

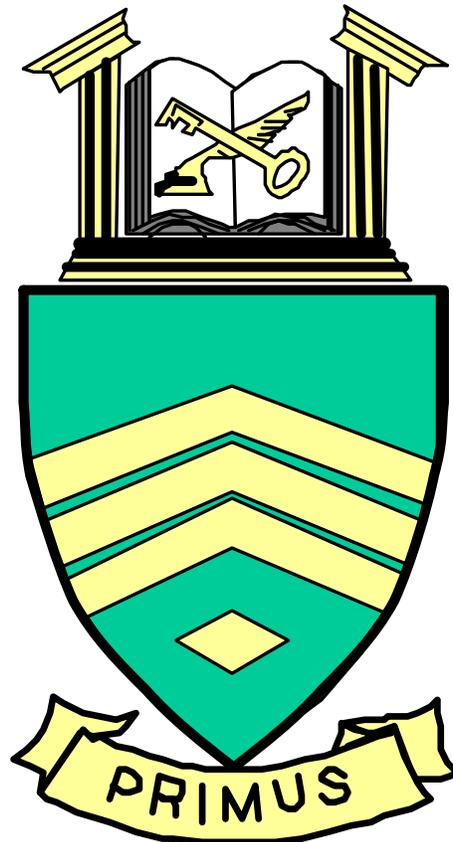
U.S. ARMY SERGEANTS MAJOR ACADEMY (FSC-TATS)

L670

OCT 04

SUICIDE PREVENTION

STUDENT HANDOUT



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Appendix D

HANDOUTS FOR LESSON 1: L670 version 1

This appendix contains the items listed in this table--

Title/Synopsis	Pages
SH-1, Advance Sheet	SH-1-1 and SH-1-2
SH-2, Army Suicide Prevention - A Guide for Installations and Units (Draft) and Suicide Prevention Leader Training (Draft).	SH-2-1 thru SH-2-22
SH-3, Student Notes	SH-3-1 thru SH-3-9

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Student Handout 1

Advance Sheet for L670

Lesson Hours This lesson consists of two hours of small group instruction.

Overview The Army Suicide Prevention Program (ASPP) provides a systematic environment in which commanders may effectively work to lower the risk of suicide for soldiers, family members, and civilian employees. This will lower the Army's suicide rate and impact significantly on the loss of life and productivity that can result from suicidal behavior.

Learning Objective Terminal Learning Objective (TLO)

Action:	Determine requirements and responsibilities for the Army's Suicide Prevention Program (ASPP).
Conditions:	As a first sergeant in a classroom environment given AR 600-63, DA Pam 600-24, DA Pam 600-70, and student handouts.
Standards:	Determined requirements and responsibilities for the Army's Suicide Prevention Program (ASPP) IAW AR 600-63, DA Pam 600-24, DA Pam 600-70, and student handouts.

- ELO A** Determine suicide prevention program resources.
ELO B Interpret suicide danger and warning signs.
ELO C Determine the identification and crisis intervention process.
ELO D Interpret the suicide risk management team (SRMT).
ELO E Determine soldier, leader, and commander responsibilities.
-

Assignment The student assignments for this lesson are:

- Read AR 600-85, Chapters 1 thru 8 and skim App B.
- Read SH-2.

Additional Subject Area Resources None

Bring to Class AR 600-85.
DA PAM 600-24.
DA PAM 600-70.
Student Handouts 1 thru 3.
Pen or pencil and writing paper.

Note to Students

It is your responsibility to do the homework prior to class. We expect you to come to class prepared and participate in the small group discussion by providing information you learned from your individual study, as well as your personal and observed experiences. Failure to study and read the assignments above will result in your inability to fully participate with the rest of the group. Not having your input affects the group's ability to fully discuss the information.

Student Handout 2

This Student Handout contains 21 of extracted material developed by Headquarters, Department of the Army, G1.

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Army Suicide Prevention – A Guide for Installations and Units

1. The Army's strength rests with our soldiers, civilians, retirees, and their families, each being a vital member of our institution. Suicide is detrimental to the readiness of the Army and is a personal tragedy for all those affected. Therefore, suicide has no place in our professional force!
2. We all realize the inherent stress and burdens placed upon our soldiers, civilians and their family members. What defines us as an institution is our compassion and commitment to promoting a healthy lifestyle by emphasizing physical, spiritual and mental fitness. This contributes to the overall well-being of the force and readiness of the Army. Therefore, we must remain cognizant of the potential suicidal triggers and warning signs so that we can raise awareness and increase vigilance for recognizing those whom might be at risk for suicidal behaviors. Furthermore, we must create a command climate of acceptance and support that encourages help-seeking behavior as a sign of individual strength and maturity.
3. Suicide prevention, like all leadership challenges, is a commander's program and every leader's responsibility at all levels. However, the success of the Army Suicide Prevention Program (ASPP) rests upon proactive, caring and courageous soldiers, family members and Army civilians who recognize the imminent danger and then take immediate action to save a life. We need your help to minimize the risk of suicide within the Army to stop this tragic and unnecessary loss of human life. Suicide prevention is everybody's business and in The Army, **EVERYONE MATTERS!**

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

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

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.

Jobs 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 proceed suicide behavior. Although not as serious as the danger signs previously listed, they should not be disregarded and also require immediate personal intervention. The list includes:

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

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

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

- hopelessness or helplessness
- angry or vindictive

- guilty or shameful
- desperation
- loneliness
- sad or depressed

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

2-9. Resources for Living.

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

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

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

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

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

Chapter Three – The Army Suicide Prevention Model

“Knowing is not enough, we must apply.

Willing is not enough, we must do.”

Goethe

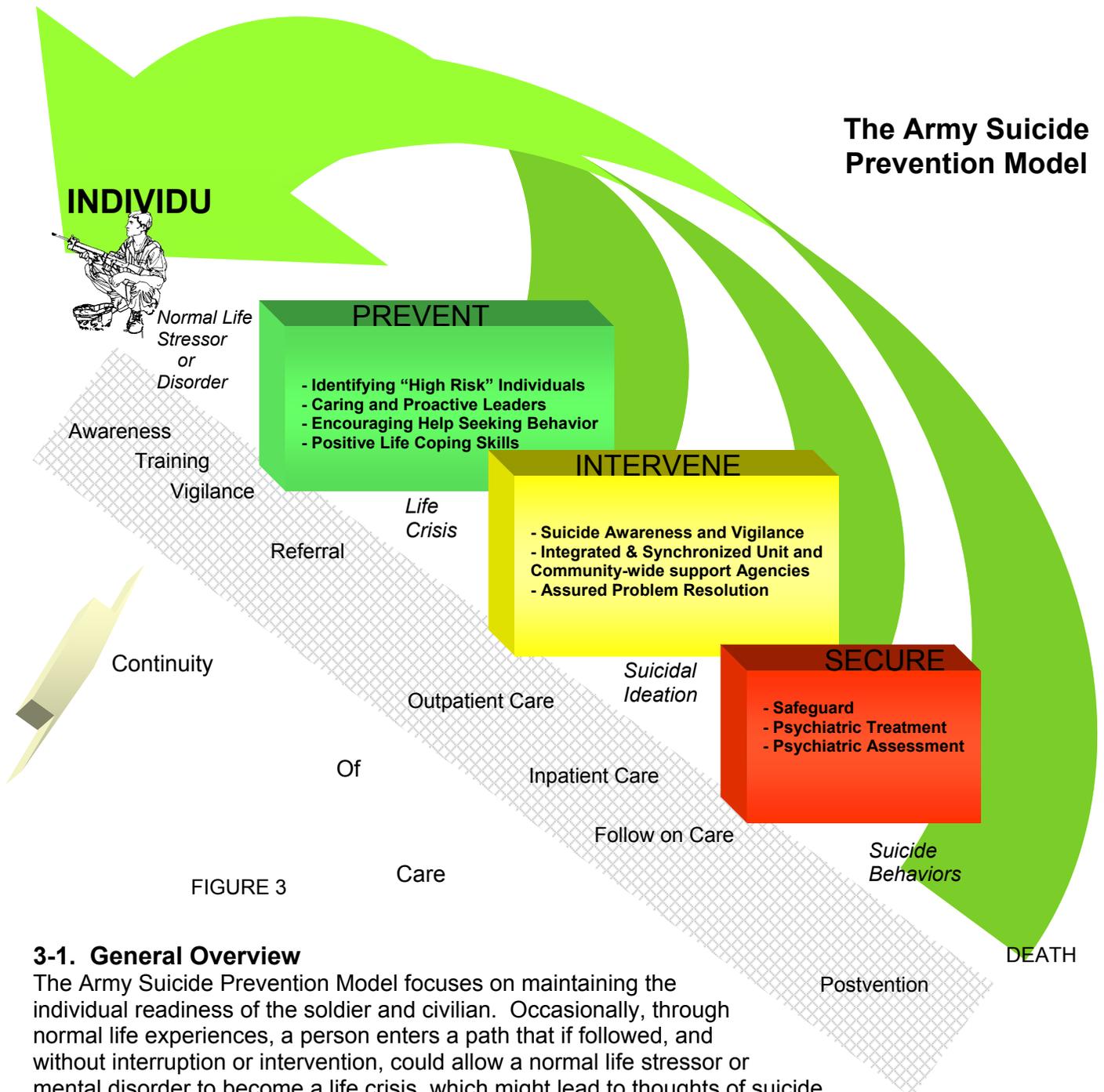


FIGURE 3

3-1. General Overview

The Army Suicide Prevention Model focuses on maintaining the individual readiness of the soldier and civilian. Occasionally, through normal life experiences, a person enters a path that if followed, and without interruption or intervention, could allow a normal life stressor or mental disorder to become a life crisis, which might lead to thoughts of suicide

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

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

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

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

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

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

Chapter Four – Prevention

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

4-1. Identifying “High Risk” Individuals

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

- 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

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

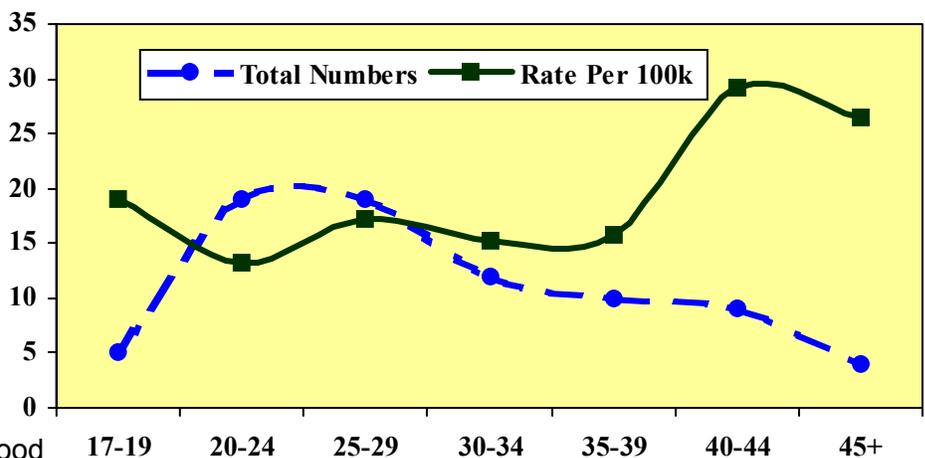
- ✓ Establish suicide prevention program specifically tailored for your installation.
- ✓ Assist the installation and local commanders in implementing their preventative programs.
- ✓ Ensure that suicide prevention policies and procedures comply with applicable laws, regulations and directives regarding 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.



GRAPH 1

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.

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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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.odcspcr.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.

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Student Handout 3

This student handout contains 8 pages of the slides, three on a page, for students to use as note taking material.

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ASPP GOAL

TO MINIMIZE SUICIDAL BEHAVIOR
AMONG OUR SOLDIERS,
RETIREES, CIVILIANS AND
FAMILY MEMBERS.

L670/OCT04M/GT-7

First Sergeant Course

ASPP TRAINING REQUIREMENTS

- In all Army leadership development courses.
- In unit officer/NCO professional development courses.
- In post level courses for civilian supervisors and CPO personnel.
- As in-service training for professionals and military police.

L670/OCT04M/GT-8

First Sergeant Course

ASPP TRAINING REQUIREMENTS (cont)

- Mental health officers “train the trainers”.
- Unit ministry teams assist with training.
- Army community services conducts education awareness program for family members.

L670/OCT04M/GT-9

First Sergeant Course

FMSPP EDUCATION AWARENESS

- **Recognize the signs of increased suicide risk.**
- **Learn about referral sources.**
- **Educational programs will focus on:**
 - **Parents.**
 - **Teenagers.**
 - **Spouses.**

L670/OCT04M/GT-10

First Sergeant Course

DANGER SIGNS

- **Talking or hinting about suicide**
- **Formulating a plan to include a 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 affairs**

L670/OCT04M/GT-11

First Sergeant Course

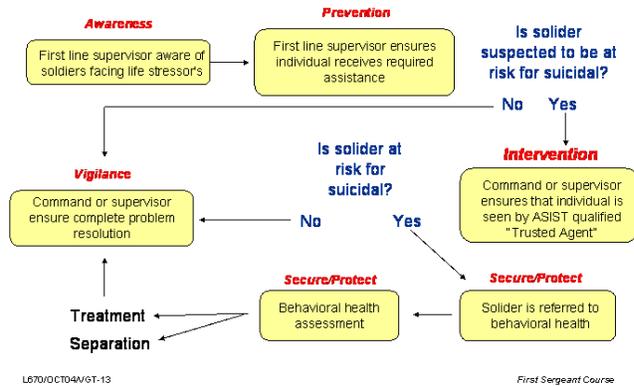
WARNING SIGNS

- **Oblivious drop in duty performance**
- **Unkempt personal appearance**
- **Feeling of Hopelessness or helplessness**
- **Family history of suicide**
- **Made previous suicide attempts**
- **Drug or alcohol abuse**
- **Social withdrawal**
- **Loss of interest in sexual activity**
- **Reckless behavior, self-mutilation**
- **Physical heath complaints, changes/loss of appetite**
- **Complaints of significant difficulties**

L670/OCT04M/GT-12

First Sergeant Course

UNIT SUICIDE PREVENTION MODEL



IDENTIFICATION AND CRISIS INTERVENTION

- **Early leader involvement.**
- **Identify persons at risk.**
- **Listen and refer person to helping agency.**
- **Take person expressing suicidal thoughts to a mental health professional.**
- **Summon law and medical personnel if individual declines help.**

L670/OCT04M/GT-14

First Sergeant Course

IDENTIFICATION AND CRISIS INTERVENTION (cont)

- **Alter crisis creation conditions.**
- **Primary 24-hour medical treatment facilities.**
- **Maximum use of civilian "hot-lines".**

L670/OCT04M/GT-15

First Sergeant Course

