

Commanding Officer's Suicide Prevention and Response Toolbox:



How many Sailors does it take to save a life?

ACT

ASK - CARE - TREAT

ASK if someone is thinking about suicide.

Let them know you **CARE**.

Get them assistance (**TREATment**) as soon as possible.

Just One.

www.suicide.navy.mil

May 2011

Suicide Prevention is an All Hands Effort

GENERAL. Commanders play a crucial role in facilitating the local actions that build lives worth living, enhance resilience, enable access to support services, and divert people from a path to suicide. They also help those left behind to pick up and start to heal if the tragedy of suicide does strike.

This kit provides commanders a synopsis of Navy policy, guidance, and resources for preventing and responding to suicides and related behaviors. The first step is for Commanders to designate a Suicide Prevention Coordinator (SPC) and make sure that person gets training to assist in implementing these steps. Outlined below are the most important steps you can take to save lives. For more information, see **TAB A** and www.suicide.navy.mil:

- Program Overview
- Program Checklist
- OPNAVINST 1720.4A (**TAB J**)

STRENGTHEN YOUR FOUNDATION. A command environment of high morale and cohesiveness sets the stage for prevention. Pay attention to your sponsor and command indoctrination programs. Engage the immediate and extended family when a Sailor first checks aboard (welcome letter to family, phone call, ombudsman contact, indoc, etc.,). In practice, readiness and prevention activities tend to reduce or lead to early recognition of factors commonly associated with suicide. Your physical readiness program, alcohol de-glamorization efforts, command financial program, sexual assault prevention, family readiness, and career development board, along with many other readiness and prevention activities all work together to build resilience and reduce stress risk. Program managers should not be working in isolation. Team up with the chaplain and embedded medical professionals when available. Use Operational Stress Control (OSC) training and materials. See also www.navynavstress.com and the Navy and Marine Corps COSC Doctrine. For more information, see **TAB B:**

- Five Guiding Principles of Resilience
- Five Guiding Principles Check List
- OSC Program Overview

ENHANCE AWARENESS. Command members, both Sailors and civilians, must understand suicide risk factors, be able to recognize warning signs, understand ACT (Ask, Care, Treat) and know local support resources and how to contact them. Family members are more likely to notice a sign of concern and less likely to know what to do about it, so use ombudsmen and various family communications channels to share key information with families. Training, posters, brochures, PSA short videos, POD notes, and newsletter articles are all available to assist in awareness enhancement. Display posters so those in crisis see a help line resource readily available without having to ask. Ask your personnel to put the national lifeline number in their cell phones 1- 800-273-TALK (8255).

BUILD SKILLS. It's not enough to know what to do. We also must know how to do it. GMT materials and the emotionally powerful video, "Suicide Prevention: A Message from Survivors," are informative tools for training, but several additional options focus on building skills. The "Peer to Peer" training DVD asks Sailors to apply knowledge to a case scenario, discussion, and exercises (about 90 minutes "out of the box"). Front Line Supervisor Training uses the PRESS (Prepare, Recognize, Engage, Send, Sustain) approach with case discussion and role-play exercises for deck plate leaders (3-4 hours, SPC led). Operational Stress Control Leader one-day course provides all E7 and above with practical tools to build resilience and mitigate stressors. Applied Suicide Intervention Skills Training (ASIST) is a two-day Living Works course aimed at improving comfort and competence in helping to prevent the immediate risk of suicide. Some chaplains have received training to facilitate ASIST workshops. One note on timing – don't time training right after a suicide. For more information, see **TAB C:**

- Description of Training Options
- POD Notes

BE PREPARED. Develop and frequently update your command crisis response plan. It does not need to be a formal SOP; it can be a go-by in the duty office binder, but this plan should include basic safety precautions on person, environment, and transporting to evaluation for someone you deem to be in acute danger until mental health evaluation takes place. The plan should include key contact information and procedures to get emergency services to someone when information arrives via phone, third party, text message, etc., that a member is in crisis outside of command spaces. Prior preparation can save critical minutes to enable that last chance to save a life. Use drills to test your plans. Use a calendar reminder to update your plan and check your phone numbers and contact information. For more information, see **TAB D:**

- Guidance for Crisis Response Plans
- Distressed Caller Form
- Emergency Contact List

INTERVENE. Encourage early use of support resources (chaplains, FFSC, Military One Source) to address potential problems before thoughts of suicide even occur. Be familiar with the process for command-directed mental health evaluations. Risk of self-harm will almost always warrant an emergent mental health evaluation. Know how to contact mental health providers for consultation, document the consultation and make sure any emergent evaluation is followed up with the required paperwork. Always err on the side of life. Communicate with emergency responders and medical and mental health personnel. You can give them key information about observations and the patient's work environment that will be important to getting an accurate assessment and treatment plan. For more information, see **TAB E:**

- Command Directed Evaluation
- CDE References

REINTEGRATE. After a Sailor receives some type of treatment or intervention, getting reintegrated back into the unit or work place (or successfully transitioning to civilian life or another job field) will improve their long-term success in recovering and significantly increase your chances that other Sailors who need help will be willing to get it. There is no better way to send a positive message that seeking and receiving needed help is a good idea, and by seeing a shipmate succeed and be a respected contributor to the unit after getting some type of help. For more information, see **TAB F:**

- Four Key Processes for Leaders
- Recommended Actions
- Follow-up During Treatment
- Factors for Determination of Psychological Fitness

RESPOND. (After a suicide or attempt). Navy is generally good at getting Sailors with observed warning signs to assistance. We don't always get that chance because events develop too rapidly or Sailors manage to hide their pain too well. Commander's actions in the aftermath of a suicide are very important in preventing long-term problems or suicide in those left behind. About half of your crew has known someone who died by suicide. Suicide death will have an impact on those close to the person who died, those exposed to the death scene as well as people with prior grief issues. For more information, see **TAB G:**

- Suicide Within a Command / Unit
- Leaders Post Suicide Checklist
- Guidance for Actions Following an Attempt

REPORT. Reporting suicide related behaviors and suicides provides situational awareness and facilitates key support for family members. Messages and the DOD Suicide Event Report (DODSER) help us learn how successful intervention occurs and where program improvements can reduce future suicides. For more information, see **TAB H:**

- Reporting flow chart
- DODSER Step by step
- Sample SITREP
- Sample Casualty Report

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- Chain of events slide
- Recent demographics
- Data overview

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TAB A: SUICIDE PREVENTION PROGRAM OVERVIEW

OPNAVINST 1720.4A establishes Navy policies and procedures for the Suicide Prevention Program. Suicide and suicide related behaviors have a negative impact upon unit readiness, morale and mission effectiveness. The Suicide Prevention Program is designed to address and minimize suicide risk factors while strengthening associated protective factors.

Key elements to minimize risk for suicide include:

- **Training:** Increases awareness of suicide concerns, and ensures that personnel know how to intervene when someone needs help.
- **Intervention:** Ensures timely access to appropriate services and establishes a plan of action for crisis response.
- **Response:** Ensures appropriate resources are available to assist Sailors, families, and commands affected by suicide..
- **Reporting:** Timely reporting of incidents of suicide and suicide related behaviors is paramount in improving both individual command and the Navy wide suicide prevention program.

Key Actions for Success:

- Appoint a Command Suicide Prevention Coordinator (SPC) and ensure the SPC receives OPNAV approved training. The command SPC is responsible for maintaining a comprehensive and robust command level suicide prevention program.
- Ensure suicide prevention training is conducted and documented annually for all personnel (service member and civilian).
- Develop and maintain a written Crisis Response Plan to assist with identification of behavioral emergencies and facilitate appropriate referral for appropriate immediate assessment and treatment.
- Provide support for those individuals who seek assistance to deal with mental health issues to include treatment, follow up and reintegration.

Commanding Officer's Responsibilities:

- Appoint an SPC (prefer E7 and above) in writing (see below for specific duties).
- Written suicide prevention/ crisis intervention plans.
- Foster a command climate that supports and promotes psychological health.
- Encourage referrals early.
- Communicate with mental health providers as needed; reintegrating service member back into the unit.

- Have safety measures in place that include restricting access to means to inflict harm and seek emergent mental health evaluation.
- Provide command support in the event of a suicide or serious suicide related behavior to families/personnel.
- In event of suicide, complete the Department of Defense Suicide Event Report (DoDSER) within 60 days of notification of death.

Suicide Prevention Coordinator's Responsibilities:

- Receive SPC training as established by OPNAV N135 as soon as possible after designation.
- Schedule annual suicide prevention training and as needed, conduct training; may use local assets to facilitate training (chaplains, FFSC, medical).
- Maintain training records.
- Training will include: everyone's duty to obtain assistance for others in the event of suicidal threats or behaviors, recognition of specific risk factors for suicide, identification of signs and symptoms of mental health concerns and operational stress, protocols for responding to crisis situations for their specific command, and contact information for local support services.
- Have crisis response plan in place and updated.
- Make certain leadership messages and communications materials are available.
- Ensure reporting process is in place.
- Collaborate with SPC network.

Command Suicide Prevention Checklist:

- Each command and environment is unique, as will be each command's suicide prevention and crisis intervention plan, but the following sample checklist may help in establishing or assessing the state of a program.
- Has the Suicide Prevention Coordinator been designated in writing?
- Has the Suicide Prevention Coordinator received training?
- Does the Suicide Prevention Coordinator have contact with ISIC and Installation Suicide Prevention Coordinators?
- Has appropriate annual suicide prevention training been conducted for all Service members, including those in the Reserve, and for all Navy civilian employees and full time contractors?
- Is suicide prevention part of life-skills/health promotions training?
- Were messages of concern sent by the senior leadership team to provide current information and guidance to all personnel on suicide prevention?
- Is there a written suicide prevention and crisis intervention plan in place (e.g., standard operating procedures, duty office checklist)?
- Is local support resource contact information easily available? Examples:
 - Chaplain/Religious Services
 - Fleet and Family Support Center
 - Medical
 - Security
 - Local Emergency Room
- Do personnel and supervisors have ready access to information about how to get help with personal problems (e.g., wallet card info, posters, plan of the day, e-mails)?
- Are the procedures in place to facilitate personnel accessing needed services (e.g., time for appointments, access to transportation, overcoming logistical barriers, discouragement of stigmatizing)?
- Are supervisors active in identifying personnel potentially in need of support (e.g., relationship problems, financial problems, recent loss, legal problems or loss of status, change in behavior or performance, showing warning signs)?
- Is there a Safety Plan for dealing with high-risk Service members (e.g., suicidal/homicidal/bizarre thoughts and behaviors) until mental health services are available? In the absence of guidance from a mental health professional, recommend:
 - Removal of personal hazards (no weapons, belt, shoes, boot straps, draw strings, shirt stays, and personal hygiene items such as toothbrush or razor).
 - Removal of environmental hazards from room (room free of sheets, elastic bands, mirrors, pencils, pens, window dressings (such as blinds), shoelaces, strings, alcohol, weapons, medication, cleaning supplies, razors, metal eating utensils, telephones, tools, or any other rope, breakable, or sharp-edged object).
 - Line of sight supervision.
- Is mental health contact information readily available?
- Is there a follow-up plan for personnel after acute evaluation?
- Is there a reintegration plan for personnel after return from treatment?

TAB B: Five Guiding Principles for Resilience

Overview

Evidence from research and observations guide Navy Operational Stress Control Program development and will continue to guide refinements and improvements as the OSC program evolves. The evidence has provided some core considerations to use as guiding points to understanding resilience and implementing stress control. These core elements are:

- Predictability
- Controllability
- Relationships
- Trust
- Meaning

Predictability

A large body of research demonstrates that adverse stress outcomes (particularly health impacts) are less likely when a challenging event is predictable. We won't jump as high to a loud noise or wince at the sting of a vaccination when something let's us know its coming. Young children more easily leave the playground or go to bed if they have been given a "5 more minutes" warning. Realistic training and drills, consistent leadership, routines, and clear communication all contribute to predictability.

Controllability

No one can control every aspect of a challenging event; however, we know that having a sense of control generally leads to more positive results. A sense that we have some control over unfolding events comes from training and experience (such as knowing what to do to respond to a fire and having practiced it before). Often the event itself may not be in our control, but our response to the event to include problem solving actions or managing our own stress reactions (controlling breathing for example) can prove helpful. Another way to improve controllability, even when the event is beyond control, is offering choices (for example the child evacuating before a flood can choose which stuffed animal to bring or the Sailors who lose a shipmate can help choose how to do the memorial service).

Relationships

The underpinning of unit cohesion and morale, family wellbeing, and community is interpersonal relationships. With strong relationships, individuals and groups can thrive despite profound challenges. When important relationships fall apart, this can be very stressful and removes a portion of the foundation of resilience. For example, across the Department of Defense, relationship failure has been the most common stressor associated with suicide. Actions to foster, develop, preserve, and repair supportive relationships should always be a consideration in stress control.

Trust

Trust plays a critical role in withstanding adversity and extends beyond individual relationships. Trust provides a positive expectation from the organization and systems in which we operate and includes integrity, dependability, and competence on the part of leaders and larger organizations. Trust is built through experience and includes certain expectations (for example that the parachute will open, the equipment will function, medical services will be there in times of need, family will be faithful, etc.). Loss of trust will erode stress control efforts and increase risks of psychological. Presence of trust increases willingness to confide which better allows concerns to be recognized and addressed before stress injuries occur.

Meaning

People fare better when they know why they are doing what they do – why the mission is important, how their duties fit in to the picture, why their family makes certain sacrifices. A consistent aspect of recovery from traumatic events involves establishing meaning regarding the event and the changes in the person's life. Leader activities like after action reviews can help speed this process by planting the seeds of shared meaning after a challenge. In addition, having a greater sense of purpose before significant challenges or stressful events occur makes it much easier to perform and grow.

Five Guiding Principles Checklist

For every evolution, ask yourself the following questions:

- Does this action/evolution make future challenges more predictable (for Sailors / Crew / Family)?
- Does it communicate what to expect?
- Does it demonstrate what to expect?
- Does it allow practice of what to expect (drill / training)?
(Remember that consistency and following clear policies make situations more predictable.)
- Does this action / evolution give the Sailor / Crew / Family some control over the situation, their actions, or their reactions?
- Does it give some options or choices?
- Does it build skills that gives them confidence to respond to the challenge?
- Does it build skills that enable them to control their thoughts, attitudes, emotions, focus of attention, or physiology in the face of the challenge?
- Does it help them to recognize those aspects of the challenge (situation, action, reaction) that can be controlled and those that cannot?
- Does this action / evolution strengthen key relationships?
- Does it help build sense of belonging and cohesion in the group?
- Does it improve the crew's or family's ability to work as a team?
- Does it build skills to improve effective communication and conflict resolution?
- Does it enhance mutual understanding and appreciation of diverse contributors?
- Does this action / evolution build trust?
- Does it improve understanding between individuals?
- Does it demonstrate reliability (of the equipment, procedure, process) or effective use of contingency?
- Does it lead to a positive result (e.g. success or near success with clear pathway to future success) after experience slightly outside of usual "comfort zone"
- Does this action / evolution enhance meaning?
- Does it communicate the big picture mission and how the individual, crew, and family fits in or contributes to the big picture?
- Does it clearly demonstrate to the individuals the positive impact of their actions?
- Does it help understand the "why's" and construct a shared understanding? (before or after an event)

OPERATIONAL STRESS CONTROL

History: Operational Stress Control (OSC) Concept of Operations was established in November 2008 with the understanding that “helping sailors build resilience, and develop timely and appropriate responses to stress is critical to our operational readiness.” The Combat and Operational Stress Control Doctrine was released December 2010 (NTTP 1-15M). To meet that end the program fosters a culture of resiliency and mutual support that enables Sailors to perform and thrive. The Navy’s Operational Stress Control Program focuses on prevention - building psychological resilience. Resilience is defined as “the human capacity to prepare for, recover from, and adjust to life in the face of stress, adversity or trauma.” The Navy is committed to a culture that fosters individual, family and command resilience and well-being. Stress is a fact of life. Navy leaders have a responsibility to help Sailors cope with stress issues. By teaching Sailors to navigate stress, we are increasing mission effectiveness and force readiness. OSC is a leadership issue.

Important information is as follows:

Common Language: The first step in recognizing and addressing stress is having a common language. We’ve adopted the Stress Continuum, a model that recognizes that stress reactions occur across a continuum, or stress zones. The model uses four colors: Green, Yellow, Orange, and Red to help people understand the different stress zones:

- Green – Ready – not stress free but coping well
- Yellow – Reacting – normal responses to stressful situation but ones that can cause us some distress such as trouble sleeping or increased irritability
- Orange – Injured – when we need to admit that our stress may be more than we can handle alone ... when we need to seek help
- Red – Ill – when we can no longer manage well and medical attention is required

By making tools and training available, OSC aims to help leaders, Sailors and their families identify their own and other’s stress indicators and most importantly know what to do to return to the Ready “Green” Zone. (See Stress Continuum graphic)

Leadership: is essential for Operational Stress Control (OSC) success. OSC has developed five core leadership functions that, if given daily hands-on attention will demonstrate a leader’s commitment to making a difference in the lives of Sailors, their families and overall command health.

- Strengthen – Enhance and build resilience in individuals, units, and families.
- Mitigate – Mitigating stress is about balance: - Optimal mitigation of stress requires the balancing of priorities. On one side is the need to intentionally subject Sailors to stress in order to train and season them. On the other side ensure adequate sleep, rest, and restoration to allow recovery from stress

- Identify – Identify stress reactions or injuries early, before they become entrenched. Leaders must know the individuals in their commands and recognize when their confidence has been shaken. Most importantly, leaders need to know which stress zone their Sailors are in on a day-to-day basis.
- Treat – Ensure Sailors with a stress injury or illness get the help they need. Treatments options may include:
 - Activities that Sailors can do to navigate their stress and help a Shipmate.
 - Support from a leader, chaplain, counselor, or corpsman
 - Definitive medical or psychological treatment when a Sailor reaches the ill or injured stress zones.
- Reintegrate – Finally, Sailors that have received treatment for stress-related injuries or illnesses need to be effectively reintegrated back into their commands.

Key Actions for Success:

Provide OSC training and information at all levels so that leadership, Sailors, shipmates and families recognize both the positive and negative effects of stress. So far we have reached 208,000 people with instructor led and online courses designed specifically for petty officers, Chiefs, Division Officers and Department Heads, Senior Enlisted and Command Leadership.

Success –Indicators of achievement of OSC success:

- When Sailors, families, and leaders work together to help themselves and others to build resilience
- When Sailors use that resilience and strength to navigate through stressful times
- When they seek help for stress issues before they become stress problems
- When seeking help is considered sign of strength
- When Shipmates who have received assistance for stress issues are fully integrated back into their commands and communities.

Measuring Success - In June 2010 OSC sponsored a Behavioral Health Quick Poll (BHQP) that was conducted by the Navy Personnel Research, Studies, & Technology (NPRST). The survey revealed a seven percent increase of awareness of the Stress Continuum among enlisted Sailors, and an 11 percent increase among officers. Sailors are also showing more drive to use positive methods to cope with stress, such as thinking of a plan to solve problems or exercising or playing sports. Active leadership support of these positive stress navigation skills is paramount to continue this trend.

Tools and Resources:

OSC Tools include:

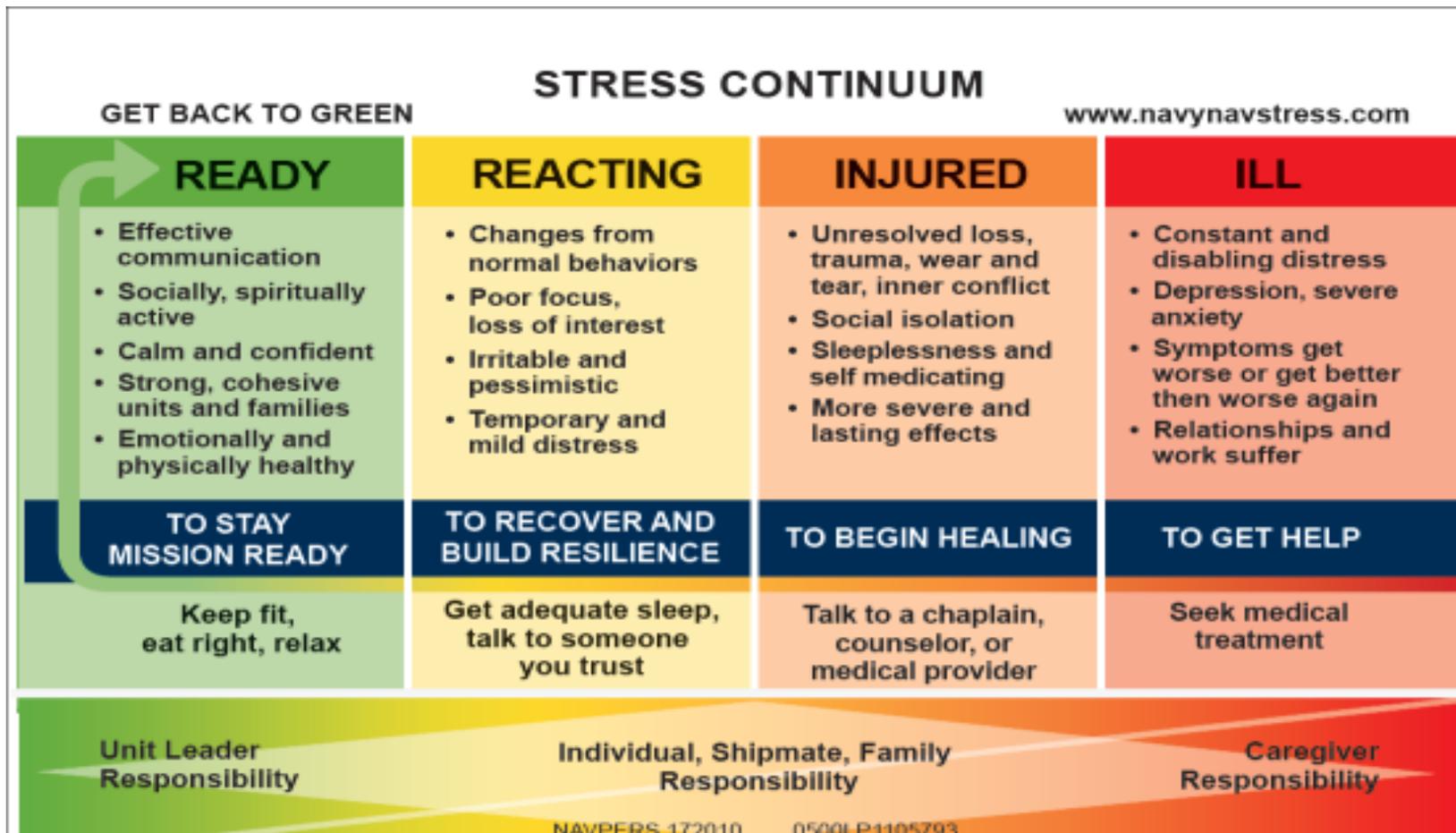
- **Command OSC Monitoring:** A practical tool that can help leaders monitor the operational stress status of every member of their command. In addition to monitoring where each individual is on the Stress Continuum, leaders can also assess the operational stress of their Division/Department or the Command as a whole. As important as it is to know an individual's stress level, it is more important for leaders to determine what they are doing to assist their Sailors in moving back to the Green Zone.
- **After Action Reviews (AARs):** After Action Reviews are not new; they have been around in the Navy in one form or another for years. AARs can be done after any major event or evolution, and with just minor changes in focus, the AAR can help the leader not only determine lessons learned but can also serve as a proactive way to assess where Sailors are at on the Stress Continuum. This is a time where the leader gets a chance to compare their Sailor's current status from previous baseline. The sooner changes in function or behavior are noticed, and help is applied, the less likely a stress reaction will develop into a more serious stress injury or illness. The AAR is also an opportunity for Sailors to gain confidence in the leader. This process fosters communication, builds unit cohesion and resilience

There are many resources available to aid leaders and Sailors in the management of operational stress. These include:

- Navy and Marine Corps Public Health Center (NEHC) Leader's Guide for Managing Personnel in Distress Web page <http://www.nmcphc.med.navy.mil/lguide/index.aspx>
- Military OneSource hot line 1-800-342-9647 and Web site www.militaryonesource.com.
- Navy Suicide Prevention Program web-site: www.suicide.navy.mil.
- Support personnel such as chaplains, medical personnel and mental health professionals can assist leaders in operational stress control functions.
- For more information about OSC and its related programs, visit <http://navynavstress.com/>

Visit OSC on Facebook at www.facebook.com/navstress or on Twitter at www.twitter.com/navstress.

Operational Stress Control Tools:



Command OSC Monitoring

Date:						
GROUP	Green	Yellow	Orange	Red	Leader's Comments	
Name	X					
	X					
	X					
	X					
	X					
	X					
	X				Worried about doing a good job, stresses over performance --good stress could lead to "overload"	
	X					
		X			Marriage Issues, placed on low stress jobs	
	X					
	X					
		X			Not talking about incidents, internalizing, less communicative	
	X					
	X					
			X		Irritable to hostile, does not work well with others (never has but more so now), counseled, referred to stress team	
	X					
				X	Unable to safely complete duties. Fixated on events of last deployment. Referred to mental health.	

TAB C: Training Resources

- GMT power point slide presentation (NKO) and instructor guide.
- Video: “Suicide Prevention: A Message from Survivors” augments facilitated training with powerful accounts from Sailors and family members who were impacted by a suicide loss or helped overcome a suicide crisis. Note: This is not a stand-alone training - a facilitator guide is provided for appropriate presentation.
- Peer to Peer Suicide Awareness and Prevention Training – a 90 minute training aimed at junior Sailors that applies information about risk and protective factors, warning signs, and ACT (Ask, Care, Treat) to a scenario and includes video clips, discussion and role play exercises, plus a music video. The CD and facilitators guide can be ordered from the Navy Logistics Library.
- Front Line Supervisor Training – a 3 to 4 hour facilitator led interactive training that provides deck plate supervisors realistic role play, case examples, and discussion to learn how to prepare an environment to recognize and engage a shipmate in distress and refer them to appropriate support when needed. No special skills are needed to facilitate, and Train the Trainer has been provided to Suicide Prevention Coordinators.

POD Notes

Put it in your cell phone

Make sure you have key phone numbers programmed into your cell phone. Include the National Suicide Prevention Lifeline 1 800 273 8255, base emergency numbers, and key command numbers.

ACT To Prevent Suicide

If you believe your shipmate might be in trouble **ACT**: **Ask** if someone is thinking about suicide. Let them know you **Care**. Get **Treatment** as soon as possible. Life counts!

ACT to prevent suicide

If you believe your shipmate or co-worker might be in trouble **ACT**:

- **Ask** if someone is thinking about suicide
- Let them know you **Care**
- Get **Treatment** as soon as possible
- Life counts!

Know your Suicide Prevention Resources.

- Chain of Command
- Fleet and Family Support Center
- Chaplains
- Medical and Mental Health Providers
- Navy Suicide Prevention www.suicide.navy.mil
- Military OneSource 800-342-9647 www.militaryonesource.com
- National Lifeline 1800 273 TALK (1 800 273 8255)

Life Counts! Live It!

Suicide is a permanent solution to a temporary problem. **Life counts... Live it!**

Every member of the Navy team is important...Sailors, civilians, contractors and family members. We all experience ups and downs in both our work and personal lives, so don't let those down times win. Hope is always available...remember **Life Counts-Live it!**

TAB D: Guidance for Developing a Crisis Response Plan

1. Overall in the Navy, suicide is the third leading cause of death. Suicidal thoughts and distress in various forms are not uncommon, but psychological crises are uncommon enough at the individual command level that personnel on duty may not have had the chance to learn from experience how to respond effectively.
2. It is not possible to plan for every event, but, in many situations, a written crisis response plan, easily accessible in the duty office and/or similar location, can help avoid wasting critical time spent looking for contacts or information.
3. Consider the following questions:
 - What would the duty section or a supervisor do if a Sailor or dependent called in distress or thinking of suicide?
 - What if a Sailor began behaving in a bizarre, confused, or aggressive manner?
 - What actions would occur if a shipmate or friend called saying they had received an alarming text message from one of your Sailors?
 - If you have a Sailor who requires a safety watch until professional evaluation is possible, how will that watch be conducted?
 - What reports are required if a suicidal event occurs?
4. In developing your plan, think about your unit and circumstances:
 - Shore installation will have different considerations from afloat commands.
 - Available resources will be different in homeport compared to foreign ports.
 - Additional considerations may apply when personnel are detached or deployed away from the unit or are away on leave.
 - Medical facilities will have additional precautions and considerations, etc.
5. General guidance if you ever get a call from a suicidal caller:
 - Be yourself. "The right words" are unimportant. If you are concerned, your voice and manner will show it.
 - Listen attentively to everything that the caller says, and try to learn as much as possible about what the caller's problems are.
 - Allow the caller to cry, scream or swear. Let the person unload despair, ventilate anger. If given an opportunity to do this, he or she will feel better by the end of the call. No matter how negative the call seems, the fact that it exists is a positive sign, a cry for help.
 - Stay calm, and be supportive, sympathetic, and kind.
 - Do not be judgmental or invalidate the person's feelings. Let the caller express emotions without negative feedback.
 - After you have a good understanding of the caller's problems, summarize the problems back to him or her. This helps to preclude misunderstandings and demonstrates to the caller that you are being attentive.
 - Then ask the caller, "Are you feeling so bad that you are thinking about suicide?"
 - If the answer is yes, ask, "Have you thought about how you would do it?"
 - If the answer is yes, ask, "Do you have what you need to do it?"
 - If the answer is yes, ask, "Have you thought about when you would do it?"
 - Here are those four important questions in abbreviated form:

- Suicidal?
- Method?
- Have what you need?
- When?
- The reason for asking these questions is to assess the level of risk of suicide for the caller. If the caller answers yes to three or four questions, the risk is very high, and immediate treatment is necessary. Try to get the individual to call 911 or go to an emergency room.
- Simply talking about their problems for a length of time will give relief from loneliness and pent up feelings, awareness that another person cares, and a feeling of being understood. They also get tired -- their body chemistry changes. These things take the edge off their agitated state and help them get through a bad night.
- Avoid arguments, problem solving, advice giving, belittling or making the caller feel the need to justify his suicidal feelings. It is not how bad the problem is, but how badly it's hurting the person who has it.
- If the person is ingesting drugs, get the details (what, how much, alcohol, other medications, last meal, general health) and call Poison Control at **1-800-222-1222**. Another person can call while you continue to talk to the caller, or you can get the caller's permission and do it yourself on another phone while the caller listens to your side of the conversation. If Poison Control recommends immediate medical assistance, ask if the caller has a nearby relative, friend, or neighbor who can assist with transportation or the ambulance. In a few cases the person will initially refuse needed medical assistance. Remember that the call is still a cry for help and stay with him in a sympathetic and non-judgmental way. Ask for his address and phone number in case he changes his mind. (Call the number to make sure it's busy.)
- Do not go it alone. Get help during the call and debrief afterwards.

Your caller may be concerned about someone else who is suicidal. Just listen, reassure him that he is doing the right thing by taking the situation seriously, and sympathize with his stressful situation. With some support, many third parties will work out reasonable courses of action.

6. General guidance when you are with someone in person who is distressed and may be suicidal:
- Continue to treat the person respectfully. Remember the acronym ACT – Ask, Care, Treat
 - Manage your own response – breathe, speak in a calm, clear voice with medium volume and slow to medium rate. Use short, direct statements.
 - Focus on the person, not the rules. A person in distress may not care about regulations and rules at the moment. They care about meeting their own needs and symptom relief. Phrase issues based on purpose - (safety or healthcare issues)-not because it is a rule or policy.
 - Don't leave the person alone – even to use the restroom.
 - Consider hazards in your surroundings (blinds, scissors, moving vehicles, etc.)
 - Safely remove hazards from the person (any weapons, sharp objects, shoe laces or draw strings, medications) be sure to check pockets
 - If transporting, use child locks to increase safety.

Response Plan for Distressed Callers

Date _____

Time _____

Caller ID Number _____

If a distressed or suicidal person calls or comes into the office, ask for the following information.

The order in which you ask the questions may differ depending on the specific situation.

If a person calls or comes into the office and says things like, "I'm so depressed, I can't go on," or "Life isn't worth living," or "I wish I were dead," etc., **ASK "Are you having thoughts of suicide?"** Yes _____ No _____

Be yourself.

Show concern.

Be sympathetic.

Listen.

Stay calm.

Offer help and hope.

Stay on the phone.

Get help.

1. Have you thought about how you would harm yourself? Yes _____ No _____

Details:

2. Do you have what you need to do it? OR Do you have a gun, pills, etc?

Yes _____ No _____

If the person indicates he/she has taken pills, ask how much, when, etc.

If the person has a gun, ask:

Is it loaded? Yes _____ No _____ Where is it? _____

3. What is your name? _____

4. Who is there with you? _____

5. Where are you? (Determine specific address, building number, ship's space, etc, if at all possible)/?

Local Emergency Numbers

These numbers must be updated each time circumstances change. Different numbers will be applicable for shore stations, air squadrons, when a ship is in home port, in a foreign port, or at sea.

Emergency Numbers:

Base Security _____

Ship Security _____ Port Security/Services _____

Fire Department _____

Civilian Law Enforcement _____

NOTE: The more information you can provide to law enforcement/security, the better prepared they will be to effectively handle the situation.

Military:

Medical clinic _____ Hospital _____

Civilian:

Hospital Name/Number _____

Poison control _____

Duty Doctor _____

Chaplain _____

Fleet and Family Support Center _____

CO/OIC _____

XO _____ CMC/COB _____

IA/GSA Support Number _____

Suicide Prevention Coordinator _____

Other:

TAB E: Command Directed Evaluations

General Considerations:

While various life circumstances can produce added stress for the Sailor aside from demands of his/her rate and work duties, it is recommended that Navy leaders encourage Sailors to voluntarily seek assistance when signs of distress appear. Resources such as Military OneSource, Fleet and Family Support Centers (FFSC), and the MTF Mental Health are available for providing an evaluation and offering appropriate counseling services. With some exceptions relating to the safety of the member and others or fitness for duty, information provided by a service member during an evaluation is kept confidential. When an exception warrants, feedback of the evaluation can only be provided to the service member's Commanding Officer. It cannot be given to anyone else unless this person is designated in writing by the Commanding Officer to receive this information.

Is a Command Directed Evaluation (CDE) Appropriate?

In accordance with SECNAVINST 6320.24a, DoD Directive 6490.1, and DoD Instruction 6490.4, the Commanding Officer (CO) may direct the Sailor to undergo a mental health evaluation. A Command Directed Evaluation (CDE) is appropriate whenever the CO believes that the Sailor's mental state renders them a risk to themselves or others, or may be affecting the Sailor's ability to carry out the mission. A CDE can provide the CO with information needed to make an appropriate administrative action.

* A Command Directed Evaluation can be accomplished on a routine (non-emergency) or an emergent basis.

Routine CDE

Once a decision has been made to request a routine non-emergency CDE, the CO is required to:

1. Consult with a privileged mental health provider to determine whether a CDE is appropriate. The CO is responsible for communicating the actions and behaviors of the service member that is believed to warrant an evaluation; this responsibility cannot be delegated. The mental health provider shall provide advice and recommendations about whether a CDE is appropriate and whether it warrants an emergency CDE. The mental health provider will also discuss other options that may be appropriate. If a routine CDE is recommended, the CO should forward to the mental health provider a letter formally requesting a CDE. (see enclosure (2) in SECNAVINST 6320.24a)
2. Provide a written letter to the Sailor at least two business days prior to the evaluation (see enclosure (3) in SECNAVINST 6320.24a). The letter must include:
 - The date, time, and location of the evaluation. The name and grade or rank of the mental health professional who will be conducting the evaluation. The name and grade or rank of the mental health professional with whom the command has consulted.
 - A brief factual description of the behavior(s) that gave rise to the need for a referral.
 - A listing of the Sailor's rights per PL 102-484, section 546, "National Defense Authorization Act for Fiscal Year 1993" of Oct 1992 and SECNAVINST 6320.24a.

- The names and telephone numbers of the resources on-base that can assist Sailor (e.g., Area Defense Counsel, chaplain, Inspector General).
- The name and signature of the Commanding Officer.
- Sailor's acknowledgement of receipt of letter or command's annotation of Sailor's refusals.

3. Forward the request for a CDE to the mental health provider. It is vital for the Sailor's command to provide all available documentation concerning the Sailor's problem behaviors. This may include as available, Article 15's, Letters of Reprimand, Letters of Counseling, and Enlisted Performance Reports/Officer Performance Reports. The documentation is necessary for a comprehensive evaluation.

4. If the provider believes that the evaluation has been requested improperly, he/she will contact the command to clarify issues about the process or procedures used. If, after such discussion, the provider believes the referral may have been conducted improperly per DoDD 6490.1 or DoDD 7050.6, (reference(c)), he or she is required to report related evidence through his or her chain of command to the next higher level of the referring commanding officer.

5. The provider conducting the evaluation will provide both written and verbal feedback on the results of the evaluation that include diagnosis, treatment recommendations, and any administrative management recommendations. Be aware the evaluation may require more than one appointment to complete.

Emergency CDE

Emergency CDEs are conducted upon recommendation of the mental health provider or when in the judgment of the CO an emergent situation exists such as intent or threat to inflict harm to self or others or bizarre or dangerous behavior (hallucinating, delusional, etc.).

When an emergency CDE is determined to be necessary, the following steps need to be followed:

- Ensure safety of Sailor and others. Do not leave the Sailor alone. Take all reasonable precautions to notify and protect others who have been identified as intended targets of violence or harm.
- If at all possible, consult with mental health or other privileged healthcare provider prior to sending a Sailor for an emergency CDE. If circumstances do not permit such a consultation, contact an on-call mental health provider as soon as possible.
- Transport to care. Take action to safely transport the Sailor to the nearest mental health care provider, or if unavailable, another privileged healthcare provider, as soon as is practical. Depending on the circumstances the Emergency Department or Security may need to be involved in the transportation process.
- Provide Sailor with a letter stating the reasons for emergency referral as soon as practical. If the Sailor is seen before the letter can be provided to the Sailor, the letter and statement of rights must be provided as soon as is practical. If a mental health provider was not consulted prior to ordering the CDE, the reason for this must be explained in the letter to the Sailor.
- Provide a letter to the evaluating provider regarding request of a CDE. The letter must be sent to the treating mental health provider documenting your concerns, the patient's circumstances, and the observations that led to refer emergency referral. This should be done as soon as possible.

Checklist for Command Directed Mental Health Referrals

To ensure the legality, efficiency, and integrity of the mental health evaluation process, the DoD and SECNAV Instructions require that several steps be taken by the member's Commanding Officer in conjunction with a mental health provider to determine whether a mental health referral is appropriate. This authority may not be delegated.

- Commanding Officer: Review SECNAVINST 6320.24A, DoD Directive 6490.1, and DoD Instruction 6490.4 for a discussion of the member's rights and pitfalls to avoid in making command directed mental health referrals, and for sample letters.
- Commanding Officer: Consult with the mental health provider about making a referral. There will be some instances where a referral may not be clinically indicated.
- Commanding Officer: Send to the mental health care provider a formal, written request for mental health evaluation. For emergency referrals, this letter shall detail the circumstances and observations that led to the emergent referral and should be sent to the treating provider within 48 hours of the mental health evaluation.
- Commanding Officer: Give the member a signed letter detailing behaviors of concern, the mental health provider consulted, notification of rights, the date, time, and place of the appointment, and contact information for attorneys, IGs, chaplains, and others who can provide assistance.
 - Routine referrals - at least 48 hours in advance of the evaluation
 - Emergency referrals - as soon as possible
- Mental Health Provider: Remember that the mental health care provider must ensure that these steps have been followed properly, or a full mental health evaluation may not be conducted.

TAB F: REINTEGRATE

Four Key Processes for Leaders:

- Evaluating and forming judgments about psychological fitness and suitability for duty, including worldwide deployment. (For greater detail, see matrix on following page.)
- Assigning service members who are recovering from stress injuries or illnesses to duties that make the best use of their capabilities
- Changing attitudes in members of military units that might get in the way of accepting these individuals back in the unit
- Easing the transition to veteran and civilian status of those Sailors whose recovery is insufficient to permit return to full duty

Following Up During Treatment:

- Maintain frequent contact with Sailor until situation resolved
- Ask periodically about the status of the situation
- Check to see if the Sailor needs anything
- Sustain your commitment & stay involved
- Serious negative consequences can result from failure to follow through
- Trust but verify

Reintegration (Recommendations and Best Practices):

- Follow up with the Sailor
- Protect private personal information
- Engage peers to help supervisor with follow-up and reintegration
- Make use of encouragement and affirmation
- Check with the caregiver – where permissible
- Help Sailor feel accepted and welcome after return from treatment

Important Points:

- The 2008 DoD Survey of Health Related Behaviors found that 5% of Sailors surveyed reported seriously considering suicide in the past 12 months.
- Chances are someone on your crew is struggling in silence (maybe even a strong performer or senior person).
- The way you treat a Sailor who speaks up (before, during, and after assessment or treatment) will often determine whether you hear from the silent sufferer before its too late.

The below Guidelines for Evaluating Fitness and Deployability is a tool to help leaders evaluate the psychological fitness and deployability of a sailor being treated for a stress injury or illness. While the final decision rests with the Commanding Officer, it takes the whole Navy OSC-Leadership Team to evaluate and restore fitness.

Sources of Information and Factors For Commanders to Determine Psychological Fitness					
Source of information:		Medical and Mental Health Personnel	Chain of Command and Chaplains	Peers and Family Members	Service Members Themselves
Service Member Is Psychologically Fit and Deployable If:	In Spite of a Stress Injury or Illness:	<input type="checkbox"/> SM meets medical standards for retention <input type="checkbox"/> SM is currently <u>not significantly impaired</u> in performance of duties due to stress injury or illness symptoms <input type="checkbox"/> The expected demands of future deployments are <u>not</u> likely to cause SM to become significantly impaired <input type="checkbox"/> SM is motivated <input type="checkbox"/> Medical personnel are OK deploying with SM	<input type="checkbox"/> SM has demonstrated <u>competency</u> in all essential knowledge, skills, and attitudes throughout recent training <input type="checkbox"/> SM is <u>confident</u> in their own abilities, and in leaders, peers, and equipment <input type="checkbox"/> If SM is not now fully competent or confident, these can be regained in near future <input type="checkbox"/> SM is trusted by other members of their team <input type="checkbox"/> SM contributes positively to cohesion and morale <input type="checkbox"/> SM displays adequate leadership skills <input type="checkbox"/> SM is motivated <input type="checkbox"/> Chain of command trusts SM	<input type="checkbox"/> SM has <u>not</u> demonstrated any unsafe behaviors (e.g. strong suicidal thoughts or violent impulses) <input type="checkbox"/> SM is <u>not</u> drinking excessively or engaging in any other dangerous behavior <input type="checkbox"/> SM appears to those most familiar with him or her to have returned to their normal or usual self <input type="checkbox"/> Peers and family members are comfortable living and working with SM	<input type="checkbox"/> SM feels confident in their ability to perform effectively and remain well <input type="checkbox"/> SM is motivated to remain on active duty and deploy
	In Spite of Mental Health Treatment:	<input type="checkbox"/> Needed psychotherapy treatment will be concluded within 6-12 mos. <input type="checkbox"/> Current medications do <u>not</u> cause potentially impaired side effects <input type="checkbox"/> Current medications are on a stable dosage (e.g. 3 months or more) <input type="checkbox"/> Medication is safe to take on deployment <input type="checkbox"/> No risk for serious withdrawal symptoms if medications is stopped <input type="checkbox"/> No risk for serious worsening of symptoms if treatment is stopped	<input type="checkbox"/> SM is compliant with all prescribed treatments <input type="checkbox"/> Chain of command is OK with SM taking prescribed medications during deployment		

TAB G: Suicide Within A Command/Unit

Suicide of a Shipmate can present as one of the greatest challenges to the command leadership team. Sailors and family members will try to rationalize behavior that's just not rational (to someone who is thinking straight). People especially close to the Sailor or in the Sailor's direct chain of command will tend to question themselves as to why they didn't see a problem or why they weren't able to prevent the death. No one is immune to the feelings. Commands must understand that the negative effects of suicide on many people will not go away just because the memorial service is over and duty calls again. Conscious efforts must be made to identify those individuals that may be at higher risk following a suicide, and ensure each of these people are monitored and offered all appropriate assistance available.

A critical incident intervention team or Special Psychiatric Rapid Intervention Team (SPRINT) may be called to respond to the command's needs. Commands can access these intervention resources through their local FFSC, Chaplain's Office or MTF. These teams provide professional resources and assistance that can help avoid further problems within a command that has experienced the trauma of suicide. They can provide individual counseling; group sessions or advice to the leadership team on the long term negative effects they may experience. Simply put, don't underestimate the affect suicide can have on your Sailors.

Leader's Post-Suicide Checklist

Purpose: This checklist is designed to assist leaders in guiding their response to suicides and suicide attempts. Research suggests the response by a unit's leadership can play a role in the prevention of additional suicides/suicide events or, in worst cases, inadvertently contribute to increased suicides/suicide attempts (suicide contagion).

This checklist is intended to augment any local policies. It incorporates "lessons learned" from leaders who have experienced suicide deaths in their unit. It is a guide intended to support a leader's judgment and experience. The checklist does not outline every potential contingency which may come from a suicide or suicide attempt.

A second checklist, Guidance for Actions Following a Suicide Attempt, is attached at the end of this section.

Guidance for Actions Following a Death by Suicide

1	Contact local law enforcement/Security Forces, NCIS, and 911 (situation dependent).
2	Notify Chain of Command. Initiate Operational Reporting (OPREP) messages.
3	Notify Mental Health Clinic or Mental Health on-call provider to prepare for possible post-vention support.
4	Validate with JA and NCIS who has jurisdiction of the scene and medical investigation. Normally, local medical examiners/coroners have medical incident authority in these cases but some locations may vary.
5	Contact Casualty Assistance Call Officer (CACO) to notify Next of Kin (NOK) and receive briefing on managing casualty affairs.
6	Consult with on-call Mental Health provider to prepare announcement to unit and co-workers. Review Leaders's Guide for Post-Suicide Response PowerPoint for just-in-time considerations offered by other leaders and key components of post-suicide programming.
7	Make initial announcement to work site with a balance of "need to know" and rumor control. Consider having Mental Health provider or Chaplain present for support to potentially distraught personnel, but avoid using a "psychological debriefing" model. Make initial announcement to work site/unit.
8	Consult with Public Affairs regarding public statements about the suicide and refer to the Public Affairs Guidance (PAG) for Suicide Prevention.
9	When speaking to the work site/unit, avoid announcing specific details of the suicide. Merely state it was a suicide or reported suicide. Do not mention the method used. Location is announced as either on-base or off-base. Do not announce specific location, who found the body, whether or not a note was left, or why the member may have killed himself
10	Avoid memorializing/idealizing deceased or conveying the suicide is different from any other death. Consult with Mental Health, the Chaplain, and your mentors/Chain of Command for any actions being considered for memorial response.

11	<p>When engaging in public discussions of the suicide:</p> <ol style="list-style-type: none"> 1) Express sadness at the Navy's loss and acknowledge the grief of the survivors; 2) Emphasize the unnecessary nature of suicide as alternatives are readily available; 3) Express disappointment that the Sailor did not recognize that help was available; 4) Ensure the audience knows you and the Navy want personnel to seek assistance when distressed, including those who are presently affected; 5) Encourage shipmates to be attuned to those who may be grieving or having a difficult time following the suicide, especially those close to the deceased; and 6) Provide brief reminder of warning signs for suicide.
12	<p>After death announcement is made to the work center, follow-up your comments in an e-mail provided to the community affected. Restate the themes noted above.</p>
13	<p>Consider increasing senior leadership presence in the work area immediately following announcement of death. Engage informally with personnel and communicate message of support and information. Presence initially should be fairly intensive and then decrease over the next 30 days to a tempo you find appropriate.</p>
14	<p>Consult with Chaplain regarding Unit Sponsored Memorial Services. Memorial services are important opportunities to foster resilience by helping survivors understand, heal, and move forward in as healthy a manner as possible. However, any public communication after a suicide, including a memorial service, has the potential to either increase or decrease the suicide risk of those receiving the communication. It is important to have an appropriate balance between recognizing the member's military service and expressing disappointment about the way they died. If not conducted properly, a memorial service may lead to adulation of the suicide event and thus potentially trigger "copy cat" events among unidentified/unstable personnel. Therefore, memorial services should avoid idealizing/eulogizing deceased. Commanders should avoid commenting on personal characteristics of the deceased. Focus instead on personal feelings and feelings of survivors. Express disappointment in deceased's decision and concern for survivors. Promote help-seeking and the concept of looking out for shipmates. The goals are to:</p> <ol style="list-style-type: none"> 1) Comfort the grieving; 2) Help survivors deal with guilt; 3) Help survivors with anger; 4) Encourage Sailors/family members to seek help; and 5) Prevent "imitation" suicides.
15	<p>Public memorials such as plaques, trees, or flags at half-mast may, in rare situations, encourage other at-risk people to attempt suicide in a desperate bid to obtain respect or adulation for themselves. Therefore, these types of memorials are not recommended.</p>
16	<p>Utilize or refer grieving co-workers to MTF Mental Health resources. For Military beneficiaries, consider Mental Health, Chaplain, Fleet & Family Support Centers, and Military One Source (1-800-342-9647). For civilians, consider Employee Assistance Program. Discuss with Mental Health consultant regarding service options if non-beneficiaries (i.e., extended family members, fiancé or boy/girlfriends) are struggling and asking for help.</p>
17	<p>Participate, as requested, with any appointed independent reviewer process (JAGMAN, DODSER or Medical Incident Investigation). Avoid defensiveness. Acknowledge the processes are intended to determine if there are any 'lessons learned' in regards to suicide prevention, not to affix blame.</p>
18	<p>Anniversaries of suicide (1 month, 6 month, 1 year, etc.) are periods of increased risk. Promote healthy behaviors and peer support during these periods.</p>

Guidance for Actions Following a Suicide Attempt

Purpose: This checklist is designed to assist leaders in regards to addressing suicide attempts by those in their unit. There can be many factors considered in a person's decision to attempt suicide, and the proper response to the attempt can diminish the risk factors for another attempt, and greatly aid in restoring the individual to the work center with minimal disruption.

1	<p>As noted in the <i>Leaders's Guide for Post-Suicide Response PowerPoint</i>, suicide is an act made by a person seeking relief from real or perceived pain.</p> <p>A person who makes a suicide <u>attempt</u> may have either (1) been prevented from making an action they intended to result in death; (2) not intended to die, but felt the need to demonstrate an attempt for others to know they are in pain; (3) been under the influence of drugs (including alcohol) which caused an impaired decision (often referred to as 'impulsive'); (4) been suffering from mental illness and extremely impaired but did not die as a consequence of the suicide plan.</p>
2	<p>Contact local law enforcement/Security Forces, NCIS, and 911 (situation dependent).</p>
3	<p>Notify Chain of Command. Initiate Operational Reporting (OPREP) messages. Ensure notifications are kept to short list of "need to know" and contain minimum amount of information to convey nature of critical event. Being appropriate with "need to know" helps avoid stigmatizing the member's return to a work center where many people are aware of what happened.</p>
4	<p>If attempt was by an Active Duty Member: Notify Mental Health Clinic or Mental Health on-call provider to consult on safety planning and coordination of a Command Directed Evaluation (CDE). If an attempt was by a civilian the Mental Health Clinic or on-call provider can provide guidance on options. Generally, civilian authorities and hospitals will be the lead agents for response to the attempt.</p>
5	<p>If the attempt has occurred in the workplace: Notify local law enforcement/Security Forces, NCIS and Chain of Command. Ensure the area of the attempt has been secured and contact the Mental Health Clinic or Mental Health on-call provider for consultation.</p>

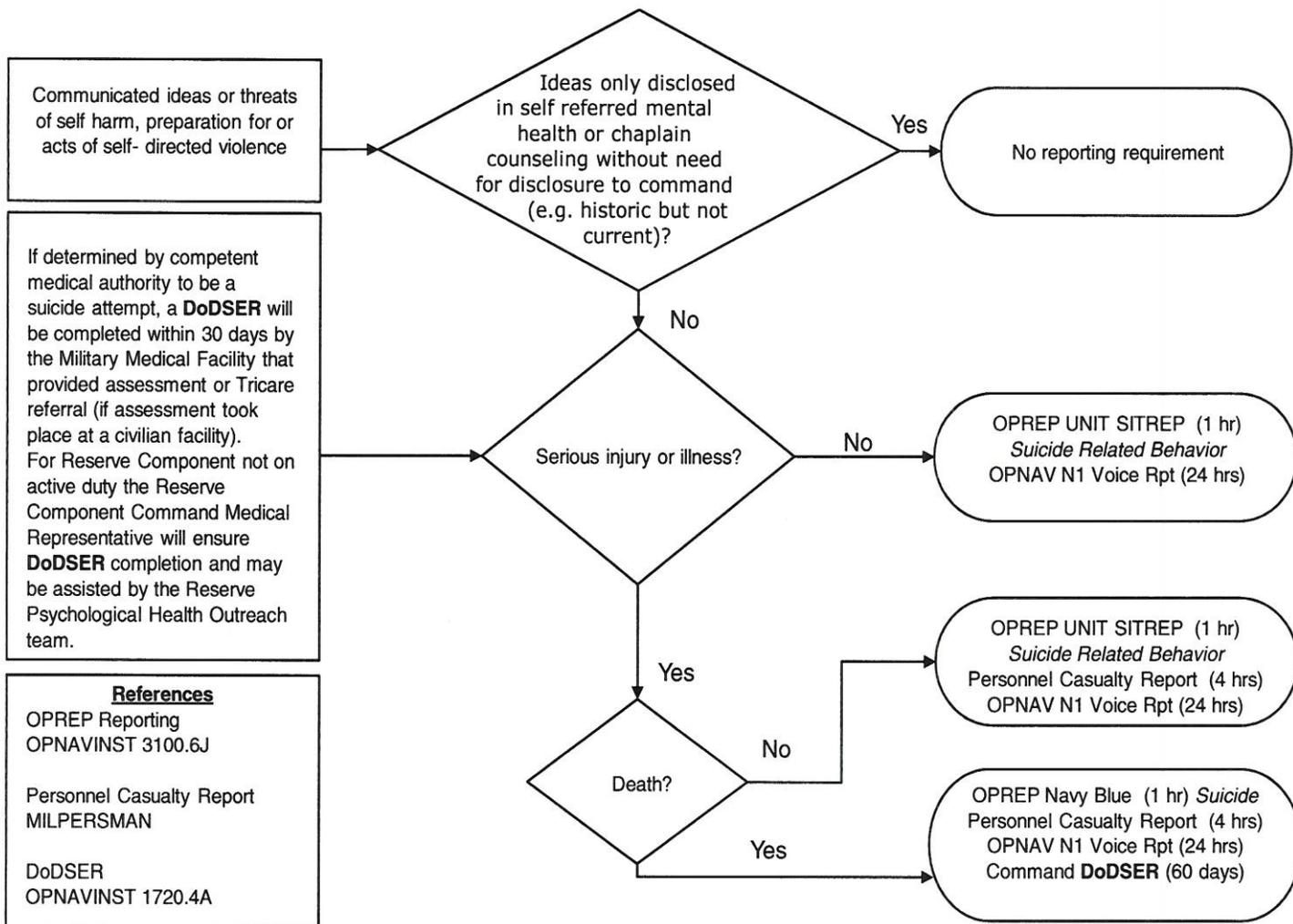
6	<p>A suicide attempt requires formal Mental Health assessment and often will result in hospitalization to stabilize the individual and ensure safety. If the member is hospitalized, it is recommended you consult with Mental Health and your Chain of Command regarding visiting the person while they are in the hospital.</p>
7	<p>Returning to work: A person who has experienced a crisis may find returning to work to be comforting (a sense of normalcy) or distressing. Work may need to be tailored to accommodate for medical/Mental Health follow-up appointments and assessed abilities of the person upon their return. The goal is to gradually return to full duties as appropriate.</p> <p>If Active Duty: Ensure Active Duty Member is cleared for return to duty by Mental Health and their Primary Care Manager. Consultation between Mental Health/Primary Care Manager and Command can ensure a work schedule that accommodates the active duty member provides additional supervision and support without risk of showing secondary gain for having attempted suicide.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> - "No Drink" order - Non-weapons bearing duties - Secure personal weapons, providing a safe alternative (i.e., base armory) <p>If civilian: Recommend discussing alcohol and weapons. Engage with employee to ensure they provide documentation indicating they are medically cleared by their treating medical/Mental Health provider to return to the work environment. Coordinate with Civilian Personnel Office on accommodations (if required) to work schedule and work environment.</p>
8	<p>A returning member should not be treated as fragile or 'damaged.' If they sense they are being 'singled out' or treated differently in the presence of peers, it can damage the recovery process. Freely speak with the employee about being receptive to their thoughts on returning to work and how to avoid either their, or your, perception of 'walking on egg shells.'</p>
9	<p>Consider leave requests carefully. Support the employee by ensuring leave requests involve structured time or planned events that will enhance them as they take time away from work.</p>
10	<p>Ensure all members of the unit are aware that seeking Mental Health is a sign of strength and helps protect mission and family by improving personal functioning instead of having personal suffering.</p>
11	<p>Never underestimate the power of the simple statement: "What can I do to be helpful to your recovery process?"</p>
12	<p>Consult with Mental Health providers to develop a supportive plan to re-integrate the Sailor into the workplace.</p>
13	<p>Engage family and support networks to increase support and surveillance of the Sailor. Encourage family and friends to reach out to the unit if they become concerned about the Sailor's emotional state.</p>

TAB H: Reporting Requirements

All suicides require immediate reporting, with follow-up reports as appropriate. The following flowchart provides guidance of the various reports as well as their timing.

- Actions required within 4 hours following a suicide
 - Personnel Casualty Report (MILPERSMAN 1770-030)
- Actions required in the initial 24 hours following a suicide
 - OPREP-3 Unit SITREP or OPREP-3 NAVY Blue if media interest is anticipated (Ref OPNAVINST 3100.6J)
 - OPNAV N1 Voice Report (OPNAVINST 3100.6J)
- Actions required within 60 days:
 - DODSER (completion guidance follow):

Suicide Reporting Flowchart



Step-By-Step Guidance for Completing DODSER

- Step 1: Register on AKO/DKO. Go to <https://www.us.army.mil>. Note: This can be tricky as it is not intuitive. IGNORE the standard LOG IN box. Move to the center of the screen and select “New User?” and then select the “Register with CAC” option.
- Step 2: Go to the DoDSER site at <https://dodser.t2.health.mil/dodser> and click on “register” at the top or “Click Here to Enter” if you are already registered.
- Step 3: Accept terms.
- Step 4: Select “Create a New Report”
- Step 5: If you need to gather more information and submit the report at a later date, you may do so. To return to the document, simply return to the website and click on the service member’s name. Completed DoDSER must be submitted within 60 days of notification of death by OPNAV N135F.
- Step 6: It is recommended that you print a PDF of the completed DoDSER in the event you need it for future reference.

Example: OPREP-3 NAVY BLUE or UNIT SITREP (Ref: OPNAVINST 3100.6J)

ACTION addresses:

ISIC
CNO WASHINGTON DC//N1//
CHINFO WASHINGTON DC//00//
General Courts Martial Authority (GCMA)

INFO addresses for all personnel incidents:

Chain of Command (up through ECHELON II Commander)
CHINFO WASHINGTON DC//00//
COMNAVPERSCOM MILLINGTON TN
OPNAV N135 MILLINGTON TN
CNIC WASHINGTON DC

Additional addresses to be considered:

NAVY JAG WASHINGTON DC
DIRNAVCRIMINVSERV WASHINGTON DC//22D/23/02/21/24//
Local NAVCRIMINVSERV office
CMC WASHINGTON DC(USMC personnel/mission incidents)
CG TECOM QUANTICO VA (USMC aviation training unit
incidents involving personnel/missions)

Message Body (Suicide):

MSGID/OPREP-3,USMTF,yyyy/USS SHIP/001//
REF/A/DESC: INITIAL VOICE REPORT TO ISIC/USS
NEVERSAIL
/160529ZJUN2009//
FLAGWORD/NAVY UNIT SITREP (OPREP-3 NAVY BLUE if media interest)/-//
TIMELOC/160430ZJUN2005/4050N13235E/INIT//
GENTEXT/INCIDENT IDENTIFICATION AND DETAILS/
1. INCIDENT: NON-HOSTILE DEATH
2. DATE OF INCIDENT: 16JUN2005
3. TIME OF INCIDENT: 0430L
4. LOCATION OF INCIDENT: BASE HOUSING, NORFOLK, VA
5. SUSPECT OR ALLEGED OFFENDER: NONE
6. GENDER: N/A
7. AGE: N/A
8. RACE: N/A
9. WEAPON: SHEET
10. ALCOHOL/DRUG: BEER, TWO 6-PACKS

11. VICTIM OR COMPLAINANT: E-4
12. SEX: MALE
13. AGE: 24 YEARS OLD
14. RACE: WHITE
15. NAVCRIMINVSERV NOTIFIED: YES
16. INSTALLATION FAMILY ADVOCACY REP NOTIFIED: N/A
17. SUMMARY/BRIEF DESCRIPTION OF INCIDENT: DEATH BY POSSIBLE SUICIDE. SM FOUND IN BERTHING SHOWER AT APPROXIMATELY 0430 WITH A SHEET KNOTTED AROUND HIS NECK, HANGING FROM WATER PIPE. MEDICAL ASSISTANCE WAS RENDERED FROM SHIP'S CREW UNTIL ARRIVAL OF EMERGENCY MEDICAL STAFF. SERVICE MEMBER WAS PRONOUNCED DEAD ON ARRIVAL AT PORTSMOUTH NAVAL HOSPITAL. MEMBER RETURNED FROM IA DEPLOYMENT TO IRAQ ON 01 MAY 2005. PDHRA WAS COMPLETED.
18. MEDIA INTEREST: NOT ANTICIPATED.
19. NAVCRIMINVSERV INVOLVEMENT: NOTIFIED
20. POC: LT BROWN, COMM 555-555-5555, DSN 555-5555, LT.BROWN@NAVY.MIL//

Message Body (Suicide Related Behavior):

1. INCIDENT: MEMBER SUICIDE RELATED BEHAVIOR
2. DATE OF INCIDENT:
3. TIME OF INCIDENT:
4. LOCATION OF INCIDENT:
5. INDIVIDUAL: E-4
6. GENDER: MALE
7. AGE: 23
8. RACE: CAUCASIAN
9. WEAPON: NONE
10. ALCOHOL/DRUG: NONE
11. NCIS NOTIFIED: NO
12. INSTALLATION FAMILY ADVOCACY REP NOTIFIED: NO
13. SUMMARY/BRIEF DESCRIPTION OF INCIDENT: ACTIVE DUTY, E-4 MALE, DURING COUNSELING SESSION WITH DIVISION LEADING PETTY OFFICER, ADMITTED TO SUICIDAL IDEATION. MEMBER WAS DIRECTED TO SPECIFIC CHIEF PETTY OFFICER SUPERVISION, AND FOLLOWING COUNSELING WITH DUTY CHAPLAIN, WAS ESCORTED TO NAVAL MEDICAL CENTER PORTSMOUTH FOR MEDICAL EVALUATION. COMMAND CURRENTLY AWAITING MEDICAL ASSESSMENT.
14. MEDIA INTEREST: NOT ANTICIPATED
15. NCIS INVOLVEMENT: NO
16. DATE AND LOCATION OF LAST DEPLOYMENT: LAST DEPLOYMENT TO AFGHANISTAN JAN to JUN 2009
17. DATE OF LAST PDHA/PDHRA: PDHRA COMPLETED DEC 2009
16. POC: LT BROWN, COMM 555-555-5555, DSN 555-5555, LT.BROWN@NAVY.MIL//

Example: Personnel Casualty Report (Ref MILPERSMAN 1770-030)

CASUALTY REPORTING COMMAND:

DATE/TIME GROUP:

REPORT TYPE: INITIAL/SUPPLEMENTAL

TYPE OF CASUALTY: Death/SI/VSI/NSI/DUSTWUN

ALPHA: Grade/rate – Name of Casualty – Social Security Number – Officer Designator

BRAVO: Status (e.g., ACDU/INACTDUTRA/ACDUTRA) Duty

Station/Point of Contact/Tel. No./E-mail Address

CHARLIE: Hostile (KIA/POW); Non-Hostile (peacetime casualties);

NEW DAWN (if applicable)

DELTA: Date (Local time of casualty incident); place;

Circumstances of incident; cause of death.

ECHO: Location of remains, funeral home's name, address, and phone number

FOXTROT: Primary next of kin (PNOK) (Name, address, relationship). Secondary next of kin (SNOK)

Name, address, relationship). Other next of kin (NOK) (e.g., step children, children from a previous marriage, parents, etc.)

GOLF: Notification of NOK: Date, time, and person making the notification

HOTEL: Date of Dependency Application/Record of Emergency Data

INDIA: Additional Remarks.

TAB I: RESOURCES AND REFERENCES

- OPNAVINST 1720.4A Suicide Prevention Program: <http://www.public.navy.mil/BUPERS-NPC/REFERENCE/Pages/default.aspx> (See OPNAV/SECNAV Instructions)
- Web Information
 - Suicide Prevention: www.suicide.navy.mil
 - Operational Stress Control: www.navynavstress.com
 - Military One Source: www.militaryonesource.com
- Phone Numbers
 - OPNAV N135F Behavioral Health: (901) 874-6613/6804/6723
 - Military One Source: (800) 273-(TALK) 8255
 - National Suicide Prevention Lifeline: (800) 273-(TALK) 8255
- Postvention Resources
 - Tragedy Assistance Program for Survivors (TAPS): www.taps.org
(800) 959-(TAPS) 8277
- General Suicide Prevention Resources
 - Suicide Prevention Resource Center (SPRC): www.sprc.org
- NMCPHC Leaders Guide to Managing Sailors in Distress:
<http://www.nmcphc.med.navy.mil/lguide/index.aspx>
- Printed Materials
 - Navy Logistics Library (NLL): <https://nll1.ahf.nmci.navy.mil/>. Excellent printed materials on both suicide prevention and Operational Stress Control are available at no cost to the command. Materials are ordered online. Access to NLL requires online registration and SAARS clearance. Materials are shipped based on your designated individual UIC address. Available printed materials are listed at the end of this section.



Operational Stress Control

Naval Logistics Library Order Sheet

Submit Orders to:
<https://nll ahf.nmci.navy.mil>
 and products will ship FREE to your command.

1

Decide which products and how many you want - Enter numbers in the order column.

2

- A.** Contact your Enlisted Storekeepers and/or Supply Corps Officers to get the appropriate Unit Identification Code (UIC) and help ordering products.
- B.** They must have an NLL account. For help ordering or setting up an account from the Naval Logistics Library call: 1-866-817-3130 or 215-697-2626/DSN 442-2626
- C.** Supply this completed form.

3

Insert Organizational UIC - All products will be shipped to physical address associated with the UIC in the System (usually a receiving office or supply delivery address for the base). **Insert UIC Here:**

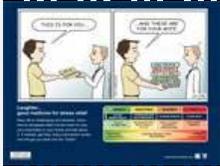
4

In addition to the UIC include an Attention Line here for delivery notification (No more than 35 characters including telephone number) **Insert Attn. Line Here:**

STOCK NUMBER	PUBLICATION NUMBER	PUBLICATION NAME		QUANTITY	ORDER
0500LP1103858	NAVPERS 172002	OSC Cartoon_1 In Law (4"x6" two-sided card)		Batch of 50	
0500LP1103861	NAVPERS 172003	OSC Cartoon_2 Video Game (4"x6" two-sided card)		Batch of 50	
0500LP1103864	NAVPERS 172004	OSC Cartoon 3 LCPO (4"x6" two-sided card)		Batch of 50	

STOCK NUMBER	PUBLICATION NUMBER	PUBLICATION NAME		QUANTITY	ORDER
0500LP1103866	NAVPERS 172005	OSC Cartoon 4 Wedding (4"x6" two-sided card)		Batch of 50	
0500LP1105789	NAVPERS 172006	OSC Sub Aviation (brochure)	 	Batch of 100	
0500LP1105790	NAVPERS 172007	OSC Family (brochure)		Batch of 100	
0500LP1105791	NAVPERS 172008	OSC Sailor (brochure)		Batch of 100	
0500LP1105792	NAVPERS 172009	OSC Expeditionary (brochure)		Batch of 100	
0500LP1105793	NAVPERS 172010	OSC Mini Stress Continuum (magnet)		Batch of 100	

STOCK NUMBER	PUBLICATION NUMBER	PUBLICATION NAME		QUANTITY	ORDER
0500LP1105794	NAVPERS 172011	OSC Combat Stress First Aid (4"x6" two-sided card - Stress Continuum on reverse)		Batch of 100	
0500LP1105795	NAVPERS 172012	OSC Decision Matrix (4"x6" two-sided card - Stress Continuum on reverse)		Batch of 100	
0500LP1105796	NAVPERS 172013	OSC In Law Cartoon (mini poster - 8.5"x11" two sided with Stress Continuum on reverse)		Order by # required Not Batched	
0500LP1105797	NAVPERS 172014	OSC LCPO Cartoon (mini poster - 8.5"x11" two sided with Stress Continuum on reverse)		Order by # required Not Batched	
0500LP1105798	NAVPERS 172015	OSC PCS Cartoon (mini poster - 8.5"x11" two sided with Stress Continuum on reverse)		Order by # required Not Batched	
0500LP1105799	NAVPERS 172016	OSC Video Game (mini poster - 8.5"x11" two sided with Stress Continuum on reverse)		Order by # required Not Batched	

STOCK NUMBER	PUBLICATION NUMBER	PUBLICATION NAME		QUANTITY	ORDER
0500LP1105800	NAVPERS 172017	OSC In Law Cartoon (poster - 11"x14" two sided with Stress Continuum on reverse)		Order by # required Not Batched	
0500LP1105801	NAVPERS 172018	OSC LCPO Cartoon (poster - 11"x14" two sided with Stress Continuum on reverse)		Order by # required Not Batched	
0500LP1105802	NAVPERS 172019	OSC PCS Cartoon (poster - 11"x14" two sided with Stress Continuum on reverse)		Order by # required Not Batched	
0500LP1105803	NAVPERS 172020	OSC Video Game (poster - 11"x14" two sided with Stress Continuum on reverse)		Order by # required Not Batched	
0500LP1105804	NAVPERS 172021	OSC Fact Sheet 1- FAQ (Frequently Asked Questions)		Batch of 100	
0500LP1105805	NAVPERS 172022	OSC Fact Sheet 2- Program Facts		Batch of 100	

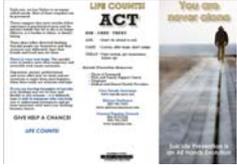
STOCK NUMBER	PUBLICATION NUMBER	PUBLICATION NAME		QUANTITY	ORDER
0500LP1098699	NAVPERS 172000	Navigating Stress 16" X 20" Poster		Order by # required Not Batched	
0500LP1098701	NAVPERS 172001	Navigating Stress Trifold		Order by # required Not Batched	

SUICIDE PREVENTION PROGRAM PRODUCTS AVAILABLE AT NAVAL LOGISTICS LIBRARY

Posters are also available for download at

http://www.npc.navy.mil/CommandSupport/SuicidePrevention/CommandLeaders/sp_posters.htm

STOCK NUMBER	PUBLICATION NUMBER	PUBLICATION NAME		QUANTITY	ORDER
0500LP1082585	NAVPERS 0177000	JUST ONE POSTER		Order by # required Not Batched	
0500LP1082586	NAVPERS 0177001	WE'RE ALL IN THIS TOGETHER POSTER		Order by # required Not Batched	

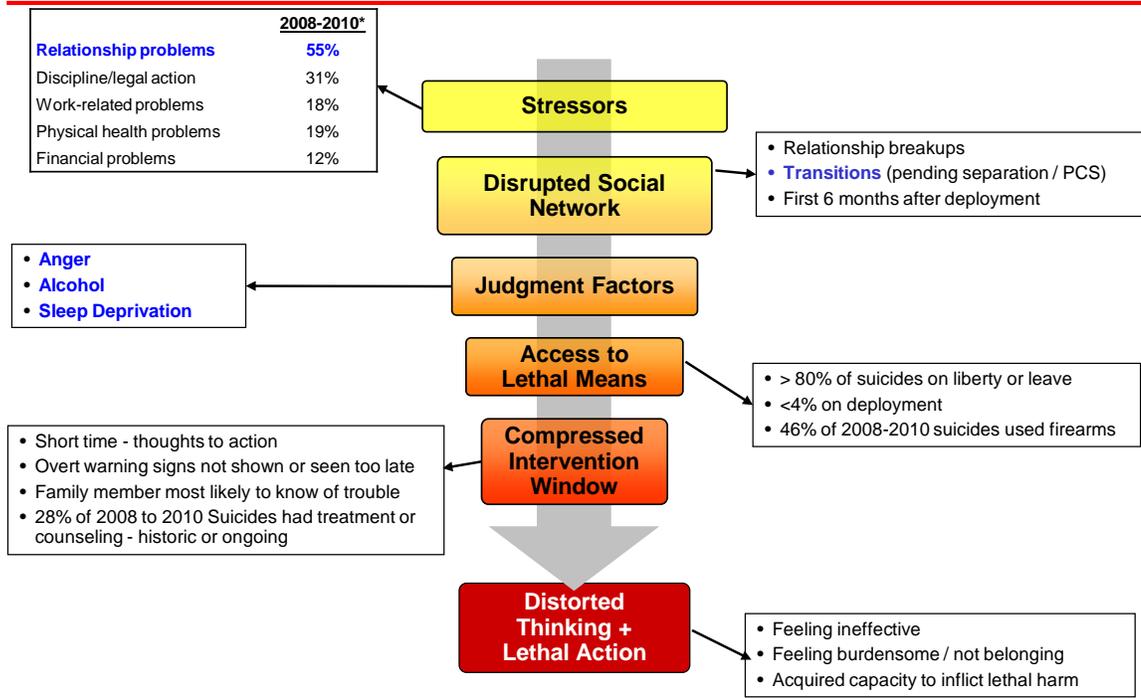
STOCK NUMBER	PUBLICATION NUMBER	PUBLICATION NAME		QUANTITY	ORDER
0500LP1082587	NAVPERS 0177002	GOT BIG PROBLEMS POSTER		Order by # required Not Batched	
0500LP1082588	NAVPERS 0177003	FOOTPRINTS POSTER		Order by # required Not Batched	
0500LP1082589	NAVPERS 0177004	SUICIDE PREVENTION TRIFOLD (Sailor Trifold)		Order by # required Not Batched	
0500LP1082590	NAVPERS 0177005	THE STRESS CONTINUUM TRIFOLD		Order by # required Not Batched	
0500LP1095303	NAVPERS 600004	NO SAILOR STANDS ALONE POSTER		Order by # required Not Batched	
0500LP1095304	NAVPERS 600005	DOESN'T HAVE TO BE THIS WAY POSTER		Order by # required Not Batched	

STOCK NUMBER	PUBLICATION NUMBER	PUBLICATION NAME		QUANTITY	ORDER
0500LP1095305	NAVPERS 600003	WARNING SIGNS POSTER		Order by # required Not Batched	
0500LP1095306	NAVPERS 600002	SUICIDE PREVENTIONS FAMILY TRIFOLD		Order by # required Not Batched	
0500LP1106073	NAVPERS 60007	Navy Suicide Prevention: Peer to Peer Training		Order by # required Not Batched	
0500LP1106072	NAVPERS 60006	Navy Suicide Prevention Videos: "After a Suicide: Helping Those Left Behind" "Overcoming a Suicidal Crisis: One Family's Insights for Care Providers"		Order by # required Not Batched	
0506LP1019435	NAVPERS 60000A	THRIVING ON STRESS POCKET GUIDE		Order by # required Not Batched	
<p>OPERATIONAL STRESS CONTROL PROGRAM PRODUCTS AVAILABLE FOR DOWNLOAD ON NKO'S OSC PAGE: https://wwwa.nko.navy.mil/portal/operationstresscontrol/operationstresscontrol?paf_default_view=true</p>					

STOCK NUMBER	PUBLICATION NUMBER	PUBLICATION NAME		QUANTITY	ORDER
		OSC Combat Stress First Aid Sheet		1 per page	
		OSC Combat Stress First Aid Sheet		1 per page	
Suicide Prevention Program Products - From sources other than NKO or Naval Logistics Library					
Order Number 00444667	Available through http://www.defenseimagery.mil To Order Call Customer Service direct at (888)743-4662	Suicide Prevention - A message From Survivors		each	
Contact: Suicide Outreach Coordinator OPNAV N135, Millington, TN 901-874-6723	Available only upon phone request. 901-874-6723	Suicide Awareness and Prevention Tools		each	



Factors: Chain of Events



2

Analysis of Navy suicides has shown a common pattern that includes one (or often multiple) life stressors, conditions around the time of the event where social network was disrupted in some way, and in which judgment was impaired at the time of the event by alcohol, sleep deprivation, or acute anger. Easy access to lethal means in states of impaired judgment increases the likelihood of impulsive suicide – an important percentage of Navy suicides could be avoided if the person had to delay more than 30 minutes before acting. Note: very few suicides occur on shipboard deployment where social support is often strong and access to means more difficult.

- When clear warning signs are shown to command members, intervention almost always takes place (these instances are found in SITREPS). In many of the deaths, no clear warning signs were seen by fellow Sailors or command. It is common for a significant precipitating factor to occur on liberty and the Sailor dies before seeing the command again - leaving no time for intervention once in crisis. When someone was aware a Sailor was having problems or thoughts of suicide, this was most often a family member or significant other. Prevention must move upstream before thoughts of suicide even occur and families need to learn to recognize warning signs and access assistance.
- Although there are many pathways leading to psychological pain and suicide, Thomas Joiner's evidence based theory suggests that all lead to a common cluster of distorted thinking and beliefs. The individual feels they do not belong or have become a burden to others and that they are no longer effective. People work up to the capacity for lethal harm through means such as vicarious exposure to pain, mental rehearsal, learned pain tolerance in training, sports, or habitual self-injury, or progressive risky behaviors.
- Most Sailors never got in the door to professional help before taking their lives, but 23% of 2009 deaths had received some type of counseling or mental health treatment within the year of their death. One focus area is making sure mental health providers have the state of the art tools for assessing and managing suicide risk and that effective processes are put in place related to communication between

leaders and medical providers to balance privacy and safety and best support the Sailor to heal and reintegrate.



Recent Navy Suicide Demographics

	2008	2009	2010	2011 Q1
Male	38	44	36	17
Female	1	2	2	0
Caucasian	27	32	28	13
Hispanic	2	7	2	1
African American	6	4	5	3
Asian/PI	3	3	1	0
Native American	1	0	1	0
Other	0	0	1	0
17-24	17	14	21	5
25-34	14	21	9	9
35-44	4	8	8	2
45+	4	3	0	1

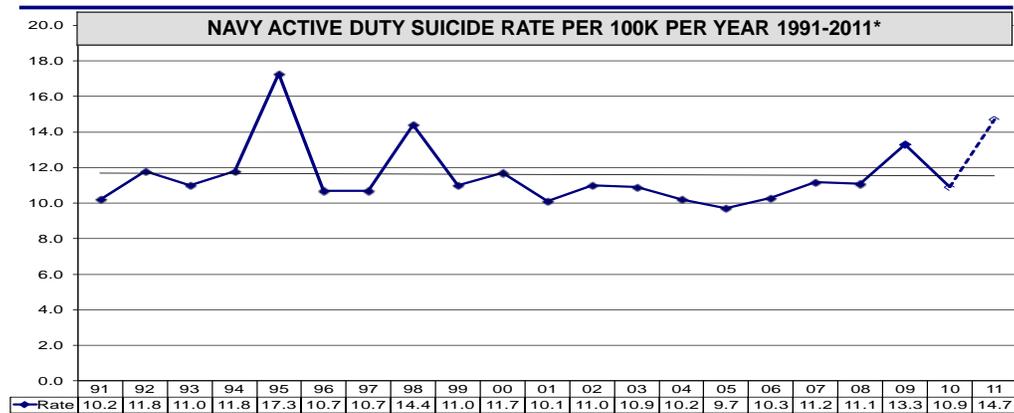
	2008	2009	2010	2011 Q1
E1-E3	11	5	14	2
E4-E6	23	32	18	13
E7-E9	2	7	3	0
W-O3	2	1	2	1
O4-O6	1	1	1	1
Gunshot	21	21	17	11
Asphyxiation	11	15	12	6
Ingestion	1	1	4	0
Carbon Monoxide	2	4	1	0
Jumping	0	2	2	0
Stabbing/Cutting	2	3	2	0
Unknown / Other	2	0	0	0

* 2010 and 2011 deaths include suspected suicides pending final medical examiner determination of cause of death.

Suicide demographics generally reflect Navy's population distribution



Data Overview - Recent Data



* 2010 preliminary rate includes suspected cases pending confirmation, 2011 12 month estimated rolling rate 3/31/11

In 2010, 1484 Suicide Related Behaviors were reported by commands. These Sailors received assessment, intervention and support
Ratio of SRB to Suicides
2010: 39 to 1 2009: 29 to 1
More intervention - fewer deaths



DEPARTMENT OF THE NAVY
OFFICE OF THE CHIEF OF NAVAL OPERATIONS
2000 NAVY PENTAGON
WASHINGTON, DC 20350-2000

OPNAVINST 1720.4A

N135

4 Aug 09

OPNAV INSTRUCTION 1720.4A

From: Chief of Naval Operations

Subj: SUICIDE PREVENTION PROGRAM

Ref: (a) OPNAVINST 6100.2A
(b) SECNAVINST 6320.24A
(c) MILPERSMAN 1770
(d) OPNAVINST F3100.6H (NOTAL)

Encl: (1) Suicide Risk Factors, Protective Factors, and Resources
(2) Definitions of Suicide Related Behaviors
(3) Sample Command Suicide Prevention/Crisis Response Plan Checklist

1. Purpose. To provide policy, procedures and assign responsibilities for the Navy's Suicide Prevention Program per references (a) through (d).

2. Cancellation. OPNAVINST 1720.4.

3. Applicability. Provisions of this instruction apply to all Active and Reserve Navy units within the Department of the Navy (DON).

4. Background

a. Suicide is a preventable personnel loss that impacts unit readiness, morale and mission effectiveness. Relationship disruption, substance abuse, financial problems, legal problems, and mental health problems (such as depression) can interfere with individual efficiency and unit effectiveness and also increase a person's suicide risk. Factors including positive attitude, solid spirituality, good problem solving skills, and healthy stress control can increase individual efficiency and unit effectiveness and reduce risk of intentional self harm. As such, preventing suicide in the Navy begins with promotion of health and wellness consistent with keeping Service members

ready to accomplish the mission. Enclosure (1) contains a list of suicide risk factors, protective factors and resources for assistance.

b. Navy suicide prevention programs consist of four elements:

(1) Training - increasing awareness of suicide concerns, improving wellness and ensuring personnel know how to intervene when someone needs help.

(2) Intervention - ensuring timely access to needed services and having a plan of action for crisis response.

(3) Response - assisting families, units and Service members affected by suicide behaviors.

(4) Reporting - reporting incidents of suicide and suicide-related behaviors (procedures outlined in subparagraph 5d below).

c. Medical personnel, chaplains, Fleet and Family Support Center (FFSC) counselors, health promotion program leaders, the Navy Reserve Psychological Health Outreach team, substance-abuse counselors, and command Suicide Prevention Coordinators (SPCs) support local leaders with information in their areas of expertise, intervention services, and assistance in crisis management.

d. Terms used in this instruction are included in enclosure (2).

5. Policy. Command suicide prevention programs, consistent with reference (a), shall be implemented to reduce the risk of suicide, to minimize adverse effects of suicidal behavior on command readiness and morale, and to preserve mission effectiveness and war-fighting capability. Suicide prevention programs shall include the following:

a. Training

(1) Suicide prevention training shall be conducted at least annually for all Active Component (AC) and Reserve Component (RC) Service members and for all Navy civilian

employees and full-time contractors who work on military installations. General Military Training (GMT) materials may fulfill part of this training requirement but must be supplemented with information on local action plans and support resources. Suicide prevention training should include, but is not limited to:

(a) Everyone's duty to obtain assistance for others in the event of suicidal threats or behaviors;

(b) Recognition of specific risk factors for suicide;

(c) Identification of signs and symptoms of mental health concerns and operational stress;

(d) Protocols for responding to crisis situations involving those who may be at high risk for suicide; and

(e) Contact information for local support services.

(2) Life-skills/health promotions training, such as alcohol abuse avoidance, parenting skills and skills for managing finances, stress, conflict and relationships will be provided to enhance coping skills and reduce the incidence of problems that might detract from personal and unit readiness.

(3) Messages will be published to provide suicide prevention information and guidance to all personnel. Emphasis shall be given to promoting the health, welfare and readiness of the Navy community; to providing support for those who seek help for personal problems; and, to ensuring access to care for those who seek help.

b. Intervention

(1) Commanding Officers (COs) shall have written suicide prevention and crisis intervention plans that include the process for identification, referral, access to treatment and follow-up procedures for personnel who indicate a heightened risk of suicide.

(2) COs shall foster a command climate that supports and promotes psychological health consistent with operational stress control principles. For example:

- (a) Foster unit morale and cohesion;
- (b) Promote physical fitness;
- (c) Provide clear direction and sense of mission;
- (d) Deglamorize alcohol use;
- (e) Know your Service members;
- (f) Ensure adequate time for rest;
- (g) Encourage good communication;
- (h) Help Service members maintain a work-life balance;
- (i) Do positive after-action reviews;
- (j) Reward accomplishments;
- (k) Refer early for intervention;
- (l) Communicate/coordinate with mental health providers; and
- (m) Reintegrate Service member back into the unit after treatment.

(3) COs shall provide support for those who seek help with personal problems. Access must be provided to prevention, counseling and treatment programs and services supporting the early resolution of mental health, and family and personal problems that underlie suicidal behavior.

(4) If a Service member's comments, written communication or behaviors lead the command to believe there is imminent risk that the person may cause harm to self or others, command leadership must take safety measures that include restricting

access of at-risk personnel to means that can be used to inflict harm and seek emergent mental health evaluation consistent with reference (b).

c. Response. In the event of a suicide or serious suicide-related behavior, families and affected personnel shall be provided support by the command and local mental health resources. Commands shall use organic resources or consult with the nearest medical personnel, chaplains or FFSC counselors to assess requirements for supportive interventions for units and affected Service members and shall coordinate with all local resources to implement interventions when needed.

d. Reporting

(1) Suicides and suicide-related behaviors shall be reported per references (c) and (d). Definitions for various suicide-related behaviors are provided in enclosure (2).

(2) A suicide is a self-inflicted death with evidence (either implicit or explicit) of intent to die. In instances of suicide and undetermined deaths for which suicide has not been excluded by the medical examiner, commands shall complete the Department of Defense Suicide Event Report (DoDSER) (available at <https://dodser.amedd.army.mil/dodser>) within 60 days of notification of death. Commands are advised to maintain copies of medical, dental and service records for 6 to 8 weeks after the member's death in order to complete the DoDSER and respond to unforeseen questions.

(3) A suicide attempt is a self-inflicted potentially injurious behavior with a non-fatal outcome that may or may not result in injury and for which there is evidence (either implicit or explicit) of intent to die. A DoDSER shall be completed for all suicide attempts by AC and RC Service members, as determined by competent medical authority, within 30 days of medical evaluation. Suicide attempt DoDSERs shall be completed by the military medical provider at the facility responsible for the member's psychological assessment or (if assessment occurs at a civilian facility) by the Military Treatment Facility (MTF) responsible for the TRICARE referral or by the RC command medical representative (for RC not on active duty).

(4) MTFs have a responsibility to notify commands if a Service member's mental state or condition presents an increased imminent risk of suicide in order to coordinate appropriate preventive actions.

e. SPC. Each CO will appoint an SPC. The SPC will aid the CO in ensuring that the suicide prevention program is fully implemented.

6. Responsibilities

a. Deputy Chief of Naval Operations (Manpower, Personnel, Training and Education) (CNO (N1)) shall establish a suicide prevention program policy. As executive agent, the Office of the Chief of Naval Operations (OPNAV), Personal Readiness and Community Support Branch (N135) shall:

(1) Develop policy guidance for the Navy's Suicide Prevention Program.

(2) Provide educational support to commands for suicide prevention elements.

(3) Provide information to, and establish training for, SPCs.

(4) Monitor the number of suicides and track trends of all suicides in the Navy total force. Coordinate the development and maintenance of a database to monitor suicides in coordination with OPNAV, Navy Casualty Office (N135C), the Office of the Armed Forces Medical Examiner, the Department of Defense Center of Excellence for Psychological Health, and Bureau of Medicine and Surgery's (BUMED's) Director of Psychological Health for Navy Reserve.

(5) Maintain statistical data on suicide prevention training.

(6) Provide ongoing program evaluation to the chain of command.

b. Chief, BUMED shall:

(1) Develop procedures and policy to ensure Service members who exhibit suicide-related ideations, communications or behaviors are properly evaluated and treated.

(2) Develop written procedures and policy to ensure that medical personnel execute their responsibilities regarding suicide prevention in an appropriate and consistent manner throughout DON to include communicating and coordinating with Service member's command.

(3) Provide technical assistance to COs and Navy leaders in support of commands.

(4) Ensure all MTFs have written protocols on suicide prevention maintained in acute care areas and emergency rooms.

(5) Develop written procedures and policy to ensure completion of the DoDSER for suicide attempts for Service member patients covered in each MTF's area of responsibility.

c. OPNAV, Chief of Chaplains (N097) shall:

(1) Consult with BUMED in the development of procedures and policies to ensure Service members who exhibit suicide-related behaviors (including ideations and communications) are properly evaluated.

(2) Develop written procedures to ensure that chaplains/religious program specialists execute their suicide prevention program responsibilities throughout the Navy.

(3) Provide assistance with implementation and evaluation of the suicide prevention program upon request of commands.

d. Commander, Navy Installations Command shall:

(1) Consult with BUMED in the development of procedures and policies for FFSCs to ensure Service members who exhibit suicide-related behaviors (including ideations and communications) are properly evaluated.

(2) Develop written procedures to ensure that personnel routinely responsible for installation emergency response including security, fire and rescue personnel execute their suicide prevention program responsibilities throughout the Navy.

(3) Ensure that installation emergency response personnel receive annual training, which reviews safety precautions and procedures and de-escalation techniques, when responding to situations of potential suicide-related behaviors and psychiatric emergencies.

e. Commander, Naval Education and Training Command shall:

(1) Provide GMT, or similar annual training, curricula on suicide prevention.

(2) Include suicide prevention training at basic accession points and leadership courses of instruction, e.g., Officer Candidate School, Officer Development School, Naval Reserve Officer Training Corps, Command Leadership School, Senior Enlisted Academy and Recruit Training Command.

(3) Include rate specific suicide intervention training at "A" schools and "C" schools for hospital corpsman, religious program specialists and master-at-arms rates.

f. Commander, Navy Recruiting Command shall ensure all recruits meet minimum entry-level physical and mental readiness standards.

g. Commander, Navy Reserve Forces Command shall:

(1) Implement a suicide prevention program as outlined in paragraph 5 of this instruction.

(2) Ensure all drilling Reservists, including voluntary training unit members, complete annual suicide prevention training.

h. COs shall:

(1) Ensure an effective suicide prevention program is established and maintained, consistent with requirements of this

instruction. Enclosure (3) provides a sample command suicide prevention/crisis response plan checklist.

(2) Designate, in writing, an SPC to assist in implementing the installation/unit suicide prevention program. Whenever possible, the SPC should be E7 or above. Designate, in writing, assistant SPCs (as necessary), appropriate to command size and structure.

(3) Ensure suicide prevention training is conducted on an annual basis for all command personnel and maintain records of the training.

(4) Distribute health and fitness materials in support of OPNAV health promotion initiatives.

i. SPCs shall:

(1) Become thoroughly familiar with the contents of this instruction and advise the chain of command on all suicide prevention program matters.

(2) Receive SPC training as established by OPNAV (N135) as soon as possible after designation.

(3) Schedule and announce suicide prevention training and be prepared, as needed, to conduct training.

j. Individual Service members shall:

(1) Learn and practice skills for maintaining a healthy lifestyle that promotes psychological health, physical readiness, and positive stress control.

(2) Provide assistance and immediately notify the chain of command if a shipmate is observed to be experiencing distress or difficulty in addressing problems or exhibiting behavior consistent with suicidal ideation.

(3) Seek assistance through the chain of command for support resources when experiencing distress or difficulty in addressing problems.

4 Aug 09

(4) Participate in suicide prevention training on an annual basis as a minimum.

7. Records Management. Records created as a result of this instruction, regardless of media and format, shall be managed per Secretary of the Navy (SECNAV) Manual 5210.1 of November 2007.

8. Reports Control The reporting requirements contained in this instruction are exempt from reporting requirements per SECNAV Manual 5214.1 of December 2005.



M. E. FERGUSON III
Vice Admiral, U.S. Navy
Deputy Chief of Naval Operations
(Manpower, Personnel, Training
and Education)

Distribution:

Electronic only, via Department of the Navy Issuances Web site:
<http://doni.daps.dla.mil>.

SUICIDE RISK FACTORS, PROTECTIVE FACTORS AND RESOURCES

Risk Factors and Stressors Associated with Navy Suicides

- a. Current mental health problems, such as depression or anxiety
- b. Substance abuse
- c. Past history of suicidal threats and behaviors
- d. Relationship problems
- e. Financial problems
- f. Legal difficulties
- g. Occupational problems
- h. Social isolation
- i. Ostracism
- j. Withdrawal
- k. Preoccupation with death
- l. Impulsiveness
- m. Access to and knowledge of lethal means

2. Protective Factors that Reduce Risk of Suicide

- a. Unit cohesion/camaraderie
- b. Humor
- c. Healthy lifestyle
- d. Effective problem-solving skills
- e. Positive attitude about getting help
- f. Optimistic outlook

- g. Spiritual support
 - h. Beliefs counter to suicide that support self-preservation
3. Resources
- a. www.suicide.navy.mil
 - b. www.nmcphc.med.navy.mil/LGuide/index.htm
 - c. www.militaryonesource.com
 - d. www.militarymentalhealth.org (Funded by Department of Defense Office of Health Affairs) provides anonymous online mental health screenings
 - e. www.usmc-mccs.org/leadersguide

DEFINITIONS OF SUICIDE RELATED BEHAVIORS

1. Suicide-Related Ideations. Any self-reported thoughts of engaging in suicide-related behaviors.
2. Suicide-Related Communications. Any interpersonal act of imparting, conveying or transmitting suicide-related thoughts, wishes, desires or intent; not to be construed as the actual self-inflicted behavior or injury.
 - a. Suicide Threat. Any interpersonal action, verbal or nonverbal, without a direct self-injurious component, passive or active, for which there is evidence (either explicit or implicit) that the person is communicating that a suicide-related behavior might occur in the near future.
 - b. Suicide Plan. A proposed method of carrying out a design that can potentially result in suicide-related behaviors; or, a systematic formulation of a program of action that will potentially lead to suicide-related behaviors.
3. 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 themselves (i.e., had no intent to die). Persons engage in self-harm behaviors in order to attain some other end (e.g., to seek help, to punish others, to receive attention or to regulate negative mood). Self-harm may result in no injuries, injuries or death.
4. Self-Inflicted Unintentional Death. Death from self-inflicted injury, poisoning or suffocation where there is evidence (either explicit or implicit) that there was no intent to die. This category includes those injuries or poisonings described as unintended or "accidental."
5. Undetermined Suicide-Related Behavior. A self-inflicted potentially injurious behavior where intent is unknown. For example, the person is unable to admit positively to the intent to die, due to being unconscious, under the influence of alcohol or other drugs (and, therefore, cognitively impaired), psychotic, delusional, demented, dissociated, disoriented, delirious, or in another state of altered consciousness; or, is reluctant to admit positively to the intent to die due to other psychological states.

6. Self-Inflicted Death with Undetermined Intent. Self-inflicted death for which intent is either equivocal or unknown.

7. Suicide Attempt. A self-inflicted potentially injurious behavior with a non-fatal outcome for which there is evidence (either explicit or implicit) of intent to die. A suicide attempt may or may not result in injury.

8. Suicide. Self-inflicted death with evidence (either explicit or implicit) of intent to die.

SAMPLE COMMAND SUICIDE PREVENTION/CRISIS RESPONSE PLAN CHECKLIST

Each command and environment is unique, as will be each command's suicide prevention and crisis intervention plan, but the following sample checklist may help in establishing or assessing the state of a program.

1. Appropriate annual suicide prevention training conducted for all Service members, including those in the Reserve, and for all Navy civilian employees and full time contractors?

Yes No

2. Suicide prevention part of life-skills/health promotions training? Yes No

3. Messages of concern sent by the senior leadership team to provide current information and guidance to all personnel on suicide prevention? Yes No

4. Written suicide prevention and crisis intervention plan in place (e.g., standard operating procedures, duty office checklist)? Yes No

5. Local support resource contact information easily available?

Yes No

For example:

Chaplain/Religious Services
Fleet and Family Support Center
Medical
Security
Local Emergency Room

6. Personnel and supervisors have ready access to information about how to get help with personal problems (e.g., wallet card info, posters, plan of the day, e-mails)? Yes No

7. Procedure in place to facilitate personnel accessing needed services (e.g., time for appointments, access to transportation, overcoming logistical barriers, discouragement of stigmatizing)?

Yes No

8. Supervisors active in identifying personnel potentially in need of support (e.g., relationship problems, financial problems, recent loss, legal problems or loss of status, change in behavior or performance, showing warning signs)? Yes No

9. Safety plan for dealing with high-risk Service members (e.g., suicidal/homicidal/bizarre thoughts and behaviors) until mental health services are available. In the absence of guidance from a mental health professional, recommend:

a. Removal of personal hazards (no weapons, belt, shoes, boot straps, draw strings, shirt stays, and personal hygiene items such as toothbrush or razor).

b. Removal of environmental hazards from room (room free of sheets, elastic bands, mirrors, pencils, pens, window dressings (such as blinds), shoelaces, strings, alcohol, weapons, medication, cleaning supplies, razors, metal eating utensils, telephones, tools, or any other rope, breakable, or sharp-edged object).

c. Line of sight supervision.

10. Mental health contact information readily available?
 Yes No

11. Follow-up plan for personnel after acute evaluation?
 Yes No