-selection for advanced schooling / promotion / command?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

XI. Work Problems

Did the patient/decedent...	Yes	No	Don't know
66. experience work dissatisfaction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67. have supervisor/coworker issues/problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
68. have a poor work performance review or evaluation? (e.g. bar for reenlistment, flagged record, extra duty imposed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
69. experience recent unit or workplace hazing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
70. have any other experiences at work which may have led to the event?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what other experiences?			

XII. Financial Problems

Did the patient/decedent...	Yes	No	Don't know
71. have excessive debt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
72. experience bankruptcy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

XIII. Completing Behavioral Health Provider's Information

73. Name: _____

Phone number: _____

Phone number (DSN): _____

Email: _____

Comments: _____

XIV. Narrative Summary

74. Sequence of events culminating in the suicide behavior:

(Describe the details of the antecedent circumstances that led to the suicide attempt/completion)

75. Why did this patient/decedent choose to injure or kill him/herself?

(Provide a brief "bio-psycho-social" formulation as to WHY this patient committed the suicide attempt/completion)

76. Risk management analysis:

(Any BH clinical involvement - elaborate on any issue of concern. Also elaborate on unit actions that may have contributed)

Acknowledgements

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