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Personnel—General

Health Promotion, Risk Reduction, and Suicide Prevention

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SUMMARY of CHANGE

DA PAM 600-24

Health Promotion, Risk Reduction, and Suicide Prevention

This major revision, dated 24 November 2009-

- o Updates procedures for Health Promotion, Risk Reduction, and Suicide Prevention (throughout).
- o Makes administrative changes (throughout).


Personnel—General

Health Promotion, Risk Reduction, and Suicide Prevention

By Order of the Secretary of the Army:

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History. This publication is a major revision.

Summary. This pamphlet explains the procedures for health promotion, risk reduction, and suicide prevention efforts to mitigate high-risk behaviors.

Applicability. This pamphlet applies to the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve, unless otherwise stated.

Proponent and exception authority. The proponent of this pamphlet is the Deputy Chief of Staff, G–1. The proponent has the authority to approve exceptions or waivers to this pamphlet that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this pamphlet by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior

leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25–30 for specific guidance.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to Deputy Chief of Staff, G–1 (DAPE–HRI), 200 Army Pentagon, Washington, DC 20310–0300.

Distribution. This pamphlet is available in electronic media only and is intended for command levels C, D, and E for the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve.

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Glossary

Chapter 1 Introduction

1–1. Purpose

This pamphlet sets forth procedures for establishing health promotion, risk reduction, and suicide prevention efforts. It provides holistic guidance to improve the physical, mental, and spiritual health of Soldiers and their Families.

1–2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms

Abbreviations and special terms used in this pamphlet are listed in the glossary.

Chapter 2 Structure, Duties, and Functions

2–1. The Army Suicide Prevention Program

a. The Army Suicide Prevention Program (ASPP), a proponent of Deputy Chief of Staff, G–1 (DCS, G–1), has an Army-wide commitment to provide resources for suicide intervention skills, prevention, and follow-up in an effort to reduce the occurrence of suicidal behavior across the Army enterprise. The ASPP develops initiatives to tailor and target policies, programs, and training in order to mitigate risk and behavior associated with suicide. A function of the ASPP is to track demographic data on suicidal behaviors to assist Army leaders in the identification of trends. The goal is to minimize suicidal behavior by reducing the risk of suicide for Active Army and Reserve Component Soldiers, Army DA civilians, and Army Family members. The ASPP establishes a community approach to reduce Army suicides through the function of the Community Health Promotion Councils (CHPC). The CHPC integrates multidisciplinary capabilities to assist commanders in implementing local suicide-prevention programs, and establishes the importance of early identification of, and intervention with problems that detract from personal and unit readiness. The ASPP has 3 principle phases or categories of activities to mitigate the risk and impact of suicidal behaviors, prevention, intervention, and postvention. The ASPP Program Manager shall also serve as a member of the Department of Defense (DOD) Suicide Prevention and Risk Reduction Committee and subcommittees to ensure the ASPP is nested with the Defense Community of Excellence (DCoE) suicide prevention efforts.

b. The Office of the Surgeon General (OTSG), ICW CHPCs, OTSG will develop a specific plan to provide commanders additional guidance on ensuring at risk medications are tracked and medical peer review is completed through quality assurance. Guidance will provide commanders information on how to—

(1) Inform commanders on how to track civilians at risk medications when the health care provider (HCP) or pharmacy will not release their medication information.

(2) Determine how the Army will track medication filled by an outside DOD medical pharmacy.

c. Prevention focuses on preventing normal life “stressors” from turning into life crises. “Prevention Programming” focuses on equipping the Soldier, Family member, and Army DA civilian with coping skills to handle overwhelming life circumstances. Prevention includes early screening to establish baseline mental health and to offer specific remedial programs before dysfunctional behavior occurs. Prevention is dependent upon caring and proactive unit leaders and managers who make the effort to know their personnel, including estimating their ability to handle stress, and who offer a positive, cohesive environment which nurtures, and develops positive life-coping skills. These “gatekeepers” serve as the first line of defense to mitigate risk (See glossary for “gatekeeper” explanation).

d. Intervention attempts to prevent a life crisis or mental disorder from leading to thoughts of suicide, to help someone manage suicidal thoughts and takes action to intervene when a suicide appears imminent. It encourages and/or mandates professional assistance 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 that produced the current crisis, treatment of underlying psychiatric disorder(s) that contributed to suicidal thoughts, and follow-up care to assure problem resolution. This also could include controlling a person’s environment such as removing the means and enacting watchful care from a buddy. Commanders play an integral part during this phase, as it is their responsibility to ensure access to behavioral health care and that a particular problem or crisis has been resolved before assuming the person is out of danger.

e. Postvention is required when an individual has attempted or completed a suicide. After an attempt, commanders, non commissioned officers (NCOs), and installation gatekeepers must take steps to secure and protect such individuals before they can harm themselves and/or others. “Postvention” activities also include unit-level interventions following completed suicidal acts, to minimize psychological reactions to the event, prevent or minimize potential for suicide contagion, strengthen unit cohesion, and promote continued mission readiness.

2-2. Army Suicide Prevention Program strategy

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

b. Leaders must know their subordinates and assure that timely assistance is provided when needed. Commanders and DA civilian leaders will establish standardized protocols so that individuals identified as having increased risk are referred to appropriate agencies to receive help. Examples include community mental health service (CMHS), emergency room of the medical treatment facility, or local hospital. The unit commander/supervisor must track the individual's progress to ensure that the problem is resolved.

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

d. The ASPP provides support for commanders to lower the risk of suicide for Soldiers, Family members, and DA civilian employees. This will lead to lower suicide rates in the Army and will impact significantly on the loss of life and productivity that can result from suicidal behavior.

e. Review and evaluate suicide prevention programs and their implementation to assess performance and effectiveness.

2-3. Leadership

The success of a health promotion, risk reduction and suicide prevention program depends on the concentrated focus of leadership on activities that encompass the physical, behavioral, spiritual, social, and cultural dimensions in their respective communities. (See AR 600-63 for a comprehensive explanation) The total effect of a solid program is an overall improvement in unit and organizational performance by enhancing individual well-being. Diagrams depicting relationships among key proponents are shown at appendix C.

2-4. Brigade and battalion commanders

The brigade and battalion commanders will—

a. Establish task forces, committees, and risk reduction teams to facilitate health promotion initiatives to reduce high-risk behaviors and build resiliency.

b. Ensure that command leadership personnel are educated regarding behavioral health issues such as suicidal ideation, substance abuse, and other high-risk behaviors and their effect on unit climate. Ensure all officer/NCO counseling sessions and the Army Mentorship Program include these issues.

c. Follow information outlined in FM 6-22, appendix B, Counseling.

d. Attend meetings of health promotion, risk reduction, suicide prevention program counsels, committees, task forces, and so on, as applicable.

e. Publish a suicide prevention policy (AR 600-63, para 1-24). See appendix C of this DA Pam for an example of a suicide prevention policy.

f. Provide required annual training for suicide awareness/intervention in accordance with AR 600-63, paragraph 4-4j(2). Training is to be provided to those serving in the Active Army, National Guard/Reserve, and DA civilian Government Service employees. DA civilians may be excused from the Army Suicide Prevention Training if they believe the training is offensive or may be emotionally or psychologically stressful to them. Managers and supervisors who excuse DA civilians from the scheduled training will offer those employees alternatives to the training, such as written materials on suicide prevention. Training shall be made available to full-time contractors unless the following limitations apply:

(1) Public Law 106-58, September 29, 1999, 113 Stat 430, provides that: "SEC. 625. (a) None of the funds made available in this or any other Act may be obligated or expended for any employee training;

(2) Does not meet identified needs for knowledge, skills, and abilities bearing directly upon the performance of official duties;

(3) Contains elements likely to induce high levels of emotional response or psychological stress in some participants;

(4) Does not require prior employee notification of the content and methods to be used in the training and written end of course evaluation;

(5) Contains any methods or content associated with religious or quasi-religious belief systems or "new age" belief systems as defined in Equal Employment Opportunity Commission Notice N-915.022, dated September 2, 1988; or

(6) Is offensive to, or designed to change, participants' personal values or lifestyle outside the workplace.

(7) Contractor employees may only attend suicide training on government time (that is, the government is charged for the time spent at training) if such training is part of the contract.

(8) If contractors will be required to attend, the requirement must be required specifically in each contract involved, and this training must be conducted “on the clock” (paid) for the contractor’s training.

(9) Wherever practical, training shall be conducted in person and in small groups, rather than using large group, VTC, or web-based trainings.

g. Track and assess mandatory suicide prevention training of individual Soldiers in accordance with AR 350–1.

2–5. Commander responsibilities

a. All Commanders—

(1) Will remain sensitive and responsive to the needs of Soldiers, Army DA civilians, Family members, and retirees. Ensure that unit leaders utilize principles of counseling provided in FM 6–22, appendix B.

(2) Inform all subordinates of available assistance agencies.

(3) Prepare a commander’s policy letter, (in accordance with AR 600–63, para 4–4j2) See appendix C of this DA Pam for an example.

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

(5) Incorporate suicide prevention training into the yearly training plan.

(6) Must keep records of Soldiers’ annual suicide prevention awareness training.

(7) Provide command support for unit participation in suicide awareness and prevention activities.

(8) Reduce stigma. Build a command climate that encourages and enables Soldiers and civilians to seek help.

(9) Educate leaders regarding policy to eliminate belittling Soldiers who seek behavioral health assistance.

(10) Manage at-risk Soldiers, to include processing for separation as appropriate in a timely manner. Indicators of risk are listed in paragraph 3–7c(1).

(11) Refer individuals who are identified as having personal or emotional problems to an appropriate source for help. It is essential that commanders follow through to assure the problem is either resolved or continuing help is being provided. Civilian HCP will not release health care information due to Health Insurance Portability and Accountability Act (HIPPA) restrictions. Commanders must coordinate through their nearest Medical Treatment Facility (MTF) to gain updates of Soldier status of care.

(12) Utilize the AR 15–6 investigation for death of a Soldier. Civilian causes of death will be determined by the local medical examiner or coroner. Commands from all components will conduct an AR 15–6 investigation on every suicide or equivocal death which is being investigated as a possible suicide for Soldiers (See AR 600–63, chap 1–23 for commanders’ responsibilities). AR 15–6 procedures are not utilized for civilian deaths.

(13) Use the unit risk inventory (URI), the reintegration unit risk inventory (R-URI), the DD Form 2796 (Post–Deployment Health Assessment (PDHA)), and the DD Form 2900 (Post–Deployment Health Reassessment (PDHRA)) to identify Soldier’s issues that need command attention and additional resources.

(14) The Suicide Psychological Reporting Format at appendix B, line 34, to report suicides or attempted suicides to their higher Headquarters, and to the DCS, G–1. This includes all suicides resulting in death, or attempted suicides where injury but death did not occur. See AR 600–63, chapter 4, Behavioral Health, for specific guidance on use and restrictions for this report.

b. Senior commanders will—

(1) Have the overall responsibility for health promotion, risk reduction, and suicide prevention efforts.

(2) Designate, as appropriate, garrison commanders to serve as the representative of the CHPC.

c. Garrison commanders will—

(1) Develop a comprehensive, all-encompassing health promotion, risk reduction, and suicide prevention strategy that links garrison, MTF staffs, and activities and is readily recognized and acknowledged by unit commanders, Soldiers, DA civilians, and Family members.

(2) Establish a comprehensive strategy to combat the stigma associated with Soldiers seeking behavioral health care.

(3) Review the Operational Tempo (OPTEMPO) of units to synchronize/implement Soldier and Family member resiliency-focused programs.

(4) Support programs that actively engage leaders and their spouses in a comprehensive health promotion, risk reduction, and suicide prevention program to strengthen relationships.

(5) Ensure a CHPC is established. See paragraph 2–11 of this DA Pam for information about the CHPC.

d. The MTF Commanders will—

(1) Work closely with the Criminal Investigative Division (CID), Fatality Review Board (FRB), and AR 15–6/Line of Duty (LOD) investigator to ensure timely and accurate reporting of suicide-related event data on the Department of Defense Suicide Event Report (DODSER).

(2) Monitor primary health care and behavioral health care provider consolidation (co-location) to provide comprehensive medical treatment, share treatment plan information, and reduce stigma.

(3) Ensure primary/behavioral health care providers treat patients comprehensively with current medical health care commensurate with Family medical care (for example; facility, equipment, and specialty consultation and services).

(4) Ensure “at risk medication” prescriptions are tracked and peer reviewed through a quality assurance process from other medical doctors under normal medical peer review. “At risk” prescribing would include (label and off label use) drug combinations comprised of three or more of the following: Opioid Narcotics, Anxiolytics, Antipsychotics, Sedative-hypnotics, mood stabilizers, and anti-convulsants.

e. The Army Service Component Command is responsible for publishing a theater-level Suicide Prevention Action Plan (SPAP) and ensuring that proper training and oversight of programs occurs.

f. First line leaders will—

(1) Promote a climate of support, minimize stigma, and encourage help seeking behavior.

(2) Understand leader responsibilities regarding suicide prevention, intervention and postvention.

(3) Take a personal interest and know what is going on in subordinate Soldiers’ personal lives. Provide support, where needed.

(4) Teach suicide prevention to all Soldiers in their chain of command.

(5) Implement the battle buddy system in accordance with AR 600–63. Foster a sense of responsibility in Soldiers to provide watchful care and support to peers.

2–6. Soldiers

a. Live up to the Army Values in caring for your buddy.

b. Seek out your buddy for advice, protection, and support.

c. Recognize that seeking help is a sign of strength.

d. Report all concerns that a buddy may harm themselves.

2–7. Chaplains

a. Are integrated with behavioral health professional in units, and with Combat Stress Control Teams and with Military Family Life Consultants to provide multi-disciplinary support, naturalize referrals, and reduce stigma associated with help-seeking behavior.

b. Strong Bonds is a command-initiated, Chaplain-led program in which the Chief of Chaplains offers an incentive grant to encourage commanders to plan and execute within their commands. Commanders are expected to fully fund all logistical requirements which are above and beyond the total amount of the Chief of Chaplains Incentive Grant. Strong Bonds is a relationship education and skills focused training program conducted in an off-site and overnight retreat setting. Various training programs are offered for single Soldiers, couples, and Family members. Attendance is voluntary. During the retreat, Soldiers and Families participate in small group activities that strengthen relationship bonds, nurture resiliency, and support long-distance relationships. In addition, Soldiers and Families gain awareness of community resources that can assist with concerns about health and wellness, even crisis intervention. Strong Bonds programs are available to all Active Duty, Army National Guard, and United States Army Reserve Soldiers and their Families.

2–8. Military family life consultants

Military family life consultants (MFLCs) are managed and deployed by the Office of the Secretary of Defense (OSD). They are professionals in private practice in the state in which they are licensed. When MFLCs come on board under contract with OSD, they close their private practice and become a consultant at a specific location. The MFLCs are available to Soldiers and Families, are incorporated into commander/unit programs, and are fully integrated with other providers, such as TRICARE Network or MTF healthcare providers, to ensure seamless coverage between contact and referral.

2–9. Criminal Investigation Division commanders or special agents in charge of the supporting U.S. Army Criminal Investigation Command element

a. Investigates all suicides or suspected suicides of Soldiers on Active Duty at the time of death (see AR 195–2).

b. Establishes liaison with local civilian law enforcement agencies, coroners, and medical examiners, as appropriate, to obtain information regarding suicide related events involving military personnel, their Families, or DA civilian employees, which may have occurred off–post, and provide such information to the task force. Such liaison activity will be in compliance with applicable statutes of the local civilian community.

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

d. Coordinates with commanders regarding equivocal death investigations to ensure commanders take appropriate, timely actions (AR 15–6/LOD, and so on), in the event that the equivocal death is determined to be a suicide.

2-10. Line of duty investigators

- a. The LOD Investigators are appointed by the unit commander.
- b. Perform an LOD determination for all deaths and injuries arising from suicide-related events (equivocal deaths, attempts, and acts of self harm) for Soldiers in an active duty or IDT status in accordance with AR 600-8-4.
- c. Coordinate and communicate with an appropriate MTF behavioral health officer to obtain an opinion from that officer regarding whether the Soldier who died of suicide was “mentally sound” at the time of the suicide incident.

2-11. Councils, task forces, and teams

a. *Community Health Promotion Council.* The roles and responsibilities of the CHPC are outlined in AR 600-63, chapter 2. The CHPC’s primary responsibilities related to suicide prevention are to establish, plan, implement, and manage the ASPP for their installation, state Joint Force Headquarters (JFHQ), Army Command/Army Service Component Command/or Direct Reporting Unit (ACOM/ASCC/DRU). For geographically-dispersed commands, a CHPC may not be practical. In these situations, commanders will develop and implement alternative strategies to accomplish similar goals, to include establishing a Suicide Prevention Task Force (SPTF) in accordance with the requirements of AR 600-63, paragraph 2-4. It will maximize and focus available resources and ensure unit ASPPs are nested within the overall plan. The CHPC—

(1) It is chaired by the garrison commander, ACSS/ACOM/DRU commander, the Adjutant General, or their designee. The structure, function, and efforts of the CHPC are outlined in AR 600-63, paragraph 2-2c-g.

(2) Will have a charter that includes the following: purpose, mission/scope, objectives, membership/organizational structure, meeting schedule/meeting agenda, standard products/services, marketing/outreach, and production/metrics.

(3) Provides a comprehensive approach to health promotion, and is concerned with the environment and its relationship to people at individual, organizational, and community levels.

(4) Identifies and eliminates redundancies and voids in programs and services by evaluating population needs, assessing existing programs, and coordinating targeted interventions.

(5) Ensures health promotion programs include a comprehensive health education/health promotion process which raises individual and community awareness, encourages proactive public health policies, and sustains healthy lifestyles for a mission ready Army.

(6) Initiates preventive interventions that directly impact the total population (Active, Army Reserve, and Army National Guard Soldiers, Family members, retirees, and Army DA civilians).

(7) Assists, develops, and implements means to allow commanders to monitor program goals and objectives.

(8) Ensures necessary health promotion knowledge, skills, and training are available for the Community, to include responsible sexual behavior, substance abuse, fitness and health, injury prevention, ergonomics, oral health, nutrition, and weight management.

b. *Suicide Prevention Task Force.*

(1) Each installation, Army Reserve ACSS/ACOM/DRU and state JFHQs will establish a SPTF to plan, implement, and manage the local ASPP. The SPTF is a sub-committee of the CHPC where one exists. The membership of this committee will be tailored to meet local needs.

(2) All commanders will assign the suicide prevention mission to the Suicide Prevention Program Manager (SPPM) – who serves as the chair of the SPTF and a member of the CHPC. The task force members, with respect to suicide prevention, must be clearly establish the following.

(3) The SPTF should consist of the following personnel or their local equivalent:

(a) The Suicide Prevention Program Manager (SPPM).

(b) The Alcohol Drug Control Officer (ADCO).

(c) Chaplain.

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

(e) The Division/Command Surgeon (DS).

(f) The Chief, CMHS.

(g) The Division Mental Health Officer (DMHO)/Director of Psychological Health (DPH).

(h) The Public Affairs Officer (PAO).

(i) The Director, Human Resources (DHR).

(j) The Provost Marshal (PM).

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

(l) The Staff Judge Advocate (SJA).

(m) The Army Community Services Officer (ACS).

(n) The Director of Family, Morale, Welfare, and Recreation (DFMWR).

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

(p) A representative of the post Family member schools.

- (q) Other installation, organization, and community agencies, as needed.
- (4) In accordance with AR 600–63, chap 2, paragraph 2–4a and b. The SPTF will—
 - (a) Coordinate program activities and the suicide prevention activities of the command, interested agencies, and persons.
 - (b) Evaluate program needs of the installation or organization and make appropriate recommendations to the commander on a quarterly basis.
 - (c) Review, refine, add, or delete items to the program based on an on–going evaluation of needs.
 - (d) Develop awareness training for their installation’s/organization’s suicide prevention activities and identify appropriate forums for training.
 - (e) Evaluate the impact of the pace of training and military operations on the quality of individual and Family life in the military community.
 - (f) Recommend command policy guidance for training and operations issues to assure that Soldiers and their leaders have sufficient opportunity for quality Family life.
 - (g) Be aware of publicity generated with respect to suicides in the community and develop public awareness articles for publication.
 - (h) Meet as scheduled or at the discretion of the task force presiding officer.
 - (i) Coordinate with civilian support agencies as necessary.
 - (j) The SPTFs implement an integrated Family member suicide prevention program.
 - (k) Maintain demographics and statistical data on every confirmed suicide for Soldiers and DA civilians; and comparative data for civilians in the national and local civilian population for statistical comparison.
 - (l) Supports the efforts of the Fatality Review Board (FRB), as appropriate. See paragraph 2–12d of this publication for information about the FRB.
- (5) Functions of the Suicide Prevention Task Force members. The following list of specific functions (in accordance with AR 600–63, chap 2) for task force members and other staff agencies is provided as a guide for the efficient operation of the SPTF.
 - (a) The Suicide Prevention Program Manager (SPPM)—
 1. Serves as the presiding officer of the Suicide Prevention Task Force and coordinates the efforts of task force members.
 2. Serves as a member of the CHPC, reporting data and trends gleaned from the SPTF.
 3. Tracks the training of all personnel certified in the DCS, G–1 approved Suicide Intervention Skills Training and ACE training for the installation, State, and ACSS/ACOM/DRU. A minimum of two certified trainers are required to effectively conduct Suicide Intervention Skills Training.
 4. Serves as the point of contact for program information and advice to the commander and to major subordinate commands.
 5. Integrates suicide prevention into community, Family, and Soldier support programs, as appropriate.
 - (b) The ADCO—
 1. Serves as the task force presiding officer in the absence of the SPPM.
 2. Advises the commander regarding the impact of alcohol and drug abuse on suicide risk.
 3. Assures that the Army Substance Abuse Program (ASAP) staff are trained in suicide risk identification factors and in the management of suicidal clients.
 4. Informs the task force of the current ASAP training requirements of the command and estimates the impact of their requirements on the quality of life within the area served by the task force.
 - (c) Chaplain—
 1. Serves as a member of the SPTF.
 2. Advises commanders on moral and ethical issues and other stress factors that may result in an increased risk.
 3. Assures that all chaplains within the command are trained to identify individuals who may be at increased risk of suicide and make appropriate referrals. This training will be conducted with the assistance of local mental health officers.
 4. Provides the training expertise to assist the command in the education–awareness training process. Unit chaplains provide and assist unit level suicide prevention training for leaders, supervisors, Soldiers, and DA civilian employees. Chaplains advise and assist other staff members and task force members in satisfying identified training needs.
 - (d) The Director of Health Services—
 1. Serves as a member of the SPTF.
 2. Assesses and advises the installation commander on stress factors that may result in increased numbers of persons at risk.
 3. Provide mental health officers to train other trainers in the education—awareness program.
 - (e) The Division Surgeon—
 1. Serves as a member of the SPTF.

2. Assures that division health care providers are trained in crisis intervention techniques using periodic in-service education.
 3. Serves as liaison with the Medical Department Activity (MEDDAC) Mental Health Service and the Division Mental Service.
 4. Coordinates training activities with the chaplains.
- (f) The Army Community Service Officer—
1. Serves as a member of the SPTF.
 2. Serves as the staff officer responsible for the Family Member Suicide Prevention Program.
 3. Continues operation of advocacy and out-reach programs dealing in areas of stress and Family violence.
 4. Through the SPTF informs the PAO, heightens public awareness of the support and helping mechanisms available within the community.
 5. Conducts appropriate in-service training of ACS staff members including volunteers who routinely assist Soldiers, DA civilian employees, and Family members who might be at risk of suicide.
 6. Emphasizes support agencies and programs during Family member orientations and other appropriate briefings.
 7. Serves as the specific task force participant responsible for coordinating with civilian support agencies.
- (g) The PAO—
1. Serves as member of the SPTF.
 2. Coordinates the community awareness needs of the task force.
- (h) The PM—
1. Serves as a member of the SPTF.
 2. Ensures military police forces respond to potential suicide situations discretely and cautiously to avoid increasing stress for the personnel in suicidal crisis (that is, normally the use of emergency equipment (lights or sirens) would be inappropriate).
 3. Provides feedback information to the task force, as appropriate, on any suicide related events that may have occurred on post.
 4. Reinforces instruction presented at the U.S. Army Military Police School concerning identification of persons at risk for suicide, and emphasizes that actions taken by military police in the line of duty may cause some people to be at increased risk of suicide. An example might be a teenager who has been arrested for shoplifting and is greatly embarrassed about their behavior. Awareness training, using the assistance and advice of chaplains and mental health professionals, may be conducted at in-service training and professional development classes.
- (i) Commander or special agent-in-charge of the supporting USACIDC element—
1. Serves as a member of the SPTF.
 2. Investigates all suicides or suspected suicides (see AR 195-2).
 3. Establishes liaison with local Civilian law enforcement agencies, coroners and medical examiners, as appropriate, to obtain information regarding suicide related events involving military personnel, their Families, or DA civilian employees, which may have occurred off-post, and provide such information to the task force. Such liaison activity will be in compliance with applicable statutes of the local Civilian community.
 4. As allowed by appropriate regulations, provides the task force extracts from the CID reports of investigation (including psychological autopsy), which may be useful in understanding the reasons for a suicide and in formulating future prevention plans.
- (j) The SJA—
1. Serves as a member of the SPTF.
 2. Provides suicide prevention awareness training for personnel assigned to the Office of the Staff Judge Advocate and Trial Defense Service with the advice and assistance of chaplains and behavioral health professionals. In the course of performing their duties, Trial Defense Service and legal assistance personnel may be providing assistance to Soldiers, Family Members, and, in limited circumstances, civilian employees, who are in crisis, not only from administrative and legal actions, but also from other causes. Such crises may cause them to be at increased risk of suicide. As such, Trial Defense Service and legal assistance will remain vigilant and take the necessary steps to help ensure that their clients receive appropriate assistance, if any of the known suicide risk factors become apparent; however, at all times they must ensure client confidentiality.
- (k) The Director, Human Resources—
1. Serves as a member of the SPTF.
 2. Assures that local programs take into consideration the needs of the DA civilian work force.
 3. Is responsible for coordinating the training for DA civilian managers and supervisors.
- (l) The Director, DFMWR—
1. Serves as a member of the SPTF.
 2. Serves as the point of contact for program information and advice to the commander and to major subordinate commands.

3. Integrates suicide prevention into community, Family and Soldier support programs, as appropriate.

(m) The Director, DPT—

1. Serves as a member of the SPTF.

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

3. Develops schedules for all training and operational requirements.

c. Risk Management Team (RMT) formerly called the Suicide Risk Management Team (SRMT). Army divisions and other large activities with adequate support should consider establishing a RMT in accordance with AR 600–63. This is an optional element of the ASPP. The team is charged with the responsibility of addressing the medical and administrative needs presented by high risk cases. The RMT will not become involved in rescue or emergency lifesaving operations with respect to suicide attempts. It is the role of the RMT to address those problems and issues that precipitated the suicide attempt and to deal expeditiously with them.

d. The Suicide Response Team (SRT), at the discretion of the commander the SRT will convene within 48 hours of an attempted or completed suicide to support the command and installation effected. As an adjunct to the CHPC, its function is to assist the commander in assessing the situation, determining appropriate courses of action, directing immediate interagency and inter staff actions, and advising the commander. See AR 600–63 for specific information regarding team intervention and composition.

e. The Division/Command Surgeon or Director of Psychological Health—

(1) Assumes primary responsibility as the SRT coordinator.

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

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

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

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

(6) Provides for collection, evaluation, and dissemination of all data pertaining to attempted suicides or suicide related behavior. Family members of the deceased have privacy rights that are protected under the Privacy Act. Any decision to release information must adhere to these rights and must protect the military interest.

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

f. The Division Psychiatrist—

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

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

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

(4) Provides battalion and separate company commander's information about Soldiers who may be at increased risk of suicide, when it is necessary for the commander to take action to protect a Soldier or civilian.

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

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

g. The chaplain representative—

(1) Is available with the division/command surgeon during a suicide crisis upon request.

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

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

(4) Assists the surgeon in providing training to Soldiers in stress management, suicide prevention, and Family advocacy issues.

h. The DCS G–1/Adjutant General Corps (AG) personnel representative—

(1) Is available during a suicide crisis when requested by the surgeon.

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

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

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

i. The Provost Marshal Representative—

(1) Is available during a suicide crisis when requested by the surgeon.

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

(3) Provides for immediate protection and well being of Soldiers, Family members, or DA civilians at high risk for suicide until unit or medical personnel are on the scene.

j. Representatives of the adjutant general, staff judge advocate, ADCO, and an ACS Officer—

(1) Is available during a suicide crisis when requested by the surgeon.

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

k. The HQDA Suicide Specialized Augmentation Response Team (SSART)—

(1) The SSART which will be a trained and quick response force ready to respond to pockets of increased suicide-related events in all components. This team will include, at a minimum, a behavioral health professional, chaplain, and command personnel.

(2) In the event that several suicides occur on an installation, the SSART is designed to support commanders during suicide outbreaks to help them address unfamiliar epidemiologic concerns.

2-12. Other programs, entities, resources, and personnel

a. Risk Reduction Program.

(1) The Risk Reduction Program (RRP), established by the Army Center for Substance Abuse Programs, is a tool to help commanders reduce high-risk behavior in their Soldiers. It has evolved into an efficient way of assisting commanders in ascertaining and addressing high-risk behavioral problems. Using the RRP, commanders can call upon installation resources for support in reducing or preventing high-risk behaviors from impacting mission readiness. It promotes a prevention-focused approach when dealing with suicidal and/or high-risk behaviors and promotes focused, coordinated actions on the part of the installation agencies and the chain of command in units with potentially high-risk profiles. The ADCO serves as the local proponent for the RRP.

(2) Commanders determine interventions after quarterly consultations using their own chain of command and available installation expertise, including the Installation Prevention Team (IPT) to solve issues. The Risk Reduction Program Coordinator (RRPC) facilitates development and delivery of risk reduction products from installation activities for mission commanders.

b. Installation Prevention Team.

(1) The IPT is composed of many representatives from the installation human services agencies such as the ASAP, Family Advocacy Program (FAP), Army Community Service (ACS), preventive medicine, chaplain, and the SJA. The focus of the IPT is to review and analyze the installation's risk reduction unit data and, in collaboration with commanders, develop prevention strategies and interventions to address high risk factors affecting units. IPT members will also collaborate to develop and implement Installation Prevention Plan's (IPP). See AR 600-85 for specific details regarding the IPT.

(2) The RRPC interfaces directly with risk managers of installation units and activities as the facilitator of the IPT in order to oversee data collection, processing, and analysis to produce tailored, timely, and accurate risk assessments and recommend courses of action for mitigation efforts. The RRPC provides an outreach consultation capability that works directly with commanders requiring assistance in develop unit-specific risk management plans.

(3) The two prominent tools of the RRP are the unit risk inventory (URI)/re-integration unit risk inventory (R-URI). These command climate surveys help commanders determine the actual occurrences of high-risk behaviors, not just report incidences, because Soldiers complete the surveys anonymously. Combined with data on actual occurrences of high-risk behaviors and the expertise of the IPT, these surveys help installation health care providers target appropriate intervention strategies where they are needed most. Commanders will coordinate with the installation ASAP to administer the URI to all deploying Soldiers at least 90 days before an operational deployment and the R-URI to redeploying Soldiers between 90 and 180 days of their return from deployment. Commanders may coordinate with the installation ASAP to administer the URI to their units at any time; however, incoming commanders should consider this a necessary action during their change of command. See AR 600-85 for more information regarding URI and R-URI dissemination.

c. Case Review Committee. The Case Review Committee (CRC) is a multidisciplinary team supervised by the MTF commander. The CRC, through Social Work Services, assesses reports of spouse and child abuse, recommends treatment plans and ensures that each case receives a determination of substantiated or unsubstantiated. The purpose of the CRC is to coordinate medical, legal, law enforcement, and social work assessment, identification, command intervention, investigation, and treatment functions from the initial report of spouse or child abuse to case closure. A

treatment team may handle both spouse and child abuse, or separate teams may be organized to handle each type of abuse. The CRC is not a public meeting, and membership is limited to those individuals identified in AR 608–18, paragraph 2–3b. Members must have supervisory or functional responsibility for prevention, identification, reporting, investigation, diagnosis, and treatment of spouse and child abuse.

d. Fatality Review Board. In the event of a suicide, review the results of the psychological autopsy (as applicable) to look for the possible causes of the suicide and, if necessary, evaluate prevention efforts and make recommendations to the commander. The Fatality Review Board (FRB) meets regularly to review all known or suspected domestic violence or child abuse related homicides and suicides to include all infant and child deaths in which the manner of death is undetermined at autopsy involving any of the following: a member of the Army on active duty; a current or former dependent of a member of the Army on active duty; or a current or former intimate partner who has a child in common or has shared a common domicile with a member of the Army on active duty. The review should take place after related law enforcement investigations, autopsies, and court trials have ended. The review process is not a public meeting and the attendance is limited to the members of the FRB and consultants, as appropriate. At a minimum, the FRB should be comprised of the following members within the chain of command of the Soldier involved—

- (1) Brigade Command Sergeant Major.
- (2) Battalion Command Sergeant Major.
- (3) Company First Sergeant.
- (4) Platoon Sergeant.
- (5) Immediate supervisor of the Soldier involved.
- (6) Brigade safety advisor, if assigned/detailed.
- (7) Senior enlisted Soldiers from staff offices, as requested.

2–13. Reporting

All committees, teams, and councils report information and data trends to the Community Health Promotion Council on a quarterly basis.

Chapter 3 Prevention

3–1. Suicide prevention

Suicide prevention is a continuum of awareness, intervention, and postvention to help save lives. Prevention refers to all efforts that build resilience, reduce stigma, and build awareness of suicide and related behaviors. Ultimately, the goal of prevention is to develop healthy, resilient Soldiers to the state that suicide is not an option. Prevention focuses on reducing life stressors and intervening when life crises become so overwhelming that suicide becomes a serious consideration. It is important to establish a culture that reinforces help-seeking behavior as an appropriate and generally accepted part of being responsible. Training can be provided to improve intervention skills, increase knowledge and build confidence in Soldiers to respond appropriately to a suicidal threat. Specific training modules are to be developed for military medics and medical personnel focusing on the review of clinical protocols for responding to crisis situations involving Service members who may be at high risk for suicide, and clinical tracking requirements and protocols for those known to be at increased risk of suicide.

3–2. Factors contributing to suicide

Individuals may have difficulty coping with intense feelings or emotions and consider taking drastic measures to deal with the emotional pain. Strategies to address suicide should include both the mitigation of these intense emotions and the circumstances which lead to them. Most suicides and suicide attempts are reactions to one or more of the following intense feelings:

a. Loneliness is an emotional state in which a person experiences powerful feelings of emptiness and spiritual isolation. Loneliness often stems from feeling disconnected from other people. Loneliness is a feeling of being cut off, disconnected from the world, and alienated from other people. Strengthening one's spiritual fitness and building connections with other people is the key to helping individuals withstand grief and loss. This connection allows individuals to rebound from severe disappointments of life.

b. Worthlessness is an emotional state in which an individual lacks any feelings of being valued by others.

c. Hopelessness is a strong sense of futility, due to the belief that the future holds no escape from current negative circumstances. The intensity of this emotion is fed by the belief that no resources exist to bring relief or change the current perception of reality.

d. Helplessness is a condition or event where the Soldier thinks that they have no control over their situation and whatever they do is futile, such as repeated failures, to include failed relationships, and so on.

e. Guilt is a primary emotion experienced by individuals who feel a strong sense of shame associated with actions they believe are wrong (that is, Uniform Code of Military Justice (UCMJ)).

3–3. Life skills and resiliency

a. Resiliency-building programs help Soldiers and Families develop life skills and directly impact the success of suicide prevention efforts by enhancing protective factors and mitigating stressors at the earliest stages. Life skills classes are available on a wide variety of subjects to include couples communication, child rearing, money management, stress management, conflict resolution, anger management, and problem solving. Commanders at all levels are encouraged to work with ACS and local agencies to make these classes available to Soldiers and Families.

b. Resiliency is the ability to recover and adapt despite adversity, trauma, illness, changes or misfortunes. Resiliency means “bouncing back” from difficult situations. Soldier resiliency is a combination of factors including a sense of belonging in the unit, having inner strength to face adversity and fears, connecting with buddies, maintaining caring and supportive relationships within and outside the Family, maintaining a positive view of self, having confidence in strengths and abilities to function as a Soldier, and managing strong feelings and impulses.

c. The following are some adaptive behaviors, thoughts, and actions that can mitigate the negative effects of trauma, adversity, and emotional stress:

- (1) Attend life skills or related training.
- (2) Seek out a mentor in which to confide.
- (3) Actively and frequently participate in unit activities.
- (4) Join social support groups, faith-based organizations and self-help groups.
- (5) Recognize, accept, and face fears.
- (6) Nurture good relationships with family and close friends which may include counseling.
- (7) Learn to regulate your emotions and avoid impulsive behavior.
- (8) Maintain realistic optimism. Believe in your ability to survive and function as a good Soldier.
- (9) Recognize that no one has the resources to manage all personal problems alone. Practice help seeking behavior as a sign of strength.
- (10) Commit to practices that maintain good physical and behavioral health.
- (11) Avoid isolation when faced with stressors.
- (12) Develop and maintain spiritual fitness.

d. Programs and services which support resiliency but do not directly fall under suicide prevention are quite varied. Some of these programs are as follows:

- (1) Yellow Ribbon Program/Deployment Cycle Support.
- (2) Family Program and Family Assistance Centers.
- (3) Prevention Relationship Enhancement Program (PREP) for couples and singles.
- (4) Army Emergency Relief Fund.
- (5) Army Substance Abuse Program.
- (6) Warrior Transition Units.
- (7) Employer support of the Guard and Reserve.
- (8) Life skills training.
- (9) CoPeer to Peer programs.
- (10) Comprehensive Soldier Fitness (CSF).

3–4. Stigma reduction

One of the greatest barriers to preventing suicides is a culture that shames Soldiers into believing it is not safe to seek help. Stigma can render suicide prevention efforts ineffective unless elements are incorporated into the program to counter these destructive attitudes.

a. Individuals may not seek help because they believe that their problems or behavioral health issues should remain a secret. Reasons for this may include shame and embarrassment, fear that their careers are affected, concern that personal issues are exposed, belief that seeking help is a sign of weakness, and a feeling of helplessness and hopelessness.

b. Keeping personal problems or behavioral health issues a secret can result in the development of depression and anxiety, compounded stressors, degraded ability to think clearly, difficulty making decisions, thoughts of suicide, suicidal attempts, and completed suicides.

c. The stigma associated with receiving behavioral health care takes on an added significance in the Army. In addition to worrying about their careers and suffering embarrassment, Soldiers have the concern that their commander will discover that they are seeking treatment. Commanders have a legitimate “need to know” about the mental and physical capabilities of their Soldiers in order to safely and efficiently carry out their mission. However, Soldiers may feel they cannot acknowledge the need for help without negatively impacting their careers. To combat the belief that

seeking help is a sign of weakness, commanders are encouraged to reinforce the personal courage it takes to seek mental health help.

d. We must all reduce actual and perceived stigma of seeking help. Stigma is a cultural issue that will take a deliberate and focused effort to combat. The key to stigma reduction is leadership emphasis at all levels. Leaders can accomplish this by:

- (1) Eliminating policies that discriminate against Soldiers who receive mental health counseling.
- (2) Supporting confidentiality between the Soldier and his/her mental health care provider.
- (3) Reviewing policies and procedures that could preclude Soldiers from receiving all necessary and available assistance.
- (4) Educating all Soldiers, Family members, and DA civilians about anxiety, stress, depression, Post Traumatic Stress Disorder (PTSD), and treatment.
- (5) Increasing behavioral health visibility and presence in Soldier areas.
- (6) Encouraging help from mental health providers that precludes treatment, similar to critical incident stress debriefings.
- (7) Reinforce the “power” of the buddy system as a support system in times of crisis.
- (8) Educate leaders regarding AR 600–63, paragraph 1–24(e) prohibits Soldiers from belittling other Soldiers for seeking behavioral health care.
- (9) Normalize healthy help-seeking behavior through an aggressive strategic communications plan.

3–5. Awareness

a. An essential foundation to the suicide prevention program is communicating key suicide prevention messages to Soldiers, Leaders, DA civilians, and Families. As a result, the following goals may be achieved:

- (1) The subject of suicide is normalized. Soldiers and Families need to feel comfortable discussing suicide and asking those who are contemplating suicide the tough questions. Individuals need to be aware that they are not alone and do not need to suffer in isolation and silence.
- (2) The seriousness of the problem is highlighted, with specific emphasis on consequences and long-lasting effects of suicide on the Family members and loved ones who are directly affected.
- (3) Stigma is reduced and help-seeking behavior is encouraged.
- (4) Warning signs and symptoms are recognized. Individuals struggling with thoughts of suicide may be identified.
- (5) The ACE model is used to intervene with someone who may be at risk of suicide.
- (6) Soldiers are encouraged to take responsibility for their buddy. The “battle buddy” system is reinforced as a way to emphasize Army Values at the personal level.
- (7) Soldiers, Families, and DA civilians are informed of helping resources available to them.
- (8) Training opportunities and events are announced and individuals participate in local community activities.
- (9) Soldier and leader responsibilities for suicide prevention in the Army are emphasized.
- (10) Involvement in resiliency building activities is encouraged to promote well being for the whole Soldier – physical, mental and spiritual wellbeing.

b. Awareness communication can take many forms. A large selection of materials is available through the United States Army Center for Health Promotion and Preventative Medicine (USACHPPM) and the Suicide Prevention Resource Center (SPRC).

(1) Commanders at all levels may wish to produce their own materials, especially for inclusion in unit newsletters or newspapers. It is important to coordinate with subject matter experts, public affairs offices and local community health services for accuracy and appropriateness of content of the information in unit newsletters. Media items may be published prior to periods or events that are likely to produce a higher than normal incident of suicide (for example, the summer moving months of July and August have a higher incidence of suicide).

(2) Printed media may include posters, brochures, tip cards, command newsletters/newspapers, and magazines. Briefings, trainings, stand downs, chain teachings, and command messages given during formations are great ways for leaders to communicate key suicide prevention messages. Other methods include static displays, films, day/week/month observances, media events, opportunities to participate in local events, and strategic communication plans.

(3) The Army routinely observes Suicide Prevention Week in conjunction with the National Suicide Prevention Week, and the World Suicide Prevention Day. The Army usually observes Suicide Prevention Month in the same month in which the national observance falls (September). This ensures that all Soldiers are able to participate throughout the Army Force Generation (ARFORGEN) cycle.

3–6. Strategic Communication Plan

A Strategic Communication Plan is designed to increase awareness regarding programs, training, and resources available to assist in suicide prevention. Every effort must be made to decrease the stigma associated with seeking behavioral health treatment, thereby reducing suicides and suicidal behaviors. The SPTF should work with the local

public affairs office to develop and distribute a yearly strategic communication plan which includes the following elements:

a. A standardized marketing program that creates awareness of the existence, nature and availability of all Army health promotion, risk reduction and suicide prevention products, and services. This includes standardized delivery of resultant communications and metrics to measure awareness of products and services by Soldiers and their Families.

b. A cohesive, coordinated effort to build and maintain a continuum of awareness at the local level, in conjunction with prescribed training and awareness that should be updated on at least an annual basis and at a minimum will include the following points:

- (1) Purpose/issue.
- (2) Public/command information (theme).
- (3) Engagement strategy.
- (4) Strategic context.
- (5) Overarching theme/overarching messages.
- (6) Key talking points.
- (7) Desired effects.

c. The use of public service-type announcements/commercials using leaders and/or celebrities with a message encouraging help seeking behaviors and suicide intervention practices.

d. Publication and promotion of existing military and civilian crisis hot line numbers in local media and resource materials.

e. Publication and internet availability of articles on stress, depression, Family violence and abuse, substance abuse, and the identification of agencies that can help.

f. Publication and dissemination of a list of online resources for information and support.

g. Tailored community awareness activities that have been evaluated by the SPTF.

h. Annual Army-wide guidance and recommended activities for observance of Suicide Prevention Week for Active Component (AC); and Month for Reserve Component (RC).

i. Formally scheduled, regular health promotion, risk reduction, and suicide prevention observances/activities.

j. Clear and consistent key messages that include the following:

- (1) Suicide prevention is critical in the Army.
- (2) Suicide prevention is about Soldiers taking care of Soldiers. In the Army, we always take care of our battle buddies.
- (3) Taking care of our own is part of our culture and ethos.
- (4) Everyone in the Army Family needs to be involved in suicide prevention.
- (5) We are committed to decreasing stigma, improving access to care, and incorporating suicide prevention training into all training programs.
- (6) World class training and resources are available to assist Soldiers, Families, and Army DA civilians.
- (7) The loss of a Soldier's life is a tragedy regardless of the reason.
- (8) The goal is to provide Soldiers and their Families the best available support to overcome stressors.

3-7. Intervention

a. Intervention attempts to prevent a life crisis or mental disorder from leading to suicidal behavior, and includes managing suicidal thoughts that may arise. At its most basic level, intervention may simply include listening, showing empathy, and escorting a person to a helping agency. This is something that can be done by any Soldier, Family member, or DA civilian with minimal training at the unit level. Army approved training for this level includes CHPPM's suicide prevention training programs for Soldiers, leaders, Families, and DA civilians.

b. Intervention may also include the use of more advanced skills by trained personnel who are capable of providing a greater level of crisis intervention, screening, care, and referral. Junior leaders may receive training in peer-to-peer intervention that will give added skills, knowledge, and confidence to intervene in a crisis. This training can take many forms from specified suicide intervention training to broader crisis intervention training. The approved Army program for Peer Suicide Intervention Training is the 3 hour ACE Peer Suicide Intervention Training developed by CHPPM. An even greater level of intervention is provided by formally trained gatekeepers. Primary gatekeepers can be chaplains, Family Advocacy Program workers, and medical providers whose primary duties involve assisting people who are more susceptible to suicidal ideation. Secondary gatekeepers are personnel who by the nature of their job may come in contact with a person at risk. These can include Military Police, Inspectors General, Red Cross staff members, and first line supervisors. Applied Suicide Intervention Skills Training is the Army-approved training for gatekeepers.

c. The loss of a family member, especially the loss of a child due to suicide, is perhaps the most difficult form of death for survivors to accept. On top of their grief over the death of a loved one, families of suicide victims often experience shame, humiliation, and embarrassment. Other common reactions are fear, denial, anger, and guilt, all of which combine to produce one of the most difficult crisis a family will ever experience. At these times the complete

resources of the military community must be mobilized to assist the family. The ASPP will make explicit provisions for assisting families who have experienced such a loss to the extent permitted by applicable laws and regulations.

(1) *Risk factors and warning signs.* Individuals who are frequently in close contact with others are often in the best position to identify persons at risk if they know the risk factors and warning signs. Individuals can include leaders, Family members, buddies, close friends, and coworkers. Recognizing risk factors and warning signs are a common part of awareness and intervention training.

(a) Certain factors increase one's risk for suicide. Some risk factors include the following:

1. Failed intimate relationship or relationship strain.
2. Previous suicide attempts.
3. Family history of suicide, suicide attempts, depression, or other psychiatric illness.
4. Depression and/or history of PTSD or other mental illness.
5. Significant loss (death of loved one, loss due to natural disasters, and so on).
6. Poor social skills to include difficulty interacting with others (social isolation).
7. Drug or alcohol abuse.
8. Violence in the home or social environment.
9. Access to means of suicide (particularly, handguns in the home).
10. Current/pending disciplinary or legal actions (Article 15, UCMJ).
11. Serious medical problems or physical illness.
12. Work related problems.
13. Excessive debt.
14. Severe, prolonged, and/or perceived unmanageable stress.

(b) *Suicide can be prevented.* While some suicides occur without any obvious warning, most individuals who are suicidal do give warning signs. Warning signs of suicide include the following:

1. Noticeable changes in eating/sleeping habits and personal hygiene.
2. Talking/hinting about suicide, expressing a strong wish to die, or a desire to kill someone else.
3. Obsession with death (for example: in music, poetry, artwork).
4. Change in mood (for example: depression, irritability, rage, anger).
5. Isolation and withdrawal from social situations. Increased alcohol and/or drug use or abuse.
6. Giving away possessions or disregard for what happens to possessions/suddenly making a will.
7. Feeling sad, depressed, hopeless, anxious, psychic pain or inner tension.
8. Finalizing personal affairs.
9. Themes of death in letters and notes.
10. Problems with girlfriend/boyfriend or spouse.
11. Soldier experiencing financial problems or in trouble for misconduct (Article 15, UCMJ, and so on.)
12. Sudden or impulsive purchase of a firearm or obtaining other means of killing oneself such as poisons, medications.

(2) Widespread promotion of suicide prevention and general crisis hotlines provide a confidential means for Soldiers, Families, and DA civilians to reach out for help in a non-threatening way. Military One Source (1-800-342-9647) is a general crisis intervention with professional health providers with Master's degrees. There is also an option that is sponsored by the Veterans Administration (VA) for callers to talk directly with a veteran's representative if that is their preference. Needs text.

d. Screening is an important part of prevention and intervention. Since areas such as sexual assault, substance abuse, domestic violence, depression, and PTSD are significant contributors to suicidal ideation, collaboration with subject matter experts in these fields is crucial, especially when screening Soldiers. Screening can be done in person, online or made available as a self assessment. These can be used to target specific populations who may be at higher risk due to recent crisis events or as a matter of routine before, during, and after times of expected higher stress. It is important that all screening includes referral to appropriate resources and, where possible, a tracking mechanism for follow up of high risk individuals.

(1) The PDHA is normally completed at the demobilization station, not to exceed 30 days after re-deployment. The PDHRA is completed 90-180 days after that, during the 3- to 6-month time period after return from deployment, ideally at the three to four month mark. The reassessment is scheduled for completion before the end of 180 days after return so that Reserve Component members have the option of treatment using their TRICARE health benefit. These are completed and involve a face to face session with referrals where necessary. Leaders should support Soldiers and DA civilians by providing encouragement to follow through with referrals, coordinating transportation, and time off during the duty day, and helping identify appropriate resources.

(2) Assessments for people entering programs such as Substance Abuse Counseling, Child and Family Services, Domestic Violence, Sexual Assault, Social Work Services, and behavioral health should include questions to help assess for risk of suicide.

(3) Self screening is available through various sites on the internet to help assess for depression, bi-polar disorder, anxiety disorders, post traumatic stress, suicide, and other issues. This information is available at <http://mental-healthscreening.org/military> is a site sponsored by the Department of Defense through the Mental Health Self Assessment Program (MHSAP). Most sites provide recommendations and referral, and some will even connect at-risk individuals directly with helping professionals.

e. The ACE is the Army approved model for peer intervention and provides an easy to remember acronym that any Soldier, Leader, Family member, or DA civilian can use. Training in the use of ACE is available through the many products produced by the CHPPM. These include Suicide Prevention for Soldiers, Leaders, Families, DA civilians, and the ACE Peer Intervention Training. Other products reinforce the use of ACE to include Beyond the Front interactive video simulation and the Shoulder to Shoulder video.

(1) *Ask.*

(a) Take threats seriously. Trust your suspicions as some warning signs may be subtle. Do not ignore cries for help.

(b) Confront the problem directly. Ask the question and stay calm, for example, “Are you thinking of killing yourself?” “Do you want to die?” “Do you wish you were dead?” “Have you thought of how you would kill yourself?”

(c) Talk openly about suicide. Don’t be afraid to discuss suicide with the person. Be willing to listen and allow the person to express feelings. Don’t make moral judgments, act shocked, or make light of the situation. Don’t try to minimize the problem. Trying to convince a person it’s not that bad or they have everything to live for may only increase their feeling of guilt and hopelessness.

(2) *Care.*

(a) Care for the person. They may be in pain. Persons who attempt suicide most often feel alone, worthless, and unloved. You can help by letting them know that they are not alone, that you are always there for them to talk to. By assuring the person that help is available, you are throwing them a lifeline.

(b) Remove any means that could be used for self-injury.

(c) Active listening may produce relief.

(d) Calmly control the situation; do not use force.

(e) Encourage the person to seek help voluntarily. Do not force the person.

(f) Reassure the person that help is available, depression is treatable, and that suicidal feelings are normally temporary.

(3) *Escort.*

(a) Never leave the person alone.

(b) Escort the person to an emergency room, chain of command, chaplain, behavioral health professional, or primary care provider.

(c) Emergency rooms and urgent care rooms are the primary 24-hour crisis intervention facilities on most Army installations and in most communities.

(d) Sometimes it is necessary to refer directly to the person’s primary care manager to get a referral to a behavioral health provider.

(e) Never try to force someone to get help. Law enforcement and medical personnel should be summoned to the scene if the individual declines assistance.

f. Standardized qualification of suicide prevention trainers—

(1) ACE Certification—

(a) The ACE trainer is certified to instruct the Army Suicide Intervention Program and to provide ACE suicide intervention as needed. The ACE Warrior is certified to provide suicide intervention as needed.

(b) UASCHPPM Mobil Training Team is available to train installation UMTs in the ACE (Train the Trainer Model). This training certifies the UMT to train trainers who in turn train Soldiers, DA civilians, and Family Members in ACE suicide intervention.

(2) Standardized qualifications for other suicide intervention skills training will be provided by the DCS, G-1, as required.

g. The unit watch program is designed to complement the guidance established in DODD 6490.1 and DODI 6490.4 The unit watch program must ensure—

(1) Positive control of the Soldier, especially during periods of transition from unit events to other appointments.

(2) Soldiers under watch are escorted at all times, and not left alone or unsupervised.

(3) Those entrusted to conduct unit watch are thoroughly briefed on the importance of being with the Soldier at all times.

(4) While in unit watch status, the Soldier receives close follow up by behavioral health.

(5) That no unnecessary measures are enacted which bring undue attention, shame, or humiliation upon the Soldier.

h. Special considerations.

(1) Soldiers pending UCMJ action. Commanders, military law enforcement and Judge Advocates should develop

procedures to mitigate risk factors during investigations, adjudication, and other adverse actions. Soldiers pending UCMJ become high risk and they should be supported during and after proceedings.

(2) An encounter with a suicidal person can be a deeply emotional experience, especially when someone is not trained to provide assistance or has limited experience with people in crisis. In these situations, it is important to process the experience with someone trained and knowledgeable.

(3) Although a person may think he/she wants to die, he/she has an innate will to live, and is more likely hoping to be rescued. Probing for ambivalence can be an effective way to break through the desire to die and convince someone to voluntarily get help.

(4) Care should be taken when referring both active duty and non-active duty Soldiers to civilian resources. This could set them up for increased financial stress due to medical bills they may not have resources to cover. Never assume that the Army will pay without confirming it through the Soldiers chain of command beforehand.

(5) Leaders play an important role in ensuring the crisis has been mitigated and that conditions which produced the current crisis have been addressed. Healthcare providers may provide treatment to reduce ideation and behavior, but it is the leaders on the ground that are in a position to work with the Soldier to resolve situational issues and develop strategies to prevent them from developing to crisis level again. Leaders must be careful to not presume a threat has passed simply because there are no immediate concerns.

(6) Use of social networking technologies are popular means used today to communicate important personal information. Although these sites are not normally authorized access for government computers, when available they can be great resources for information on the well being of our Soldiers. Leaders can stay tuned to the personal lives of Soldiers and their Families, to include identifying warning signs that someone may be in crisis. Leveraging these types of generational communication may help to accelerate identification and response time to prevent suicide.

3–8. Ask, care, escort certification

a. The ACE trainer is certified to instruct the Army Suicide Intervention Program and to provide ACE suicide intervention as needed. The ACE Warrior is certified to provide suicide intervention, as needed.

b. The USACHPPM Mobil Training Team is available to train installation UMTs in the ACE (Train the Trainer Model). This training certifies the UMT to train trainers who in turn train Soldiers, DA civilians, and Family members in ACE suicide intervention.

c. Standardized qualifications for other suicide intervention skills training will be provided by the DCS, G–1, as required.

Chapter 4 Postvention

4–1. General

Postvention consists of a sequence of planned support and interventions carried out with survivors in the aftermath of a completed suicide or suicide attempt. Postvention is prevention for survivors. The goal of suicide postvention is to support those affected by a suicide or attempt, promote healthy recovery, reduce the possibility of suicide contagion, strengthen unit cohesion, and promote continued mission readiness.

a. When implementing a Postvention program, commanders will do the following:

(1) Provide long term support to Families, unit members, and co-workers who experience loss due to suicide. Care can be provided via external services and outreach programs including civilian services for grief and recovery (that is, Department of Veterans Affairs Bereavement Counseling, Tragedy Assistance Program for Survivors (TAPS), Survivor Outreach Services (SOS)).

(2) Participate with the Casualty Assistance Officer to meet and talk with the immediate Family.

(3) Request support of the SRT to assist in coordinating and leveraging support and services (See chap 2, for specific roles and responsibilities of the SRT).

b. Postvention activities include unit-level interventions following an attempted or completed suicidal in order to minimize psychological reactions to the event, prevent or minimize the potential for copy cat suicides, strengthen unit cohesion, and promote continued mission readiness. Postvention activities may include the following:

(1) Provide care for a Soldier who has expressed suicidal ideation or has attempted suicide. Commanders should ensure that Soldiers receive help navigating the health care/behavioral health care system to receive appropriate care. Consider the following resources when assisting Soldiers: The Veteran’s Administration, Military OneSource, chaplains, crisis hotline contact numbers, behavioral health staff members, Army Substance Abuse Program staff members.

(2) Provide care to the Family of those individuals who have attempted or completed suicide. Ensure Family members stay connected to a support system. Department of Veterans Affairs Bereavement Counseling is now being offered to parents, spouses, and children of Armed Forces personnel who died in the service of their country. Also eligible are Family members of Reservists and National Guardsmen who die while on duty. The TAPS, <http://www.taps.va.gov>

taps.org/, is a nationwide support organization for anyone connected with the military that has experienced the loss of a loved one. The SOS is available for survivors of Soldiers who died during any National conflict, whether or not the death was combat-related.

(3) Provide care to the friends of someone who has attempted or completed suicide. The command must proactively address the situation and provide an outlet for those affected to express and process their emotions. Ensure each Soldier in the unit is notified of a death and given the information and command support to attend the funeral. Have a chaplain or behavioral health provider available to address the Soldiers as a group and be available to Soldiers who need to talk further. Specifically identify Soldiers who were close to the deceased and have an appropriate person in their chain of command offer support. In the aftermath of a suicide, promote the idea that the outcome of a crisis need not be suicide. There are other alternatives.

(4) Educate leaders on the importance of the buddy system.

(5) Honor the Soldier and support the disposition of remains. Funeral honors are an important part of the healing process for fellow Soldiers of the deceased and Family members.

(6) Collect and communicate suicide data for lessons learned, trend analysis, and to enhance quality of care.

4-2. Army suicide behavior surveillance

Army suicide behavior surveillance is a critical postvention activity which includes the collection of informational data about suicide behavior by all components. In conjunction with Office of the Deputy Chief of Staff, G-1, ASPP, the CHPPM will analyze informational data about suicide behavior in order to provide an ongoing statistical understanding about the problem, identify behavioral health trends, and formulate lessons learned. The DCS, G-1 ASPP will develop strategies to distribute lessons learned back down to commanders in a timely manner.

a. The DODSER will be completed for all fatalities, hospitalizations, and evacuations of Active Duty Soldiers where the injury or injurious intent is self-directed, in accordance with AR 600-63, paragraph 4-4. The DODSER (Army version formerly called the Army Suicide Event Report - (ASER)) was developed to examine the causes and circumstances of suicide behaviors among military personnel. The DODSER standardizes the data collected on all suicide events. It is an integral part of the Army's Suicide Prevention Program. The DODSER does not replace the psychological autopsy, which is used when the manner of death is uncertain. Each Medical Treatment Facility Commander will designate a behavioral health professional to complete the DODSER and submit to the following secure Web site: <https://abhto.amedd.army.mil/dodser>.

b. Psychological autopsies may be requested by the Armed Forces Medical Examiner (AFME) and/or the Criminal Investigation Command (CID) on Active Duty deaths under special circumstances, in accordance with AR 600-63, paragraph 4-4. Additionally, the senior commander may request a psychological autopsy through CID. The psychological autopsy is a forensic investigative tool that is used to confirm or refute the death of an individual by suicide. It is not to be confused with gathering of information for suicide event surveillance for epidemiological purposes. Specifically, psychological autopsies assist in ascertaining the manner of death; and will primarily be used to resolve cases where there is an equivocal cause of death; that is, death cannot be readily established as natural, accidental, a suicide, or a homicide. Some examples might include a single car motor accident or incidents involving unusual or suspicious circumstances, such as deaths due to substance abuse or resulting from apparently unintentional, self-inflicted gunshot wounds. Subjects for investigation include all Active Army Soldiers and any active member of other Armed Forces of the United States assigned or attached to an Army unit or installation. (See app B for an example of psychological autopsy questions/categories.)

c. For all completed and attempted suicides:

(1) Ensure the disclosure of medical information to non-medical entities conforms to confidentiality laws; and appropriate protocols for information sharing are followed. The type and amount of information disclosed is based on Health Insurance Portability and Accountability Act (HIPAA) confidentiality laws.

(2) Ensure appropriate protocols for information sharing are followed.

(3) Ensure the quality improvement/quality assessment program performs root cause analysis on all deaths that occur within 31 days of last scheduled medical appointment.

(4) Liaise with local law enforcement, coroners, and medical examiners to document the death determination and to collect epidemiological data regarding off-post suspected suicides of Reserve Component Soldiers.

(5) Ensure AR 15-6 investigations are completed on all suicides (AR 600-63, chap 1).

d. Other investigative information available as part of the postvention process includes—

(1) AR 15-6: Commands from all components will conduct an AR 15-6 investigation on every suicide or equivocal death which is being investigated as a possible suicide. Commands from all components will conduct an AR 15-6 investigation on every suicide or equivocal death which is being investigated as a possible suicide. (See AR 600-63, chap 1 for commander responsibilities.)

(2) The CID conducts investigations on Active Duty equivocal deaths to determine if criminal activity was involved. For non-active duty deaths, CID has limited legal authority to conduct investigations, but can leverage professional relationships to liaise with local authorities where appropriate under the guidelines of AR 195-2 to support local commanders in obtaining police reports, coroner's reports, and death certificates.

(3) The LODs are conducted on all deaths of Soldiers who at the time of death were on Active Duty, in an IDT status, or where the death is suspected to be connected to a previous duty incident. The LODs are conducted in accordance with AR 600–8–4. (See AR 600–63, para 4–4 and AR 600–8–24, para 4–13.)

Chapter 5

Geographically–Dispersed Soldiers

5–1. Geographically-dispersed Soldiers

Geographically-dispersed Soldiers and their Families have challenges to access services related to health promotion, risk reduction, and suicide prevention. Active Duty Soldiers and their Families who cannot easily access an installation are in danger of becoming isolated from critical support services normally available to them. Lack of entitlements for Army Reserve and Army National Guard Soldiers limit access to many services readily available to the active force. It is important for commands of geographically-dispersed Soldiers to implement strategies to leverage non-installation based services available at the national, State, and local levels to ensure Soldiers have appropriate support regardless of their location. Some of these resources are as follows:

a. TRICARE Remote. Soldiers on active duty orders for more than 30 days, and their Families, can utilize benefits at approved local clinics. Information can be found at <http://www.military.com/benefits/tricare/tricare-prime/tricare-prime-remote-overview>. Respective TRICARE representatives can clarify benefits and help locate appropriate services.

b. Memorandums of agreement. Many state and county mental health organizations can provide services to Soldiers and their Families free of charge or on a sliding fee scale through memorandum of agreement (MOAs) established with state JFHQs.

c. Military OneSource (MOS). Specifically geared to serve geographically dispersed Soldiers and Families, MOS at www.militaryonesource.com provides resources and support 24 hours a day, seven days a week, on a wide variety of subjects. Among available services are consultations on child care and relocation, translation services in more than 140 languages, up to 12 professional counseling sessions, educational materials and web based interactive media. Services are provided by the Department of Defense at no cost to all Service members, active duty, National Guard and Reserve, and their Families.

d. Family assistance centers. There are 325 family assistance centers (FACs) hosted by the National Guard and are strategically placed in local communities in every state for use by military members and their Families regardless of Service or component. Families can find the FAC closest to them by accessing www.myarmyonesource.com and clicking on “Family Programs and Services” (on the left side of the screen), then “Family Programs,” and then “Soldier Family Assistance Center.” In addition, Warrior Family Assistance Centers (WFAC) supports Army Reserve Soldiers and Families. Information can be obtained at www.arfp.org/wfac.

e. Several national non-profit organizations reach out to communities nationwide on behalf of Soldiers and their Families.

f. Online resources provide another avenue to reach geographically-dispersed Soldiers and their Families. Web-based services that support health promotion, risk reduction and suicide prevention are accessible from any geographical location with a web connection. A partial list of important Web sites is in appendix D of this DA Pam.

5–2. Case management for high-risk Soldiers

Case Management for high-risk Soldiers in the Reserve Components is available in many instances by the State Director of Psychological Health.

5–3. Collaboration

a. Active, Guard, and Reserve components should collaborate in order to take care of Soldiers and Families in geographically remote areas. Active Army recruiters may be located far from installation-based services and yet be within easy reach of services available to Reserve Component Soldiers. The opposite may also be true.

b. Just as the Army Reserve is regionally based and the National Guard is state based, so also are many of the community services that would benefit our Soldiers. The Reserve and the Guard should work together to leverage these resources. The ASCCs/ACOMs/DRUs will work to harness regionally based services that would be available to all components, and the state JFHQs can in return, do the same for state based services. Developing MOAs to expand availability of services across components will ensure maximum coverage for all Soldiers.

5–4. National, State, and local support

a. There are many national, State, and local services available for geographically dispersed Soldiers and their Families. The SPTFs should develop a well thought out and deliberate Strategic Communications Plan to communicate important suicide prevention messages and provide listings of available services and how to access them.

b. The geographically dispersed live outside of exposure to installation-based mass media campaigns. To effectively reach them, communication should be through means relevant to the location and situation of the target audience.

Communication channels may include e-mail, unit newsletters, mass mailings, Armory bulletin boards, command letters, organizational Web sites, and printed media.

c. A list of available prevention, intervention, and postvention resources can be found in appendix D of this DA Pam.

5-5. Suicide incident reporting

There are challenges in suicide incident reporting for geographically dispersed Soldiers, especially those in the Reserve Components. State and local ordinances vary regarding release of police reports, coroner's reports, and vital statistical records such as death certificates. These ordinances can be very restrictive and have the potential to limit the Army's ability to gather data and confirm means of death. Confusion on applying HIPAA and privacy laws also can restrict information gathering. Implementing the following strategies can help to alleviate some of these situations.

a. The SPTF should create memorandums of agreement with local authorities for sharing of documents and information when a Soldier dies.

b. Acquire death certificates from the military personnel office which processes Soldier Group Life Insurance (SGLI) claims for survivors.

c. Integrate a representative into suicide prevention and behavioral health councils to build and leverage professional contacts.

d. Initiate a relationship with the state coroner's office to solicit aid in acquiring documentation.

e. Solicit help from CID to liaison with local authorities to obtain documentation.

5-6. Suicide Prevention Month

a. The Army will observe suicide prevention month in September as an expansion to the designated National Suicide Prevention Month. This will allow leaders in all components to highlight suicide prevention and impact all Soldiers.

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

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

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

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

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

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

Table 5-1
Lethality of suicide behavior rating scale

Lethality: Absent

Rating: 0

Statement: Death is impossible result of the "suicidal behavior."

Lethality: Low

Rating: 1

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

Lethality: Low

Rating: 2

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

Lethality: Low

Rating: 3

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

Lethality: Medium

Rating: 4

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

Lethality: Medium

Rating: 5

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

Table 5–1
Lethality of suicide behavior rating scale—Continued

Makes communication (directly or indirectly).
Performs act in public where they are likely to be helped or discovered.

Lethality: High

Rating: 6

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

Makes no direct communication
Takes action in private

Lethality: High

Rating: 7

Statement: Death is the highly probable outcome. “Chance” intervention and/or unforeseen circumstances may save the victim. Two of the following conditions also exist.

No communication is made
Effort is put forth to obscure act from helper’s attention.
Precautions against being found are instituted.

Lethality: High

Rating: 8

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

Chapter 6

Deployment

6–1. Introduction

a. When Soldiers and DA civilians are deployed, it is vital that continental United States (CONUS)-based suicide prevention program efforts are continued so that complete coverage can be maintained from garrison to theater and back to garrison.

b. Deployment can cause unique stress for Soldiers and DA civilians and, therefore, requires due vigilance on the part of the command to ensure the health and safety of all assigned personnel. During challenging missions in austere environments, the state of mental health of the individual Soldier and DA civilian may unintentionally get overlooked. Considerable effort must be made to maintain care and treatment for Soldiers at risk.

6–2. Deployment cycle support

a. The deployment cycle support (DCS) requirements provided by DCS, G–1 mandate suicide prevention training for six of the seven stages of the deployment cycle. These include suicide prevention training for Soldiers, DA civilians, leaders (per DCS Directive 02-2007), and gatekeepers. Specific training to meet these requirements is identified at <http://www.armyG-1.army.mil/dcs/default.asp>. Commanders are encouraged to increase the number of Soldiers, leaders, and DA civilians trained in advanced intervention skills during the pre-deployment phase. This will provide the commander with expanded ability to monitor Soldiers and DA civilians before, during, and after periods of higher stress and exposure to combat-related events. It is especially useful during the deployment stage when units or individuals are away from CONUS, at Outside the Continental United States (OCONUS) installations, and in the designated Theater. Other applicable products are the 3-hour ACE (peer) Suicide Intervention Program and the Applied Suicide Intervention Skills Training (ASIST).

b. During deployment, one period of high susceptibility for suicide may be around mid-term leave, periods of rest and relaxation, or emergency leave. It is important that Soldiers and DA civilians are presented with suicide prevention training in anticipation of and upon return from these periods of down time. It would also be beneficial for leaders to interview Soldiers and DA civilians regarding expectations, problems back home, and any anticipated stressors they may face during this down time. This interview time could provide opportunities for intervention to support the Soldier

and DA civilian to mitigate risk. It will also help to highlight issues for the command to monitor upon the Soldier's return.

6-3. Family Support during the deployment cycle support process

a. Families are just as susceptible as Soldiers to higher levels of stress during deployment. Each phase of the cycle presents its own unique stressors. DCS is a comprehensive process that ensures that Soldiers, DA civilians, and their Families are better prepared and sustained throughout the deployment cycle. Services for DA civilians and Families are integrated in every stage of the process and they are highly encouraged to take advantage of available resources.

b. Operation READY Pre-Deployment Battle mind Training for Spouses, and an accompanying brochure are provided during the Train-Up/Preparation stages of the DCS. Also, Operation READY Post-Deployment Battle mind Training for Spouses, and Operation READY Reunion and Reintegration Training to Families of re-deploying Soldiers and DA civilians are provided during the re-deployment and post-deployment stages of the DCS.

c. Although there are no formal requirements to train Families in suicide prevention during the deployment cycle, it is important to equip them with skills to recognize the warning signs, seek help for themselves, and to intervene with a Family member. It can be beneficial to provide suicide prevention training to Families during times when they are anticipating the departure of the Soldier, during the long separation, and during the stressful time of reintegration. This training should address the needs of the spouse and children, if applicable (for married Soldiers) and parents, boyfriends, and girlfriends of single Soldier.

Chapter 7

Family Member Suicide Prevention

7-1. Introduction

Family member suicide prevention program is based on existing military and civilian Family and social service resources as well as new and innovative programs. Family members as defined by Defense Eligibility Enrollment Reporting System (DEERS) are entitled to and receive the same services and treatment as their military sponsor. Among these resources are chaplains and chaplain assistants, behavioral and mental health specialists, substance abuse counselors, social workers, and TRICARE services. Subject matter experts in various disciplines and organizations provide suicide prevention support. Family members may seek help independently or use their sponsor's chain of command to initiate their request for suicide prevention services and for assistance at any point during the period of need.

7-2. Education awareness services

Education awareness information and/or services are available from any of the following:

a. Military OneSource (MOS) – is the Defense Department's one-stop, web-based resource for service or Family members at www.militaryonesource.com. Military OneSource connects users around the world to service-specific support through a central portal available 24 hours a day. Military OneSource is an internet web-based service that includes up to 12 face-to-face, web-based or telephonic counseling sessions. Military OneSource consultants are professionally qualified with a minimum of a Master's degree in social work or a counseling discipline. Military One Source will provide referrals to professional civilian counselors for assistance in CONUS Alaska, Hawaii, Puerto Rico, and the U.S. Virgin Islands. Outside the continental United States, face-to-face counseling is provided via existing MTF services. Services are available on-demand in more than 100 languages.

b. Army OneSource (AOS) – can be reached through Military OneSource, or directly at www.armyonesource.com. It is a service designed to provide round-the-clock information and referrals to Soldiers and their immediate Families, as well as to deployed DA civilians and their Families. Through the website, AOS can provide information on the closest military resource for services regardless of your geographic location or Army Component. AOS ensures that a standard of baseline services are provided to all Soldiers and Family members wherever they are located. Information and services that are available to all Army Components include referral to counseling services, childcare referrals, financial assistance, and referral to TRICARE services.

c. The Army Community Service (ACS) FAP helps strengthen Family relationships through education and prevention tactics. The program is dedicated to enhancing individual coping skills and alleviating the underlying causes of unhealthy stress associated with Family violence. The FAP provides prevention education services to restore and maintain healthy relationships, while respecting customer confidentiality. The ACS will assist with referrals for additional support, as needed.

d. Other resources include military Family life consultants (MFLC) as clinical providers (section 7-3), Chaplains (section 7-4), the ASAP (AR 600-85), and local law enforcement authorities.

7-3. Family life support

Family support services and education can be accessed through the sponsor's chain of command or any of the following:

a. The MFLC Program:

(1) The MFLCs are licensed clinical providers who provide counseling services to address issues that occur across the military lifestyle and help Service members and their Families cope with normal reactions to the stressful/adverse situations created by deployments and reintegration. The MFLC program provides anonymous, confidential, situational, short-term, non-medical, problem-solving counseling to all Army Component members and their Families, to augment existing military support programs. Soldiers and Families are entitled to 12 face-to-face counseling sessions at no cost. The MFLCs are licensed clinicians with Masters Degrees or PhDs and at least 5 years experience in social work, counseling, or a related clinical discipline. Consultants are trained on military specific topics including a basic orientation to the deployment cycle, military culture, and the chain of command.

(2) The MFLCs assist Service Members and their Families with issues they may face through the cycle of deployment – from leaving their loved ones and possibly living and working in harm's way, to reintegrating with the community and Family. The MFLCs provide support for a range of issues including relationships, crisis intervention, stress management, grief, victim support services, psycho-education, occupational, and other individual and Family issues. Psycho-educational presentations on reunion/reintegration, stress/coping, grief/loss, and deployment are given to commands, Family Readiness Groups (FRGs), Soldier Readiness Processing and other requested locations. MFLC support is also provided through child, youth and school services.

(3) The MFLCs deliver counseling services in flexible formats to meet the diverse needs of the military community. Services can be delivered onsite, telephonically, or online. Mobile services are routinely delivered throughout the United States. Units that return from deployment may request MFLC through ACS.

b. Other Family support training includes the following:

- (1) Child development and parenting classes.
- (2) Communication skills workshops.
- (3) Assertiveness training.
- (4) Stress management training.
- (5) Financial management assistance.

7-4. Chaplain support

Religious support is available through any Army Chaplain. In addition to standard religious and pastoral services, chaplains also facilitate the Strong Bonds programs focused on developing and maintaining strong relationships.

a. Army Chaplains initiated Strong Bonds, a comprehensive relationship skills training program. Chaplains support the importance of Army Families and the effectiveness of their Soldiers and recognize that Soldiers with strong relationships make better Soldiers. Strong Bonds is a sharply focused prevention-oriented program available to Active Component, National Guard, Army Reserve Soldiers, and their Families. Strong Bonds has programs for single Soldiers, couples, and Families.

(1) Strong Bonds for single Soldiers focuses on the skills for building and maintaining great relationships.

(2) Strong Bonds for couples focuses on strengthening the marital bond, giving couples the tools and information they need for better communication, relationship building, and problem solving.

(3) Strong Bonds for Families gives both adults and their children the relationship bonding skills and information necessary to thrive during the transition of mobilization, deployments, and temporary duty.

(4) Strong Bonds for Deployment and Mobilization offers Reserve Component Soldiers, their spouses, and their children the skills necessary to reunite and bond upon returning home.

b. All Strong Bonds programs are led by chaplains in comfortable and relaxing retreat settings using relevant and meaningful practical exercises.

c. All Strong Bonds programs are led by chaplains in comfortable and relaxing retreat settings using relevant and meaningful practical exercises.

Chapter 8 Database/Information Sharing

8-1. Introduction

The Army routinely collects and analyzes suicide-related data on the risk factors surrounding suicidal behavior to inform the development and/or sustainment of effective strategies to reduce suicides and suicide attempts. It is important that commanders have access to this timely and accurate information in order to identify or mitigate emerging situations before they become critical. The information system regarding health promotion, risk reduction and suicide prevention is constantly changing and all agencies should take advantage of the latest technological solutions

for information transmission and dissemination, whenever possible. Responsible agents should ensure that information identified here is sent and received by the most expedient means possible (Directive Type Memorandum 07-015-USD (P&R) – “DOD Social Security (SSN) Reduction Plan”). The Suicide Comprehensive Database must follow applicable requirements under the Privacy Act to ensure an individual’s Personal Identifiable Information (PII) is protected (AR 600–63, para 1–24(s)). The DODSER Program Manager for the Army supports the Army enterprise by collecting a DODSER on every active duty suicide. The DODSER Program Manager will assist in the completion of an annual DODSER Report (AR 600–63, para 4–4). If a commander has any questions regarding who has a need to know, they should contact the servicing judge advocate before sharing any information (AR 600–63, para 1–24r).

8–2. Prevention

Soldier Risk Reduction Program Commanders should use the information and data in the Risk Reduction Program developed by the Army Center for Substance Abuse Programs. The Risk Reduction Program incorporates data from 21 high-risk factors and is provided to commanders on a quarterly basis. Commanders get a snapshot of the areas of risk in the battalion and can match that risk against total Army rates.

8–3. Intervention

a. Records sharing is one important key to intervention in the chain of events which may mitigate risk factors associated with suicide.

b. Continuity of Records – Soldiers enrolled in behavioral health will utilize and implement in- and out-processing procedures. If identified at risk during in and out processing, the installation or garrison normally refers the person at risk immediately and ensures the person at risk is escorted to the nearest medical for assessment. This information should only be shared with the respective behavioral health and/or substance abuse treatment facility. Soldiers being referred will NOT have their medical records accompany their DCS Checklist in any circumstance to prevent a HIPPA Act violation. This will ensure a verifiable exchange of information for individuals receiving care. Continuity of support services will occur through such exchange of information from the losing installation to the gaining installation. If Soldiers conduct a permanent change of station (PCS) while engaged in a treatment program, they will have their behavioral health and/or substance abuse treatment information transferred to the gaining treatment facility in accordance with AR 600–85, paragraph 14–3c(3)(b) and AR 40–66, paragraph 8–6a.

c. Accessions and Separations – To integrate Soldier medical processes [administrative separations, Military One Source, Medical Retention Board (MMRB), Medical Evaluation Board (MEB), Physical Evaluation Board (PEB), disciplinary actions, Warrior Transition Unit (WTU) referrals, and so on, appropriate administrators will integrate relevant information to commanders and “helping agencies” (for example, law enforcement, ACS, the Army Substance Abuse Program) who have a “need-to-know.” (AR 600–85, chap 14).

d. Substance Abuse – The Drug and Alcohol Management Information System (DAMIS) is used by The Army Center for Substance Abuse (ACSAP) and ASAP field sites to record all urinalysis, patient, and program management information concerning the ASAP. The database consolidates all of the Army’s drug and alcohol-related data. This system can be used to identify Soldiers with recent or prolonged histories of drug and alcohol abuse and failure to complete required treatment.

e. Law Enforcement – Centralized Operations Police Suite managed by the Military Police Corps and Automated Criminal Investigation and Criminal Intelligence (ACI2) contain records of on-going investigations. Soldier involvement in serious illegal situations such as Driving Under the Influence citations and courts-martial activity could be indicators of an impending crisis situation which might result in suicidal behavior. The ADCOs and other individuals who provide assistance play a role in the collection and reporting of data. The ADCO has access to information presented in COPS for purposes of situational awareness.

f. Family Advocacy Program – The Army Central Registry (ACR) is an Army-wide, centralized database containing a confidential index of substantiated victim-based reported spouse and child abuse cases. Such activities are highly correlated with suicidal behavior and merit close attention from a suicide prevention standpoint. To the extent permitted by applicable law, physician assistants, nurse practitioners, social workers, physicians, dentists, nurses, and law enforcement personnel may share relevant case records in order to mitigate high-risk behavior (AR 608–18, para 6-2). More information regarding the Army Family Advocacy Program is found in AR 608–18, chapter 5.

8–4. Postvention

a. Data from the investigations and information gathering system listed below will be collected and maintained by the CHPPM suicide analysis cell in conjunction with the DCS, G–1 ASPP (AR 600–63, para 4–4). The suicide analysis cell will vigilantly study the data for all components on a regular basis to provide a statistical understanding, identify trends and formulate lessons learned. The DCS, G–1 will develop strategies to distribute trends and lessons learned back down to commanders in a timely manner.

b. Postvention data gathering activities include—

(1) Psychological autopsies, as part of a forensic investigation.

(2) AR 15–6 investigations are required for any serious incident. AR 600–63 provides that commands from all

components will conduct an AR 15–6 investigation on every suicide or equivocal death which is being investigated as a possible suicide.

c. The LOD determinations are generally conducted whenever a Soldier acquires a disease, incurs a significant injury, or is injured under unusual circumstances.

8–5. Digital/electronic resources

For more information on suicide prevention, access the following Web sites:

- a.* CHPPM: chppm-www.apgea.army.mil/dhpw/readiness/suicide.aspx.
- b.* DCS, G–1 (HRC): www.armyG-1.army.mil/hr/suicide/default.asp.

Appendix A References

Section I Required Publications

AR 195-2

Criminal Investigations Activities (Cited in paras 2-9, 2-11, and 4-2.)

AR 600-63

Army Health Promotion Program (Cited in paras 2-3, 2-4, and 2-11.)

AR 600-85

The Army Substance Abuse Program (Cited in paras 2-12, 7-2, and 8-3.)

Section II Related Publications

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

AR 15-6

Procedures for Investigating Officers and Boards of Officers

AR 40-66

Medical Record Administration and Health Care Documentation

AR 350-1

Army Training and Leader Development

AR 600-8-1

Army Casualty Program

AR 600-8-4

Line of Duty Policy, Procedures, and Investigations

AR 608-1

Army Community Service Center

AR 608-18

The Army Family Advocacy Program

AR 930-4

Army Emergency Relief

DODD 6490.1

Mental Health Evaluations of Members of the Armed Forces (Available at <http://www.dtic/whs/army.mil>.)

DODI 5154.30

Armed Forces Institute of Pathology (Available at <http://www.dtic/whs/army.mil>.)

DODI 6490-4

Requirements for Mental Health Evaluations of Members of the Armed Forces (Available at <http://www.dtic/whs/army.mil>.)

FM 6-22.5

Combat and Operational Stress Control Manual for Leaders and Soldiers

UMCJ, Art. 15

Commanding Officer's Non-Judicial Punishment (Available at <http://www.au.af.mil/au/awc/awcgate/ucmj.htm>.)

Section III

Prescribed Forms

This section contains no entries.

Section IV

Referenced Forms

DD Form 2796

Post-Deployment Health Assessment (PDHA)

DD Form 2900

Post-Deployment Health Reassessment (PDHRA)

Appendix B

Psychological Autopsy

B–1. General

a. The psychological autopsy is a procedure for investigating a person's death by reconstructing what the person thought, felt, and did preceding their death. This reconstruction is based upon information gathered from personal documents, police reports, medical and coroner's records, and face-to-face interviews with families, friends, and others who had contact with the person before the death. The purpose of the psychological autopsy is to—

- (1) Resolve cases where there is an equivocal cause of death.
- (2) Provide the victim's commander with information about the death.
- (3) Enable the unit and the Army to develop future prevention programs and capture lessons learned so that Soldiers and Family members are better served.

b. The retrospective analysis of deaths serves to increase the accuracy of reports and will promote the epidemiological study of suicide in the military population. A review of the status of the victim with those who had a special relationship with them prior to the act (for example, supervisors, co-workers, physician, relatives, and friends) will provide a source of information for future prevention actions.

c. When results of the psychological autopsy are available, offices responsible for examining investigative findings, (for example, CID, CHPPM, ASPP, SPTF) determining trends, pulling data points, and capturing/distributing lessons learned will follow guidelines outlined in AR 600–63 to utilize the results of the psychological autopsy, to the fullest extent possible. When available include information from the DD1300, LOD, and AR 15–6.

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

e. At present there are at least two distinct questions that the psychological autopsy can help to answer—

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

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

B–2. Operational criteria for the classification of suicide

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

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

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

- (1) Explicit verbal or nonverbal expressions of intent to kill self.
- (2) Implicit or indirect evidence of intent to die such as the following:
 - (a) Preparations for death, inappropriate to or unexpected in the context of the decedent's life.

- (b) Expressions of farewell or desire to die, or acknowledgment of impending death.
- (c) Expressions of hopelessness.
- (d) Efforts to procure or learn about means of death or rehearse fatal behavior.
- (e) Precautions to avoid rescue.
- (f) Evidence that decedent recognized high potential lethality of means of death.
- (g) Previous suicide attempt.
- (h) Previous suicide threat.
- (i) Stressful events or significant losses (actual or threatened).
- (j) Serious depression or mental disorder.

B-3. Motivation for suicide

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

- (1) A wish to escape from mental or physical pain.
- (2) A fantasy of eternal rest or life with a loved one.
- (3) Anger, rage, revenge.
- (4) Guilt, shame, and atonement.
- (5) A wish to be rescued, reborn, start over.
- (6) A wish to make an important statement or communication.

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

B-4. Role of intent

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

- (1) The victim's intention was ambivalent, with coexisting wishes both to live and to die.
- (2) The self-destructive action itself was inconclusive.
- (3) Death followed the action after a considerable delay.

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

B-5. Classification of suicides by intent

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

- (1) First-degree suicide: deliberate, planned, premeditated, self-murder.
- (2) Second-degree suicide: impulsive, unplanned, under great provocation, or compromising circumstances.
- (3) Third-degree suicide: victim placed his or her life in jeopardy by voluntary self-injury, but we infer the intention to die was relatively low because the method of self-injury was relatively harmless, or because provisions for rescue were made. The victim was "unlucky" enough to die.

b. The following are 2 other categories of self-inflicted death that are not typically classified as suicide because the intention to die cannot be established.

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

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

B-6. Lethality

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

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

c. The lethality of the victim's behavior, whether or not it results in death, may be judged to be in one of four

classes: high, medium, low, or absent. This may be accomplished using the lethality Behavior Rating Scale of Suicide below. The numerical scale will be used to rate the lethality of the suicidal behavior of the victim. The lethality rating will be the number of the statement that best characterizes the suicidal act. Lethality will then be characterized as being high, medium, low, or absent.

d. The lethality rating derived from the scale below relates to the classification system based on degree of intention as follows:

- (1) A first-degree suicide would require a high lethality rating. There is no doubt as to the victim's intention to die.
- (2) A second-degree suicide may be either rated as high or medium in lethality. The victim knew that the suicidal behavior would likely result in death, however, the act was impulsive and unplanned.
- (3) A third-degree suicide would be rated as being either medium or low in lethality.
- (4) Suicidal behavior resulting in a sub-intentioned death would always be rated as low in lethality.
- (5) Where the capacity for intention is absent or where the victim played no role in effecting his or her own death, it may be said that lethality was absent in the victim's behavior.

Table B-1
Lethality of suicide behavior rating scale

Lethality: Absent

Rating: 0

Statement: Death is impossible result of the "suicidal behavior."

Lethality: Low

Rating: 1

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

Lethality: Low

Rating: 2

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

Lethality: Low

Rating: 3

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

Lethality: Medium

Rating: 4

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

Lethality: Medium

Rating: 5

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

Makes communication (directly or indirectly).

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

Lethality: High

Rating: 6

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

Makes no direct communication.

Takes action in private.

Lethality: High

Rating: 7

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

No communication is made.

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

Precautions against being found are instituted.

B-7. Death Investigation Team

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

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

B-8. Procedure for psychological autopsy

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

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

- (1) Life history.
- (2) Psychiatric-psychological data.
- (3) Clues to or communications of suicide intent.
- (4) Recent life events.
- (5) Miscellaneous data that may be relevant to the death, but not necessarily psychological in nature (for example, physical evidence from the scene of the death).

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

- (1) Inpatient and outpatient medical records.
- (2) Physical autopsy (necropsy) report including toxicology results.
- (3) Military police and Criminal Investigation Division investigation results.
- (4) Line of duty investigation report.
- (5) Any records existing in the Community Mental Health Service, hospital departments of psychiatry and social work, Army Substance Abuse Program, Army Family Advocacy Program, or other Army programs.

B-9. Psychological autopsy report

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

a. *Identifying information.* As a preliminary step in conducting a psychological autopsy, should review the following data:

- (1) Name.
- (2) Rank/Grade.
- (3) SSN.
- (4) Age/Date of Birth.
- (5) Sex.
- (6) Race.
- (7) Marital Status (married, single, divorced, widowed, separated).
- (8) Military Occupational Specialty.
- (9) Unit/Station.
- (10) Level of Education.
- (11) Home Address (where victim was living at time of death).

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

c. *Details of death.*

- (1) Date/Time (provide date and time of suicidal act and death if different).
- (2) Location (address and description, that is, friend's house, parents home, victim's off-post residence, motel, and so forth).
- (3) Method.
- (4) Details of discovery.
- (5) Provisions for rescue (describe).
- (6) Note (contents).

- (7) Communication of suicidal intent.
- (8) Acts of violence that accompanied the suicidal act.
- (9) Other details.

d. History of prior suicide attempts.

- (1) Dates and description of prior attempts and threats.
- (2) Provisions for rescue.
- (3) Circumstances surrounding suicide attempts.

e. Physical autopsy (necropsy) results.

- (1) Cause of death.
- (2) Blood alcohol and other toxicology results.
- (3) Describe any evidence of disease process.
- (4) List and explain significant abnormalities.

f. Personality and lifestyle.

- (1) Basic personality (relaxed, intense, jovial, gregarious, withdrawn, outgoing, morose, bitter, suspicious, angry, hostile, combative, mild-mannered, other).
- (2) Describe the victim's recent changes in mood or symptoms of mental illness.
- (3) Describe the victim's recent changes in behavior such as eating, sleeping, sexual patterns, drinking, driving, taking pills, social relationships or hobbies.
- (4) Stress reactions as follows:
 - (a) Describe the victim's normal reaction to stress.
 - (b) Describe the typical patterns of stress reactions.
 - (c) State recent losses, if any.
- (5) Interpersonal relationships as follows:
 - (a) Describe the victim's interpersonal relationships (few, casual, or intense).
 - (b) State recent uncharacteristic behavior of the victim such as withdrawal from friends, gambling, spending, promiscuity, and fights.
 - (c) Describe the victim's friendship group.
 - (d) Describe the manner in which their time was spent.

g. Marital/dyadic relationship history.

- (1) Marital status.
- (2) Category of dyad trouble.
- (3) Nature of dyad trouble.
- (4) Number and length of marriages.
- (5) Current living arrangements.
- (6) Number, age, and sex of children.
- (7) Where do children live?
- (8) Changes in relationship with spouse or children.
- (9) Threats of or actual divorce or separation.
- (10) Recent deaths in Family.
- (11) History of abusive behavior.
- (12) Overall quality of current relationship.
- (13) Dating history.

h. Family of origin history.

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

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

j. Past problems. Describe any trouble, pressures, tensions, or anticipated problems during the past year.

- (1) List and describe any observed or expressed symptoms of depression.
- (2) List and describe any observed immediate danger signals.

k. Work history.

- (1) State the victim's occupation.

- (2) State the victim's level of satisfaction from work (excellent, good, fair, or poor).
 - (3) State the victim's employment history (job loss, promotion, or retirement).
- l. Military history.*
- (1) Time in service.
 - (2) Time in grade.
 - (3) Months assigned to present unit.
 - (4) Date of last PCS.
 - (5) Date of pending PCS.
 - (6) Date of last DEROS.
 - (7) Awards.
 - (8) UCMJ actions (Article 15s, Courts-martial).
 - (9) Pending unfavorable personnel actions (Bars to reenlistment, weight control program, other).
- m. Medical history.*
- (1) Describe significant illnesses and treatment.
 - (2) Describe recent loss or change in health status.
 - (3) Describe any injuries, accidents, or hospitalizations.
 - (4) List current medications and history of compliance.
 - (5) HIV positive or not.
- n. Psychiatric history.*
- (1) Hospitalizations, psychotherapy, or other therapy.
 - (2) If so, when and for how long.
 - (3) Describe the diagnosis and nature of treatment.
 - (4) Describe victim's use of psychotropic medications or sleeping pills.
 - (5) State evidence of a personality disorder or difficulties.
- o. Alcohol history.*
- (1) Describe role of alcohol or drugs in the victim's overall life style and death.
 - (2) State the victim's usual alcohol consumption.
 - (3) Identify the victim's behavior changes when drinking and drunk.
 - (4) State the evidence of addiction to alcohol, and include the number and dates of detoxifications.
 - (5) State when and where the victim was enrolled in the Army Substance Abuse Program.
- p. Drug abuse history.*
- (1) Identify drugs the victim used, if any.
 - (2) State if the victim was addicted to drugs.
 - (3) State the number and dates of detoxifications.
- q. Financial status.* Describe the victim's financial situation (recent losses, business successes or failures).
- r. Legal history.*
- (1) Describe the victim's legal actions, if any.
 - (2) State the victim's criminal record (number and length of jail or prison terms, nature of the offenses).
 - (3) State if the victim was absent without leave (AWOL) or a deserter at the time of the suicide. Provide dates of AWOL or desertion.
 - (4) State if the victim had been accused of sexual misconduct or other sexual deviations.
- s. Recent agency contacts.* List and describe all contacts with any of the following agencies during the past year.
- (1) Behavioral Health.
 - (2) Chaplain.
 - (3) Physician.
 - (4) Legal Assistance (to the extent no privileged information is involved).
 - (5) Army Emergency Relief (AER).
 - (6) Army Community Services.(ACS) .
 - (7) Family Advocacy Program (FAP).
 - (8) Army Substance Abuse Program (ASAP).
 - (9) Civilian agencies.
- t. Indications of increased suicide risk.*
- (1) List and describe any observed or expressed symptoms of depression.
 - (2) List and describe any observed immediate danger signals. Describe the response of the observer to the danger signals
- u. Duty performance, if any.*

- (1) Work or assignment related problems.
- (2) Problems in accepting Army life.
- (3) Recent changes in duty performance.
- (4) Accidents.
- (5) Problems with personal hygiene/appearance.
- (6) Problems with being late or missing work.
- (7) Problems with the quality of work.
- (8) Relationship problems with supervisors, peers, and/or subordinates.
- (9) State the victim's display of emotional state as seen by others in the work environment.

v. Deployment history.

- (1) Did the victim have orders to deploy?
- (2) Did the victim refuse to deploy?
- (3) Was the suicide event related to a deployment (past or present)?
- (4) If deployed when suicide occurred, describe the deployment at time of death.
- (5) Start date of deployment, length of deployment and location.
- (6) Provide a history of deployments prior to the time of death.

w. Specific issues relating to deployment and combat.

- (1) Did the victim experience direct combat operations?
- (2) Did the victim and his/her unit engage in battle resulting in casualties or wounded?
- (3) Did the victim become wounded or injured in combat?
- (4) Did the victim personally witness a unit member, ally, enemy, or civilian being seriously wounded or killed in combat?
- (5) Did the victim see the bodies of dead Soldiers or civilians following the battle?
- (6) Did the victim kill others in combat?

x. Assessment of intention.

- (1) State the role of the victim in their own demise.
- (2) Determine the rating of lethality (see table 5-1 for lethality of Suicide Attempt Rating Scale.)
- (3) State if the victim reasonably expected and wished to die as a result of their suicidal behavior.

y. Summary and conclusions.

- (1) State whether in the opinion of the investigator or death investigation team, this death was a suicide.
- (2) Estimate the victim's subjective state at the time of suicide.
- (3) If this death was a suicide, determine classification (first, second, or third-degree suicide, sub-intentioned death).
- (4) State the most probable reasons for the victim's decision to commit suicide (factors immediately contributing to the suicidal behavior, precipitating events).
- (5) State if the victim's commander supervisor or the medical system identified a problem before the suicide took place.
- (6) State if the suicide was—
 - (a) A bad outcome following reasonable command attention and medical care.
 - (b) The product of a system failure or inadequate medical care.
- (7) State what actions, if any, could have been taken by those who had a special relationship with the victim (supervisors, co-workers, physician, Family, and friends) that would have led to the anticipation and prevention of this suicide? State what could have been done to lower the risk of suicide in this case?
- (8) Provide comments, special features, lessons learned, and usefulness, and relevance of available suicide prevention training materials in this case.

B-10. Special considerations

For each method of suicide explore the following:

a. Gun shot.

- (1) The victim's knowledge, experience, and training with firearms.
- (2) The victim's history of handling weapons recklessly or cautiously.
- (3) The victim's prior firearms accidents.
- (4) The victim's recent purchase of a firearm.
- (5) Describe whether victim used military/duty weapon or own personal weapon.

b. Overdose.

- (1) State the victim's knowledge of drugs and their potential dangers (prescribed or street drugs and the amount).
- (2) Were there premature refill requests?
- (3) Was the victim ever seen under the influence of drugs?

- (4) What was their behavior under the influence of drugs?
- (5) Was there a history of prior overdoses and how were they treated?
- (6) Was the victim careless in the use of medications, taking more than prescribed?
- (7) How did the victim keep track of pill intake?
- (8) What were other sources of pills?

c. Hangings or asphyxia.

- (1) Explore for sexual involvement.
- (2) How was the victim clothed?
- (3) When found, state if pornographic material or sexual paraphernalia was nearby.
- (4) State the victim's known sexual activity (deviance, reading material, interests, knowledge of asphyxia techniques and experience with rope).

d. Jumping, drowning, vehicular death, drowning, fire, other method.

- (1) State the reason for the victim to be at the place of death.
- (2) With respect to the specific method, state their habitual behavior.

Table B-2
Commander 34, Line suicide reporting format

Line 1:	Name: (self-explanatory)
Line 2:	Rank: (self-explanatory)
Line 3:	MOS: (self-explanatory).
Line 4:	Time in Service: (self-explanatory).
Line 5:	Age: (self-explanatory).
Line 6:	Education: (GED, High School).
Line 7:	Marital/Significant Other Relationship and Status: (Status means the current condition of the relationship, for example, healthy and supportive or estranged. The purpose of this data point is to identify the relationship as a positive or negative force on the person).
Line 8:	Family Members relationships (mother/father, sister/brother) and Status: (Status means the current condition of the relationship (for example, healthy and supportive or estranged. The purpose of this data point is to identify the relationship as a positive or negative force on the person).
Line 9:	Living Arrangements: (Living with Friends, and so on).
Line 10:	Unit: (current unit of assignment) .
Line 11:	Date of last PCS: (self-explanatory).
Line 12:	Arrival Date to Current Unit: (self-explanatory).
Line 13:	Status of Unit at time of Incident: (Deployed or recently redeploy. The purpose of this data point is to identify where the unit is in the ARFORGEN cycle).
Line 14:	Deployment History: (# of deployments; date of last deployment).
Line 15:	Pending Deployment (date): (self-explanatory).
Line 16:	Recent Suicide Prevention Training: (name and date of training).
Line 17:	DTG Completed Suicide Stand-Down/Training (Beyond the Front, and so on): (self-explanatory).
Line 18:	DTG Completed Suicide Chain-Teach/Training: (self-explanatory).
Line 19:	DTG and location of incident (On/Off Post): (self-explanatory).
Line 20:	Details of Suspected Suicide Event: (synopsis of what happened; describes the investigation and what was found to support the manner of death.)
Line 21:	Drug or Alcohol Involvement: (explain the extent alcohol or drugs were involved in the event).
Line 22:	Evidence of prior planning of the suicide: (previous behavior that would lead one to believe that the person was planning the suicide, that is, purchasing/procuring a weapon, materials such as rope, duct tape, and so on).
Line 23:	Triggering Event: (an event that could cause an impulsive act such as an argument, a fight, a breakup of a significant relationship, filing for bankruptcy, and so on).
Line 24:	Pre-Death Signals/Indicators: (Suicide Notes, Suicide Threats, and so on).
Line 25:	Previous Gestures/Attempts: (self-explanatory).

Table B-2
Commander 34, Line suicide reporting format—Continued

Line 26:	Mental/Physical Health History: (prior incidents, injuries or hospitalizations for physical or mental disabilities which could contribute to a decision to commit suicide.)
Line 27:	Current medications and history of compliance: (any current medication that the Soldier is taking and whether or not he/she was complying with doctor's orders.)
Line 28:	Illegal Use of Drug/Addiction to Alcohol History: (any positive drug result or prior DUI; hospitalization or enrollment in an alcohol/drug treatment center.)
Line 29:	Adverse Actions/Pending Adverse Actions: (Article 15, demotion, court martial, negative counseling, and so on).
Line 30:	Financial Status: (good credit/standing, financial distress, bad check writing, filing for bankruptcy, credit debt counseling.)
Line 31:	Legal Issues: (anything other than what is reported in Line 26. These include issues such as: pending/final UCMJ or adverse administrative actions, lawsuits, restraining orders, etc - that could cause stress.)
Line 32:	Work-Related Issues: (problems at work with co-workers, lack of meeting suspenses, problems with boss/supervisor).
Line 33:	Lifestyle, Personality: (unusual sexual behavior; impulsive, high-risk behavior.)
Line 34:	Gun Ownership/Type: (self-explanatory).

Appendix C

Sample Commander's Policy Letter

A sample commander's policy letter is shown below in figure C-1.

Sample Commander's Policy Letter

OFFICE SYMBOL

DATE

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Command Policy Letter for Health Promotion, Risk Reduction, and Suicide Prevention

1. References:

2. The readiness of our Army is paramount in our ability to fight and win on the battlefield. Sustaining the health and wellbeing of our Soldiers, Family members and Army DA civilians is a preeminent responsibility of Army senior leaders and personnel at all levels. The Army's strategic approach to mitigating suicide and high-risk behavior helps build cohesive units. Promoting healthy lifestyles, reducing risk-seeking behavior and preventing suicide are priorities in this Command.

3. All commanders, leaders, supervisors, Soldiers, and Army DA civilians are responsible for creating an environment that reduces the stigma of seeking help for behavioral health issues. On a daily basis, it is incumbent on all of us to be aware of and recognize when someone may be at risk, and to be empowered to take appropriate action to save lives. Each of us is responsible for eliminating policies, procedures, and actions that inadvertently discriminate, punish, or discourage Soldiers or employees from seeking professional counseling.

4. To this end, ensure that no Soldier is belittled for requesting assistance from behavioral health professionals and social workers. Similarly, ensure civilian employees are encouraged to access help available for them. Leaders will utilize an extraordinary degree of discretion when identifying and sharing information regarding Soldiers and civilian personnel seeking help.

5. Each life lost to suicide is one life too many. Suicide prevention spans the gamut of effort from prevention to intervention to post-intervention. Each one of us has a personal role to play in preventing suicide. Task forces (such as the Community Health Promotion Council) and teams identify trends. Annual training and refresher training provide information for intervention. Response teams assist the commander in the event of a suicide.

6. There are numerous resources available for those in need of help. (List some of them here) From a fundamental perspective, the Army's "ACE"— Act, Care, Escort – initiative reflects this command's perspective on caring for the Army's most vital resource, our Soldiers.

7. POC for this action is Mr. John Doe at (444) 555-1212, FAX (444) 555-1213 or email: john.b.doe@us.army.mil.

//Signed//

JOHN Q. PUBLIC
RANK, XX
Commanding

Figure C-1. Sample commander's policy letter

Appendix D Resources

D-1. General

A list of resources available to Soldiers, Family members, and Army DA civilians.

D-2. List of resources

a. Insert Title. Substance Abuse and Mental Health Services Administration (SAMHSA) – www.samhsa.gov – helps leaders locate behavioral health resources in the communities in which Soldiers live. The state locator maps out resources by state and provides contact information.

b. Hotlines.

(1) Military OneSource (1-800-342-9647) is a source for a wide array of call-in services to include crisis intervention and domestic advice. The phone will always be answered by an individual who is a professional counselor with Master's Degree-level qualifications. In addition, the Web site is www.militaryonesource.com.

(2) The National Suicide Prevention Lifeline (1-800-273-TALK/8255) is sponsored by the Veterans Administration. Military callers have an option to speak with a Veterans representative or a crisis center in their local area. The Veterans representative has access to VA records and can work with the caller on VA registration and will ensure a warm hand-off to VA services.

(3) Wounded Soldier and Family Hotline (1-800-984-8523) is hosted by the Army National Guard and provides support to Soldiers and Families. During hurricanes, floods and other declared emergencies, services are expanded to become a 24 hour-a-day, 7 day-a-week resource.

(4) A comprehensive listing of hotlines by state can be found at www.suicide.org/suicide-hotlines.html;

(5) Army Reserve Warrior and Family Assistance Centers (WFAC) (1-866-436-6290) advocate for service members, retirees, and Family members from any branch of service. The WFAC augments chains of command by empowering and enhancing their forces. The WFAC connects partners to available benefits and entitlements. The Web site is www.arfp.org/wfac. Services are available 24 hours a day, 7 days a week.

(6) The Center for Health Promotion and Preventive Medicine (CHPPM) has presentations that include video interviews and vignettes. In addition, tip cards for enhancing resiliency and for identifying suicide risk factors accompany these presentations. The presentations can be found on CHPPM's Army Knowledge Online (AKO) suicide prevention Web site at <https://www.us.army.mil/suite/page/334798>.

Glossary

Section I Abbreviations

AC

Active Component

ACE

ask, care, escort

ACOM

Army Command

ACR

Army Central Registry

ACS

Army Community Services

ACSAP

Army Center for Substance Abuse

ADCO

Alcohol and Drug Control Officer

ADT

active duty for training

AER

Army Emergency Relief

AFME

Armed Forces Medical Examiner

AG

Adjutant General

AOS

Army OneSource

ASAP

Army Substance Abuse Program

ASCC

Army Service Component Command

ASER

Army Suicide Event Report

ASPP

Army Suicide Prevention Program

ASIST

Applied Suicide Intervention Skills Training

AWOL

absent without leave

CDS

Child Development Services

CHPC

Community Health Promotion Councils

CHPPM

Center for Health Promotion and Preventive Medicine

CID

Criminal Investigation Division

CMHS

Community Mental Health Service

CONUS

continental United States

CRC

Case Review Committee

CSF

comprehensive Soldier fitness

CSFP

Comprehensive Soldier Fitness Program

CYSS

Child Youth and School Services

DAMIS

Drug and Alcohol Information System

DCoE

Defense Center of Excellence

DCS

deployment cycle support

DCS, G-1

Deputy Chief of Staff, G-1

DEROS

Date Eligible for Return from Overseas

DHS

Director of Health Services

DMHO

Division Mental Health Officer

DMFWR

Director, Family, Morale and Welfare and Recreation

DODDs

Department of Defense Dependents Schools

DODSER

Department of Defense Suicide Event Report

DPT

Director of Plans and Training

DRU

Direct Reporting Unit

FAP

Family Advocacy Program

FAST

Family Advocacy Staff Training

FMSPP

Family Member Suicide Prevention Program

FRB

Fatality Review Board

FRG

Family Readiness Group

HCP

health care provider

HIPPA

Health Insurance Portability and Accountability Act

ICW

inConjunction with

IDT

inactive duty training

IPT

Installation Prevention Team

JFHQ

Joint Forces Headquarters

LOD

line of duty

MEB

medical evaluation board

MEDDAC

medical department activity

MFLC

military family life consultant

MHSAP

Mental Health Self Assessment Program

MMRB

MOS-Medical Retention Board

MOA

memorandum of agreement

MTF

medical treatment facility

MOS

military occupational specialty

NCO

noncommissioned officer

OCCS

operational criteria for the classification of suicide

OCONUS

outside continental United States

OPTEMPO

Operational Tempo

OSD

Office of the Secretary of Defense

OTSG

Office of the Surgeon General

PAO

public affairs officer

PCS

permanent change of station

PDHA

post deployment health assessment

PDHRA

post deployment health re-assessment

PM

Provost Marshal

PREP

Prevention Relationship Enhancement Program

PTSD

post traumatic stress disorder

RC

Reserve Component

RMT

Risk Management Team

ROI

report of investigation

RRP

Risk Reduction Program

RRPC

Risk Reduction Program Coordinator

R-URI

Re-integration Unit Risk Inventory

SJA

staff judge advocate

SPAN

Suicide Prevention Action Network

SPAP

Suicide Prevention Action Plan

SPPM

Suicide Prevention Program

SPRC

Suicide Prevention Resource Center

SPTF

Suicide Prevention Task Force

SRMT

Suicide Risk Management Team

SRT

Suicide Response Team

SSART

Suicide Specialized Augmentation Response Team

TAPS

Tragedy Assistance Program for Survivors

TRADOC

U.S. Army Training and Doctrine Command

UCMJ

Uniform Code of Military Justice

UMT

unit ministry team

URI

unit risk inventory

USACIDC

U.S. Army Criminal Investigation Command

USAR

U.S. Army Reserve

VA

veterans administration

WTU

Warrior Transition Unit

YA

youth activities

Section II

Terms

Behavioral Health Provider

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

Equivocal death

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

Gatekeepers

Individuals who, in the performance of their assigned duties and responsibilities, provide specific counseling to Soldiers and DA civilians in need are called gatekeepers. Gatekeepers will receive training in recognizing and helping individuals with suicide-related symptoms or issues. Gatekeepers can be identified either as “primary gatekeepers” (whose primary duties involve assisting those in need who are more susceptible to suicide ideation) or “secondary gatekeepers” (who may have a secondary opportunity to come in contact with a person at risk). See AR 600–63, table 4–1 for specific clarification of primary and secondary gatekeepers.

Geographically Dispersed

Organizations or individuals who are not centrally located on a post or installation are considered to be geographically dispersed. This primarily refers to Army Reserve and National Guard units and personnel whose cohesion is disrupted by distance, but also includes Active Army Soldiers who live and work more than 50 miles from an installation, such as Recruiters.

Intervention

Actions undertaken to prevent an individual experiencing a life crisis or a mental disorder from committing suicide. Examples include listening, showing empathy, and escorting a person to receive help.

Mode of death (also known as manner of death)

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

Postvention

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

Prevention

A continuum of awareness, intervention, and postvention. All efforts that surround building resiliency, reducing stigma, building awareness, and strategic communication.

Psychological autopsy

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

Self harm

A self-inflicted potentially injurious behavior for which there is evidence (either explicit or implicit) that the person did not intend to kill himself/herself (that is, had no intent to die). Persons engage in self harm behaviors when they wish to use the appearance of intending to kill themselves in order to attain some other end (for example, to seek help, punish others, to receive attention, or to regulate negative mood).

Social Networking

Web sites that build online communities of people who share interests or activities, or who are interested in exploring the interests and activities of others.

Suicide attempt

A self-inflicted potentially injurious behavior with a nonfatal outcome for which there is evidence (either explicit or

implicit) of intent to die. A suicide attempt may or may not result in injury. Therefore, this category includes behaviors where there is evidence that the individual intended to die, but the event resulted in no injuries.

Section III

Special Abbreviations and Terms

There are no special terms.

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