

13. APPENDIX B : SUICIDE PREVENTION ACTION PLAN
(SPAP)



MULTI-NATIONAL CORPS- IRAQ

Suicide Prevention Action Plan

Version 3.1
December 1, 2008

Purpose

To establish an effective suicide prevention program for the Soldiers, Sailors, Airmen, and Marines and their leaders serving within the Multi-National Corps-Iraq and equip these personnel with the right tools to help identify, prevent, and assist in the treatment of behavioral health issues experienced by their teammates.



Teammates take care of Teammates

You Can Do Something...Intervention Can Save a Life

"One Suicide is one too many"

For more information see your unit leadership, chaplain,
healthcare provider or visit

<https://mnci.intranet.iraq.centcom.mil/C1>

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Objective: To Implement and Maintain a Viable Suicide Prevention Program in the Iraq Theater of Operation (ITO) that Seeks to Eliminate or Reduce Suicidal Behavior

Suicide Action Plan Goals

- Develop positive life coping skills that eliminate suicide as an option in a teammate's mind

- Encourage a "help-seeking" environment and remove barriers to care for all teammates

- Raise teammates' awareness and vigilance towards suicide prevention

- Reinforce the idea that "Teammates take care of Teammates"

- Get all teammates involved with suicide prevention throughout the entire deployment cycle; not just after a successful or attempted suicide occurs

- Empower teammates with the tools to deal with a suicide event should it arise

Background

Based on the Army's 2007 Mental Health Advisory Team (MHAT) V conclusions, the current Army Suicide Prevention Program is not designed for the contemporary combat/deployed environment. The MHAT further believed that the Army's program needs to provide more realistic training packages focused on the phases of deployment and aimed at building psychological resiliency. The Army's suicide rate has been increasing for the past four years especially in the Iraq Theater of Operation (ITO). It is critical that an action plan be maintained and emphasized at the lowest levels if we are to positively influence and prevent suicides by military service members in Iraq.

Since 1 January 2008, there have been a total of 28 completed suicides. While an increasing number of service members are on subsequent deployments, the majority of successful suicides were committed by first-time deployed service members. This upward trend in completed or attempted suicides in the Iraq Theater of Operations must be reversed.

Current Site Picture

Currently, several MNC-I staff agencies are working efforts in suicide prevention. Other efforts are being undertaken by the behavioral health networks, Combat Stress, and other counseling services that are available and making a difference in our efforts to eliminate or reduce suicide in Iraq. The training, treatment, tracking, and regular maintenance of the program need to be coordinated and synchronized to ensure no member is left behind. Additionally, each of the Multi-National Divisions and Major Subordinate Commands all have individual programs that they maintain.

The MNC-I Suicide Prevention Action Plan takes a three-pronged approach with a keen focus on training and awareness: suicide prevention education; resiliency training; Army Suicide Intervention Skills (ASIST) program; and Unit intervention. As of 1 January 2008, the Department of Defense Suicide Event Report (DODSER), is being used to report completed suicides and attempts resulting in hospitalization for all MNC-I service members.

The MNC-I Chaplain functions as the teaching and training arm of the program using the Ask, Care, Escort (ACE) training model (train- the-trainer), along with the ASIST Program. ASIST training is comprised of three tiers:

Tier 1 Gatekeeper (Buddy level) focuses on awareness and intervention training annually spearheaded by the Chaplain.

Tier 2 Gatekeeper is the Leader level (supervisors, green tabbers, etc).

Tier 3 Gatekeeper is the Intervention level. The ASIST Program requires 1 in every 50 soldiers be trained on the procedures associated with intervention. In addition to being the theater ASIST proponent, the Chaplain also tracks and reports numbers of counseling and referrals for suicide related matters.

Behavioral Health specialists can also provide resiliency training to individuals, units, leaders and families during the pre-deployment, deployment and post-deployment phases of the operation.

Way Ahead

As is often the case, suicide is a high profile act that gains our attention only after there is a trend identified by an outside agency, or the general public. For prevention to be effective, it must begin before a team member deploys. Suicide is not a pleasant topic and some leaders think the more you talk about it, the more you will "plant the seed" in people's mind that it is a viable option. Actually, the more that suicide is talked about, the more barriers can come down and lessen the associated stigma. Leaders who stand up early and address negative indicators that can often lead to more disruptive and life-threatening behavior will improve not only the overall readiness of their organization, but will do more to ensure every teammate in distress seeks help, and makes it back home to their loved ones.

Suicide prevention training should be incorporated into every facet of the deployment cycle: pre-deployment, deployment, re-deployment, and re-integration; and it includes all members of the team: leaders, behavioral health professionals, chaplains, service members, family members and significant others. The training must be relevant, realistic, and useful to team members or it will not be internalized. Just as units prepare to combat IEDs or insurgents, they must prepare to combat the battle in the mind against negative behaviors that can lead to demise and combat ineffectiveness. We must be deliberate in our suicide prevention efforts to ensure that first-line leaders and commanders are equipped with the tools needed to identify and recognize the warning signs in their team members. They must also be familiar with the methods and procedures on how best to get them help and what resources exist to aid in this effort.

Awareness and training are the keys to preventing suicide. Teams who synchronize the elements of command emphasis, training, communication, early detection, intervention, and treatment, have the best chances of eliminating or reducing the occurrences of suicides and attempts within their organizations.

MNC-I Strategy

- ❖ Implement Theater-level Suicide Prevention Action Plan
- ❖ Execute Quarterly Theater-level Suicide Prevention Review Boards (SPRB) to review lessons learned and current trends
- ❖ Publish and Enforce the MNC-I Suicide Prevention Policy focused on:
 - ✓ Resiliency Training
 - ✓ Leadership Emphasis
 - ✓ Education
 - ✓ Awareness

- ✓ Suicide Awareness Training
- ✓ De-Stigmatization of Seeking Behavioral Health Services
- ✓ Vigilance
- ❖ Distribute leader and service member suicide prevention pocket references down to unit level
- ❖ Use a unit behavioral health survey as a risk assessment tool at unit level (consult local Combat Stress personnel for which specific tool to use)

MNC-I Approach

- ❖ Begin Suicide Prevention and Resiliency Training during pre-deployment and continue throughout deployment cycle
- ❖ Emphasize prevention at the first-line leader level (NCO's have hand on pulse)
- ❖ Integrate all players (leaders, commanders, ministry teams, medical teams, teammates, family members) in entire process
- ❖ Reduce barriers to care by removing stigma for those who seek help
- ❖ Leaders need to ensure that new teammates are integrated into the team before and during deployment. New teammates arriving during deployment should be integrated as soon as practicable
- ❖ Analyze situations (UCMJ, casualties, "Dear John" letters) that could set in motion suicidal behavior and counter with intervention
- ❖ Command emphasis from top-to-bottom
- ❖ Keep talking to troops but also listen to them!

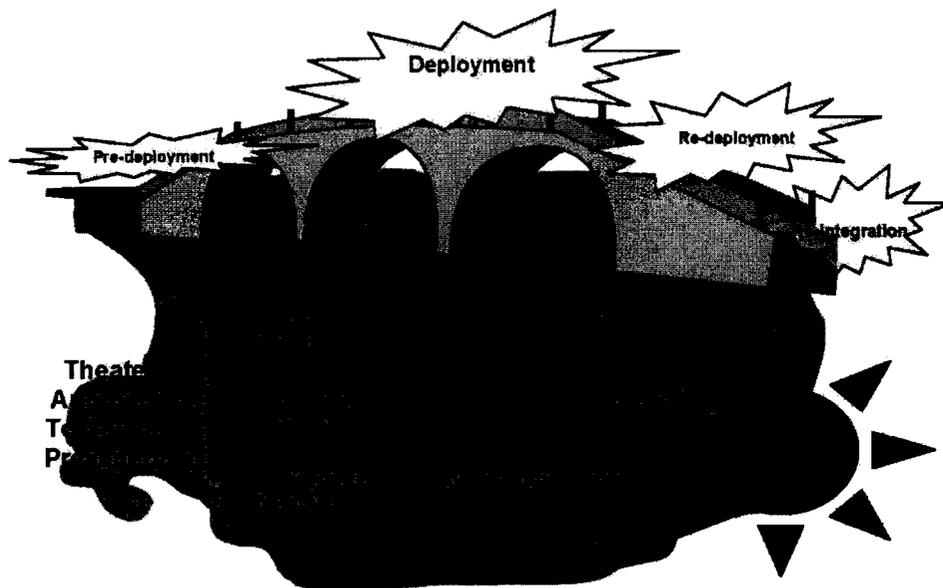
When team members feel they are valued members of the team, they feel obligated to stay in the fight and not do anything that would cause undue burdens on their comrades. This process should start from a teammate's arrival.

The buddy concept should be used as extensively as possible in our efforts to combat suicidal behaviors in our ranks. The first-line leader, the NCOIC/ squad leader, has an optimal vantage point of a team member's behavioral health especially in the deployed environment. What's easier to hide in garrison can become prevalent during a lengthy deployment. It is imperative that all leaders become very familiar with suicide prevention and intervention tools such as ACE to make a difference. Commanders must also ensure that their units have the requisite number of Soldiers trained in Army Suicide Intervention Skill Training (ASIST).

A leader should never discount how a team member views his or her situation. If it's a big deal to them, it should be seen accordingly to leaders. A team member who is preoccupied with home front issues or other stressors will not be fully engaged in execution of their duties and could become a liability, rather than a force multiplier, in combat. The leader who is attuned to his or her subordinates will know when something is wrong. The goal of this suicide prevention action plan is to ensure that teammates look out for one another and knowing what to do when one of their own exhibits the signs that could lead to suicidal behavior.

Suicide Prevention & the Deployment Cycle

The time to conduct suicide prevention training is well before the deployment ever begins and must continue throughout the entire deployment cycle.



Pre-deployment

The pre-deployment phase of the Suicide Prevention Plan incorporates three areas: (1) Prevention/Training; (2) Intervention/Early Identification; (3) Pre-deployment screening.

During pre-deployment, a unit has many training requirements. Suicide prevention training should be approached just as energetically as gunnery, an MRE, or an MRX. Suicide prevention and resiliency training shouldn't be the same old PowerPoint slide presentation that is shown during quarterly training just to meet a QTB requirement, but rather, effective training

that instructs the participants by engaging them in learning. Role playing, testimonials, short high-energy videos (10-15 minutes) that set up expectations for the deployment and what team members may realistically face should help ease the anxiety of a deployment. One of the MHAT recommendations was for all leaders to read the NATO's "*Leader's Guide to Psychological Support Across the Deployment Cycle*" throughout all the phases of the deployment.

Prevention/Training During Pre-deployment

For All

- ❖ Training focuses on recognizing risk factors and early warning signs
- ❖ Emphasizes how to seek/get assistance
- ❖ Useful, relevant, and honest training not "same old slide packet" and 1-hour brief
- ❖ Use role playing and testimonials when possible
- ❖ Involve family members
- ❖ Chaplains take lead
- ❖ All service members complete as part of pre-deployment training
- ❖ Battlemind training and similar programs are key steps in building psychological resiliency.

For Medical Personnel

Train on recognition and management of:

- ❖ Combat Operational Stress (COS)
- ❖ Post Traumatic Stress Disorder (PTSD)
- ❖ Sleep disorders
- ❖ Depression
- ❖ Coping with stress
- ❖ Battle drills for responding to critical incidents in combat
- ❖ Pairing up with unit ministry teams to work in concert in field environment

For Leaders

Commander and Senior Leader conferences to discuss:

- ❖ Wellness
- ❖ Self care
- ❖ Warrior resilience
- ❖ Importance of leader involvement
- ❖ Command referrals
- ❖ Recognizing risk factors/warning signs of suicidal behavior
- ❖ Remove barriers to care by reducing stigma to getting help

Intervention/ Early Identification

Intervention and early identification of behavioral health issues prior to deployment can help leaders focus their efforts and posture their commands for challenges that may arise during the deployment. By conducting this early assessment, commanders are better armed with information to know which team members are at risk and may require additional attention during the deployment. Commanders may also begin addressing a team member's behavioral health problems before the deployment starts and adjustments can be made which will better accommodate the team member and the mission.

Minimum Behavioral Health Standards for Deployment

- Service members with significant behavioral health problems must show three months of stability prior to deployment
- Service members currently being treated for psychosis or bipolar disorder are not deployable
- Service members who are taking medications which require laboratory monitoring such as lithium or valproic acid are not deployable
- Service members who are taking antipsychotic medications to control psychotic, bipolar, or chronic insomnia conditions are not deployable
- The continued use of psychotropic medications clinically and operationally problematic during deployments including short half-life benzodiazepines and stimulants should be balanced between the necessity for successful functioning in the theater of operations and the ability to obtain the medication, the potential for withdrawal, and the potential for abuse
- If a Service member is placed on a psychotropic medication within three months of deployment, then he/she must be improving, stable, and tolerating the medication without significant side effect to deploy

Deployment

Suicide prevention efforts must not end upon arrival into theater. Training must occur at all levels; especially in the squad/platoon-sized elements. Training should be tailored to the current phase of the deployment and the contemporary issues of the team. These issues may include home front issues, UCMJ, heavy casualties or combat losses, etc. During this training, commanders should ensure that all Soldiers (buddy teams), especially first-line NCOs are looking out for the early warning signs they learned to detect issues during pre-deployment training. First-line leaders will need to emphasize the importance of buddy maintenance and will need to assist team members in this effort. Training should be targeted for the 6th -10th months of the deployment, as these are the critical points, statistically, when most suicidal ideations, gestures, or incidents occur.

Resilience training strengthens psychological health by teaching individuals, families and teams techniques for stress reduction, post traumatic growth, self mastery and team building. Specific Warrior Resilience Training (WRT) courses are available from theater CSC and BH teams. The WRT program of instruction utilizes Warrior Ethos concepts, Army leadership principles, Rational Emotive Behavior Therapy strategies, and inspirational examples of POW and survivor resiliency to supplement pre-deployment resilience training and reduce barriers to care.

Another very important aspect of deployment and the management of healthy lifestyle habits is the establishment and enforcement of work/rest cycles. Everyone needs "down time"—even leaders. In fact, one of the most effective means for leaders to convey similar practices in their subordinates, is to exercise it themselves when the mission and conditions allow. A unit R&R plan should be established early to build predictability for team members. There are other in-theater Fighter Management Plans like Freedom Rest or the Qatar Pass Program that are options for team members to take R&R, as well as other MWR options. Leaders should remain vigilant for "tracer burn out" in their teammates. When fatigue is high, individual defenses are down and those who are already susceptible to suicidal tendencies will only become more so.

A tool that can help commanders identify systemic issues within their unit is the Unit Behavioral Health Needs Assessment Survey (UBHNAS). This survey was developed by the Walter Reed Army Medical Center and is meant to sample 10 percent of a unit, anonymously, to identify trends. It is not a clinical assessment or screening tool, but can be an invaluable tool to help the commander identify larger issues his/her unit may be dealing with. This will assist the commander in better tailoring training and other prevention options.

While deployed, team members may encounter problems and will need to develop healthy ways of working through them. The buddy system is a great network that teammates can use to looking out for each other. However, sometimes personal problems move beyond the scope and abilities of a friend to handle and will require professional assistance. Today's leaders have a variety of options available to them to assist their subordinates in attaining help. Some service members feel more comfortable with a representative from the Unit Ministry Team, while others may need more sophisticated treatment and should be referred through the unit physician to Combat Stress units. Another avenue to explore is the use of Unit Behavioral Health Advocates. This concept is very much what we have in place in units with Sexual Assault Victim Advocates. Each battalion would have a mid-level NCO (E6-E7) that would serve as the battalion advocate. They would be another available asset to work with the unit's medical and command teams as a liaison for the team members. They can help decrease the

stigma associated with getting help, help identify "at risk" team members, and assist in teaching and prevention efforts.

Suggested Medical Health Care While Deployed

- ❖ **Level 1 (Battalion Aid Station)**
- ❖ **Level 2 (Outpatient Clinic)**
 - **Physicians & PAs – first line care and intervention**
 - **Psychiatry consults**
- ❖ **Combat Stress Clinics**
 - **Located throughout OE**
 - **Improves accessibility**
- ❖ **Outreach at Patrol Bases**
 - **Highest risk for Combat and Operational Stress due to exposure**
- ❖ **Debriefings**
 - **Event Driven**
 - **Time Based**

Finally, the unit needs a plan on how to deal with team members who contemplate, attempt or succeed in harming themselves – a postvention plan. Reporting suicidal events through the Department of Defense Suicide Event Report (DODSER) is already an MNC-I requirement. It is DoD's standardized reporting apparatus for any successful event or ideation/behavior resulting in evacuation or hospitalization. This is to be done within 60 days of a completed suicide or within 30 days of an ideation/behavioral event and forwarded through the service member's chain of command to the Theater Behavioral Health Consultant located in the Task Force Medical Command.

As of 1 January 2008, the Combat and Operation Stress Control Workload and Activity Reporting System (COSC-WARS) are used to uniformly collect and record behavioral health information. This numerical worksheet is completed monthly by medical providers and can help track suicide attempts and rates of Combat Operational Stress Reactions versus Mood Disorder.

The last piece of postvention is the review process. Each brigade level unit should conduct a Suicide Review Board for all successful suicides to identify lessons learned, and take measures to prevent or reduce future occurrences.

Redeployment

Much like the pre-deployment and deployment phases, redeployment involves training, early identification/ intervention, and treatment. The major difference with the redeployment phase is that the source of anxiety for a team member may have shifted to what awaits them back at home station rather than the battlefield. These fears can manifest themselves in many ways and the unknown or pending conflict that many may experience can be too overwhelming when coupled with the fatigue of a long combat tour. One of the tools the Department of Defense has implemented to mitigate this is the Post-Deployment Health Assessment (PDHA). This assessment is completed before a service member redeploys. This assessment tool provides a commander with a good idea of which members of their unit could potentially experience problems upon re-deployment. Commanders can determine, with the advice of behavioral health professionals, which members need treatment and to what degree. If it's determined, after consultation with Behavioral Health, that a team member is a high risk to themselves or others, commanders can take appropriate measures upon arrival at home station. Service members assessed at a lower risk can be scheduled for treatment or continue treatment if started in theater.

Redeployment preparation should simultaneously occur in theater, and back at home station, to prepare service members and their families for reintegration. Rear detachment elements should work to involve family members in reintegration classes and workshops that will assist them in receiving their loved one back into the home. Family services and other applicable agencies should attempt to make families aware that the service member completed could have been life-changing. Resiliency training strengthens psychological health by teaching individuals, families and teams techniques for stress reduction, post traumatic growth, self mastery and team building.

While in theater, there are certain regulatory Deployment Cycle Support (DCS) tasks that must be completed prior to re-deployment. Each individual is required to complete a DCS checklist which includes the PDHA (DD 2796) and other required briefings (Medical Threat, Pre-Battlemind training) that address behavioral health/traumatic brain injuries issues. A complete list of the DCS requirements can be found on the MNC-I C1 SIPR website under "DCS CONPLAN/REDEPLOYMENT."

Required DCS Briefings

- Reunion Training (Chaplain)
- Communication Training (Chaplain)
- Soldier and Family Resilience (Behavioral Health)
- Suicide Awareness (Chaplain)
- Marital Assessment (Chaplain – as required)
- Finance Re-deployment Info (Finance)
- SCRA & USERRA (SJA)
- Theater Medical Threat (Medical)

- Behavioral Health (Medical)
- Post-Deployment Health Assessment (PDHA) (Medical) *NET 30 days before redeployment*
- Mild Traumatic Brain Injury (MTBI) and PTSD (Medical)
- Tricare Benefits (Medical)
- Post-Deployment Battle Mind Video (Unit Leadership)
- Unit Risk Reduction (Unit Leadership)
- Sexual Assault Prevention and Response (Unit Leadership)
- Substance Abuse Prevention (Unit Leadership)

*Briefings will be completed NET 90 days prior to redeployment unless otherwise noted.

The PDHA, which is completed in theater no earlier than 30 days before redeployment by unit providers, is used to identify any potential health issues, including behavioral health. Service members who screen positive on the PDHA for potential behavioral health issues will be categorized as low, medium, or high risk. Brigade-level surgeons should track service members requiring follow-up and consults can be completed at the PDHA website. All soldiers are also screened for Traumatic Brain Injuries (TBI) with the Defense and Veterans Brain Injury Center (DVBIC) question-four screen.

PDHA Risk Stratification

❖ Low

- Normal reactions to abnormal stressors
- Does not require further evaluation
- Recommend to seek care upon return to home
- No further outreach taken

❖ Medium

- Those who need behavioral health care, but do not present high risk for harm to themselves or others
- Advanced list sent to home station behavioral professionals to help prepare for intake before release for 2-day pass
- Outreach from local behavioral health professionals to schedule follow-up shortly after return

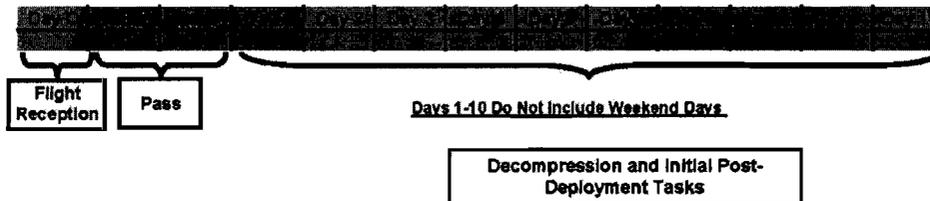
- Can't force into treatment, but will conduct aggressive outreach as they are in greater need

❖ High

- Those who present a significant risk upon return
- List is sent to commanders with pre-completed command directed evaluation packets
- Recommend that command closely monitor these individuals at unit level
- Will complete emergency command directed evaluation prior to release upon return to home station

Re-integration

Upon re-deployment, service members will finalize the PDHA (DD 2796) at their home station as part of their DSRP. This is conducted in accordance with the DCS task timeline before service members are released for block leave. The DSRP may also identify behavioral health issues and service members should be tracked and followed by the command in much the same way they were in theater only they should have greater access to care.



At the 90-day post-deployment mark, a follow-up assessment will be conducted on all service members. This follow-up assessment is designed to capture issues that have arisen since the re-deployment. The initial weeks back, the "honeymoon phase," are usually uneventful but once the re-deployed service member resumes his "normal routine", problems are more apt to surface.

Suicide Prevention/Review Board (SPRB)

The MNC-I Surgeon is the proponent for the Suicide Prevention Review Board. It meets quarterly (March, June, September, December) to plan, review trends, implement changes, and manage suicide prevention efforts in theater. The team can be assembled more frequently by the Commanding General if warranted. These memberships should not rotate due to the sensitivity of information discussed.

- a. MNC-I Deputy CG, Chair
- b. MNC-I CSM
- c. C-1
- d. MND/MSC representative (1)
- e. TF MEDCOM Behavioral Health Consultant
- f. Chaplain
- g. Surgeon
- h. Provost Marshal (PM)
- i. Staff Judge Advocate (SJA)
- j. Inspector General (IG)
- k. Public Affairs Officer (PAO)
- l. Criminal Investigation Division (CID)

Board Responsibilities:

- (1) Reviews trends suicide trends since last SPRB and calendar year cumulative statistics and demographics
- (2) Coordinates program activities and suicide prevention activities for MNC-I and its subordinate units.
- (3) Evaluates the program's needs and makes appropriate recommendations to the command.
- (4) Review and refine the program based on continuous evaluation of needs.
- (5) Develops awareness training concerning MNC-I suicide prevention activities and identifies appropriate forums for training.

(6) Evaluates the impact of the pace of combat operations and other stressors on the behavioral health of service members.

(7) Recommends command policy guidance for training and operations issues to ensure service members and leaders have sufficient opportunity for quality of life and family life.

(8) Reviews publicity generated with respect to suicides in the military community.

(9) MNC-I DCG chairs the board and coordinates the efforts of the committee members, providing overall staff guidance for the board.

**ACE
CARD
(All Service Members)
(Front)**



**ACE
CARD
(All Service Members)
(Back)**

<p>Ask your buddy</p> <ul style="list-style-type: none"> Have the courage to ask the question, but stay calm. Ask the question directly, e.g. Are you thinking of killing yourself? <p>Care for your buddy</p> <ul style="list-style-type: none"> Remember any reasons that would be used for self-harm. Clearly counsel the individual, do not use force. Actively listen to professional advice. <p>Escort your buddy</p> <ul style="list-style-type: none"> Never leave your buddy alone. Escort to the place of treatment, a Chaplain, a behavioral health professional, or a primary care provider. 	<p>Ask your buddy</p> <ul style="list-style-type: none"> Have the courage to ask the question, but stay calm. Ask the question directly, e.g. Are you thinking of killing yourself? <p>Care for your buddy</p> <ul style="list-style-type: none"> Remember any reasons that would be used for self-harm. Clearly counsel the individual, do not use force. Actively listen to professional advice. <p>Escort your buddy</p> <ul style="list-style-type: none"> Never leave your buddy alone. Escort to the place of treatment, a Chaplain, a behavioral health professional, or a primary care provider. 	<p>Ask your buddy</p> <ul style="list-style-type: none"> Have the courage to ask the question, but stay calm. Ask the question directly, e.g. Are you thinking of killing yourself? <p>Care for your buddy</p> <ul style="list-style-type: none"> Remember any reasons that would be used for self-harm. Clearly counsel the individual, do not use force. Actively listen to professional advice. <p>Escort your buddy</p> <ul style="list-style-type: none"> Never leave your buddy alone. Escort to the place of treatment, a Chaplain, a behavioral health professional, or a primary care provider. 	<p>Ask your buddy</p> <ul style="list-style-type: none"> Have the courage to ask the question, but stay calm. Ask the question directly, e.g. Are you thinking of killing yourself? <p>Care for your buddy</p> <ul style="list-style-type: none"> Remember any reasons that would be used for self-harm. Clearly counsel the individual, do not use force. Actively listen to professional advice. <p>Escort your buddy</p> <ul style="list-style-type: none"> Never leave your buddy alone. Escort to the place of treatment, a Chaplain, a behavioral health professional, or a primary care provider.
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Training Resources

The chaplains in theater have the lead on suicide prevention training at the unit level. Unit Ministry Teams can use no-cost effective training such as ACE to train small unit leaders on suicide prevention and intervention skills. These leaders, in turn, can train other leaders and service members (a train-the-trainer method). To be effective, all suicide prevention efforts must include everyone.

There are numerous stock briefs located at the Army G-1 website as well as others listed in the references. The keys to effective training are consistency, relevancy, and the ability to inspire team member participation. Additionally, training should be tailored to the service member's phase of deployment. It should lead the member through expectation management for future phases, warning signs to look for in themselves and others, and coping skills when frustrations arise. Role playing, testimonials, and short-videos (10-15 minutes of high energy) with respected or credible representatives are much more effective and better received than the non-interactive PowerPoint brief typical of many standardized training programs.

Resources

A referral to these resources can be either command directed or self-referred.

- **In Garrison:**
 - ✓ Family Life Chaplains
 - ✓ Army Community Services
 - ✓ Medical Services
 - ✓ Marriage and Family Counselors
 - ✓ Post Deployment Centers
- **During Deployment:**
 - ✓ Combat Stress Control Teams
 - ✓ Medics
 - ✓ Battalion Aid Station
 - ✓ Chaplain

All returning Soldiers from OIF or OEF can contact the Military One Source @ <https://www.militaryonesource.com>

Summary

- ❖ Suicide prevention begins before the deployment orders are published and never stops
- ❖ First-line leaders are the First-line of defense
- ❖ Positive life coping skills and resiliency training will reduce negative behaviors
- ❖ Removing barriers to care opens up opportunities to heal
- ❖ Awareness and vigilance, identification and intervention can knock down suicide as a target
- ❖ Teammates take care of Teammates.

“One suicide is one too many.”

References

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- ❖ AR 600-63, Army Health Promotion, dtd 7 May 07
- ❖ DA Pam 600-24, Suicide Prevention and Psychological Autopsy, dtd 30 Sep 88
- ❖ Suicide Prevention Manual: A Resource for the United States Army, prepared by the U. S. Army Center for Health Promotion and Preventative Medicine (USACHPPM), dtd 2007
- ❖ Warrior Resiliency Training: Jarrett, T. Warrior Resilience Training in OPERATION IRAQI FREEDOM: Combining rational emotive behavior therapy, resiliency and virtue ethics. *The AMEDD Journal*, Jul-Sep 2008: 30-36.
- ❖ NATO Leader's Guide to Psychological Support Across the Deployment Cycle, dtd 19 Jan 07
- ❖ MNC-I OPOD 08-01 (Tab A to Appendix 8 to Annex Q), Army Suicide Prevention Program
- ❖ Army G1 website: <http://www.armyg1.army.mil/hr/suicide/default.asp>
- ❖ Hooah4Health website: <http://hooah4health.com/default.htm>
- ❖ Suicide Prevention Resource Center website: <http://www.sprc.org/>
- ❖ LivingWorks.Net website: <http://www.livingworks.net/>