

INTRODUCTION

This manual replaces the previous USACHPPM Suicide Prevention: A Resource Manual for the United States Army dated 2000. This manual will focus on suicide prevention only and there are separate manuals for suicide intervention and postvention. This manual is valid only for CY 2008 and will be updated annually. All accompanying slides and graphic training aids will be available for downloading at the USACHPPM web page, <http://chppm-www.apgea.army.mil/dhpw/Readiness/suicide.aspx> .

HISTORY

Dr. David Satcher, Surgeon General of the United States, declared in 1999 that suicide is a serious public health threat, so he launched a national effort to develop strategies to prevent suicide and the suffering it causes. The Army followed his direction and in December 1999, the Chief of Staff of the Army directed a review of the Army Suicide Prevention Program. In 2000, the Army G-1, the Army Office of the Surgeon General (OTSG), and the Office of Chief of Chaplains (OCCH) completed a review and determined that the program was basically sound but needed to emphasize greater leadership involvement and offer more advanced training. In 2001, the Army implemented the Suicide Prevention Campaign Plan that emphasized prevention and intervention measures, directed commanders to take ownership, and synchronized and integrated resources at installation level. In compliance with the need for more advanced training, the Army G-1 funded intervention training in 2002 by contracting with Living Works and initiated the Applied Suicide Intervention Skills Training (ASIST) workshops with accompanying computer interactive computer disk. In 2005, the Army G-1 funded Question, Persuade, Refer (QPR) workshops Army-wide to provide an additional resource in suicide prevention awareness and intervention training.

With the advent of combat operations in Afghanistan and Iraq, completed suicides in theater increased during 2002-2006. To assess Soldiers' mental health issues and look at their suicide prevention programs, OTSG deployed Mental Health Assessment Teams (MHAT) from 2003 - 2006 to the OIF/OEF Theaters. The 2005 MHAT report verified that suicide prevention training was being conducted at specific intervals during the deployment cycle, primarily conducted by Unit Ministry Teams (UMT) with occasional assistance from behavioral health assets. The report also discovered that there was a decrease in Soldiers' perception of the adequacy of suicide prevention training.

The latest national suicide data reported by the Centers for Disease Control and Prevention (CDC) was released in February 2006 and contains data from 2003. The CDC reported that 31,484 people in the United States died by suicide in 2003 and estimated suicide attempts for 2003 at 787,000. The national suicide rate for 2003 is 10.8 per 100,000. Since 1994, the rate has fluctuated from 12.0 to 10.7. Research reveals that 90% of those individuals who committed suicides had a Diagnostic and Statistical Manual of Mental Disorders, 4th. Edition (DSM-IV) diagnosis. It also shows that men are four times more likely to commit suicide while women are three times more likely to attempt suicide.

The Army suicide rate for 2005 was 13.0 which is higher than the 2003 civilian rate but lower than the civilian demographically-adjusted rate of 19.9. The Army suicide rate has varied from 9.2 in 2001 to 15.8 in 1985. Eighty-eight Soldiers committed suicide in 2005 with one case still pending. As of 20 December, 77 Soldiers had killed themselves in 2006 with 18 cases still

pending. Eighty-nine percent (89%) of those deaths are from the Active Component (AC), 42% were either deployed or had deployed within 12 months.

ARMY SUICIDE PREVENTION PROGRAM

Suicide Prevention is a commander’s program and the responsibility of every leader. It is a required training for Army Soldiers and civilian employees but the frequency of this training is not specified, so the commander can be creative and implement training that is based on internal factors. It is highly recommended for family members, but not required. AR 600-63 states that this training can come from UMT or behavioral health personnel, or the best choice would be a collaborative effort from the different disciplines. Leaders, gatekeepers, and UMT members will receive more advanced training, and behavioral health professionals shall provide the technical expertise for this training.

The Army Suicide Prevention Program (ASPP) is defined in AR 600-63 and it involves the entire military community as the Garrison Commander will establish a Community Health Promotion Council (CHPC). The CHCP ensures that suicide prevention activities are carried out in accordance with the AR 600-63. The Garrison Commander designates a Garrison Suicide Prevention Program Coordinator to synchronize and integrate unit and community-based programs and activities. The current strategies designate layers of responsibilities for commanders, leaders, and the CHCP.

SUICIDE PREVENTION STRATEGIES

	LEADERS (L) COMMANDERS (C)	CHCP
DEVELOP POSITIVE LIFE COPING SKILLS	<ul style="list-style-type: none"> • Encourage and support programs (L) 	<ul style="list-style-type: none"> • Ensure programs are promoted and advertised
ENCOURAGE HELP-SEEKING BEHAVIOR	<ul style="list-style-type: none"> • Create positive command climate (L) • Eliminate negative policy (C) • Monitor access to services and programs (C) 	<ul style="list-style-type: none"> • Increase visibility and accessibility to local helping agencies • Monitor use of helping agencies • Coordinate with local programs
RAISE AWARENESS AND VIGILANCE TOWARDS SUICIDE PREVENTION	<ul style="list-style-type: none"> • Ensure training for all Soldiers/DA employees (C) • Coordinate training for leaders (C) • Ensure supervision and assistance to those in crisis (L) • Ensure training for UMTs (L) 	<ul style="list-style-type: none"> • Ensure training of all installation gatekeepers • Identify events that increase the risk of suicide and take appropriate measures
SYNCHRONIZE, INTEGRATE AND MANAGE THE ASPP		<ul style="list-style-type: none"> • Implement suicide prevention strategies and objectives • Establish policies and procedures for the ISRT • Create subcommittee(s) as needed
CONDUCT SUICIDE SURVEILLANCE, ANALYSIS AND REPORTING	<ul style="list-style-type: none"> • Stay aware of the problem of suicide behavior, track any demographic trends, and identify any potential event that has raised the level of risk (L) 	