

DEPARTMENT OF THE ARMY
HEADQUARTERS, U.S. ARMY FIELD ARTILLERY CENTER AND FORT SILL
FORT SILL, OKLAHOMA 73503

USAFACFS Regulation
No. 600-8

2 May 2000

Personnel-General
SUICIDE PREVENTION PLAN

Further supplementation by subordinate commander is prohibited unless specifically approved by Headquarters, USAFACFS.

1. PURPOSE. This regulation establishes a plan of action for suicide prevention at Fort Sill. Although this regulation concentrates on suicide prevention, it is only one aspect of an overall command wellness program established across the installation. It is essential that all soldiers, employees, and dependents who become known to the military as suicidal are not ignored, but are referred to appropriate agencies, military or civilian, or transported to appropriate prevention/treatment facilities. While command involvement is an important part of the Fort Sill suicide prevention plan, suicide prevention is the responsibility of all personnel regardless of actual command and control of a suicidal person.

2. APPLICABILITY. This regulation applies to assigned or attached Reserve Component (RC) and Active Component (AC) elements, Army civilian employees, and family members.

3. REFERENCES.

- a. AR 600-63, 28 April 1996, Army Health Promotion Program.
- b. DA Pamphlet 600-24, 30 Sep 88, Suicide Prevention and Psychological Autopsy.
- c. DA Pam 600-70, 1 November 1985, Guide to the Prevention of Suicide and Self-Destructive Behavior.

*This publication supersedes USAFACFS Reg 600-8, 13 Jan 88.

d. TRADOC Pamphlet 600-22, 30 Sep 85, TRADOC Suicide Prevention Planning Guide, establishes TRADOC policy and guidance concerning suicide prevention. It incorporates the U.S. Army Guide to Prevention of Suicide and Self-Destructive Behavior. The TRADOC Guide places emphasis on caring leadership and early involvement of the chain of command and professional agencies; the sensitization of junior leaders by senior leaders; and a formal commitment demonstrated by a series of actions that treats the causes of suicide rather than suicide itself.

e. Interim Change No. 3 to AR 600-63, 30 November 1994 (expired and superceded by AR 600-63, 28 April 1996) (though no longer binding, Interim Change No. 3 describes the current de facto Army-wide status concerning the Family Member Suicide Prevention Plan).

4. ORGANIZATION.

a. A Suicide Prevention Task Force (SPTF) is established to plan, implement, and manage the Fort Sill Army Suicide Prevention Program (ASPP). The task force will meet quarterly during October, January, April, July, and more frequently at the discretion of the Chief of Staff (CofS) or acting chairperson. Only Department of the Army personnel are permitted at SPTF meetings (or any ASPP meetings) at which information about individual cases is discussed unless permission of the individuals concerned is first obtained. The task force will consist of the following members:

- (1) Chief of Staff (CofS), USAFACFS, chair.
- (2) Garrison Commander (GC), co-chair.
- (3) Director of Community Activities (DCA), resource expert.
- (4) Director of Plans, Training, and Mobilization (DPTM), command training and operational advisor.
- (5) Chief, Community Mental Health Service (CMHS), Reynolds Army Community Hospital, resource expert.
- (6) Alcohol and Drug Control Officer (ADCO) (Chief, Drug and Alcohol Abuse Control Division [DAACD]), coordinator and recorder.

- (7) Post Chaplain (or Director, Family Life Center), training officer.
- (8) MEDDAC Commander, resource expert.
- (9) Law Enforcement Command (LEC), resource expert.
- (10) Staff Judge Advocate (SJA), legal advisor.
- (11) Director of Civilian Personnel (DCP), Management Employee Relations (MER) representative.
- (12) Inspector General (IG).
- (13) Criminal Investigation Division (CID) Representative.
- (14) School Liaison Officer.
- (15) Public Affairs Officer (PAO).
- (16) Army Community Service (ACS) Officer.
- (17) Post Safety Officer.
- (18) Chief, Social Work Service, RACH.
- (19) Chief, Department of Behavioral Health, RACH.
- (20) Representative from IIIId ACA.
- (21) Representative from USAFAS.

b. The SPTF Secondary Support Staff consists of personnel who may be called upon as resource experts or subject matter experts, whom the SPTF may task specifically, and who are encouraged to participate at SPTF meetings. Included on the Secondary Support Staff are the Adjutant General (AG), the Youth Activities Director, family practice physicians, and the dental staff.

c. A battalion commander (or equivalent) may convene a Suicide Risk Management Team (SRMT) during a suicide crisis. Composition and function of the SRMT are defined at paragraph 6b(4) below.

d. Following a suicide or suspected suicide, we can convene a Fatality Review Board (FRB). Composition and function of the FRB are defined at paragraph 6c(2) below.

5. RESPONSIBILITIES.

a. The SPTF--

(1) Coordinates program activities and the suicide prevention activities for the installation.

(2) Evaluates the program needs of the installation and makes appropriate recommendations to the command.

(3) Reviews, refines, adds, or deletes items to the program based on an on-going evaluation of needs.

(4) Develops awareness training about installation suicide prevention activities and identifies appropriate forums for training.

(5) Evaluates the impact of the pace of training and military operations on the quality of individual and family life in the total military community.

(6) Recommends command policy guidance about training and operations issues to ensure that soldiers and their leaders have sufficient opportunity for quality family life.

(7) Reviews publicity generated with respect to suicides in the community and develops public awareness articles for publication.

(8) Reviews the results of Fatality Review Boards and psychological autopsies to look for the possible causes of suicides and, if necessary, evaluates the prevention effort and makes recommendations to the command.

(9) Collects and analyzes local data on suicide attempts/gestures, to include the reasons for suicide attempts. Analysis includes the numbers of high, medium, and low lethality attempts by category of personnel and by unit.

(10) Coordinates with civilian support agencies as necessary.

b. CofS-

(1) Co-chairs the SPTF and coordinates the efforts of task force members, providing overall staff guidance for the ASPP and advice to each major subordinate command (MSC). For purposes of this regulation, the MSCs are IIIId ACA, USAFAS, and Garrison.

(2) Reviews the results of Fatality Review Boards and psychological autopsies.

c. GC Co-chairs the SPTF.

d. DCA-

(1) Serves as the point of contact (POC) for program information and advice to the chair.

(2) Integrates suicide prevention into community, family, and soldier support programs as appropriate.

(3) Receives and reviews the results of Fatality Review Boards and psychological autopsies and forwards to the SPTF and to the CofS as needed.

e. DPTM-

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

(2) Develops policy to assure that the impact of the pace of operations on individual and family quality of life be considered in planning for all training and operational requirements.

f. Post Chaplain-

(1) Advises installation and unit commanders on moral and ethical issues and other stress factors that may result in an increased number of persons at risk.

(2) Assures that all chaplains within the command are trained and certified to identify individuals who may be at increased risk of suicide and to make an appropriate referral.

(3) Provides the training expertise that will assist the command in the education-awareness training process. Unit

chaplains will be the cornerstone of the effort to provide unit-level suicide prevention training for leaders, supervisors, soldiers, and civilian employees. For soldiers, the units will coordinate this training with the chaplains; for civilians, the Employee Assistance Program (EAP) will coordinate with the chaplains. Chaplains will advise and assist other staff members and SPTF members in satisfying identified training needs in this area.

(4) Implements the Family Member Suicide Prevention Program (FMSPP) by working through the SPTF and coordinating with the various community components. The Post Chaplain may delegate responsibility to unit chaplains for the conduct of the FMSPP as it relates to their units.

(5) Addresses command wellness at welcome orientations in coordination with DCA.

g. Cdr, MEDDAC-

(1) Assesses and advises the command on stress factors that may result in increased numbers of persons at risk.

(2) Assures that health care providers are trained in crisis intervention techniques using periodic in-service education.

(3) Provides overall technical guidance to the SPTF.

(4) Integrates the Army Suicide Prevention Plan (ASPP) so that Emergency Room (ER), Records Management, Internal Medicine, CMHS, and Community Health Nurse Office act as a single unit to work with soldier and family.

(5) Provides mental health professionals (psychiatrists, psychologists, and social workers) to aid in training chaplains and other helping professionals (physicians, nurses, psychologists, social workers, chaplains, counselors, and military police personnel).

(6) Ensures that the appropriate flow of information exists within the MEDDAC and to the command.

h. CMHS-

(1) Provides suicide prevention training support to unit ministry teams (chaplains and chaplain's assistants) as needed and training to helping professionals.

(2) Reviews training plans for suicide prevention.

(3) Certifies civilian trainers of suicide prevention.

(4) Provides for collection, evaluation, and dissemination of all data pertaining to attempted suicides or suicide-related behavior.

(5) Clinically evaluates all referrals and walk-ins.

(6) Notifies commanders and supervisors of soldiers who are considered a substantial suicide risk IAW paragraph 6b(1) below.

(7) Provides commanders and supervisors with reporting format and instructions for suicide gestures and attempts.

(8) Provides curriculum guidance to Battery Commanders Orientation Course, PLDC, FAOBC, FAOAC, NCO Academy, Warrant Officer Course (FAS), and 41B/DCP course, to include command wellness content for courses.

(9) Prepares and submits to the DCA, CID, HQDA, and TRADOC completed psychological autopsies.

(10) Ensures that relevant information from the SPTF is passed to the Case Review Committee (CRC) Chairperson and that relevant information from the CRC is passed to the SPTF.

i. ACS-

(1) Continues operation of advocacy and out-reach programs in areas of stress and family violence.

(2) In coordination with SPTF and PAO, heightens public awareness of the support and helping mechanisms available within the community.

(3) Conducts appropriate in-service training to maintain the level of awareness of ACS staff members including volunteers who routinely assist soldiers, civilian employees, and family members who might be at risk of suicide.

(4) Emphasizes support agencies and mechanisms during family member orientations and other appropriate briefings.

(5) Coordinates with civilian support agencies on behalf of the SPTF.

j. PAO-

(1) Coordinates the community awareness needs of the SPTF within the broader context of command wellness. Promulgates command wellness awareness.

(2) Receives media requests for release of information about deaths that are potential suicides and releases such information to the media IAW paragraph 6c(8) below after coordinating with CID, the casualty assistance officer, and the SJA.

k. The Provost Marshal-

(1) Effectively trains military police forces to respond to potential suicide situations discretely and cautiously to avoid increasing stress (normally the use of emergency equipment (lights or sirens) would be inappropriate).

(2) Provides feedback information to the SPTF, as appropriate, on any suicide-related events that may have occurred on-post.

(3) Reinforces instruction presented at the U.S. Army Military Police School concerning identification of persons at risk for suicide and emphasizes that actions taken by military police in the line-of-duty may cause some people to be at increased risk of suicide.

(4) Establishes liaison with local civilian police agencies, as appropriate, to coordinate community suicide prevention programs and procedures.

l. CID-

(1) Investigates all suicides or suspected suicides.

(2) Establishes liaison with local civilian police agencies, as appropriate, to obtain information regarding suicide-related events involving military personnel, their

families, or civilian employees, which may have occurred off-post, and provide such information to the SPTF.

(3) As allowed by appropriate regulations, provides the task force extracts from the CID reports of investigation.

(4) Integrates suicide prevention and fact gathering procedures into normal operations.

(5) Coordinates with PAO on media requests concerning suicides IAW paragraph 6c(8) below.

m. SJA-

(1) Provides legal advice to the SPTF.

(2) In the event of a suicide, advises the command on the propriety of conducting an investigation IAW AR 15-6 in lieu of or in addition to a Fatality Review Board.

(3) Provides suicide prevention awareness training for the personnel of the SJA and of Trial Defense Service (TDS) using the advice and assistance of the chaplains and mental health professionals. Training will include emphasis on (a) identifying individual clients at risk of suicide and making appropriate referrals and (b) being sensitive to ASPP issues in advising commanders.

(4) Educates commanders with respect to the law concerning command referrals for mental health evaluations.

(5) Maintains sensitivity to behavior of subjects and suspects charged with wrongdoing. In the event that a subject or suspect is suspected of suicide risk, notify the appropriate commander immediately.

(6) Coordinates with PAO on media requests concerning suicides IAW paragraph 6c(8) below.

n. IG-

(1) Conducts inquiries, conducts command directed investigations, and recommends appropriate corrective actions. Characteristics of IG inquiries and investigations that may make the IG the appropriate mechanism of inquiry in a particular case are the following: (a) the IG serves as a fair and impartial fact finder; (b) the IG has a high degree of independence; (c)

the IG has direct access to all commanders; (d) the IG has unlimited access to information in the Army; (e) the IG is generally in the best position to maintain confidentiality; (f) the IG has the ability to conduct a thorough investigation, which often leads to discovery of the root cause of problems; and (g) the IG is often able to identify systemic issues.

(2) Assists commanders as requested and provides relevant and timely feedback on command climate issues.

(3) Maintains sensitivity to behavior of subjects and suspects charged with wrongdoing. In the event that a subject or suspect is suspected of suicide risk, notifies the appropriate commander immediately.

(4) Reviews the results of Fatality Review Boards for trends and systemic issues.

(5) Conducts periodic inspections or assessments of suicide prevention training and this Suicide Prevention Plan as directed by the Cdr, USAFACFS.

(6) Serves as repository of lessons learned from Fatality Review Boards and AR 15-6 investigations.

(7) Distributes information from lessons learned to units and directorates as appropriate.

o. DCP-

(1) Ensures that local programs consider the needs of the civilian work force.

(2) Coordinates with EAP the training for civilian managers and supervisors.

p. ADCO-

(1) Serves as SPTF coordinator and recorder as directed by the SPTF chair.

(2) Advises the command about the impact of alcohol and drug abuse on suicide risk.

(3) Ensures that the ADAPCP staff is trained in suicide risk identification factors and in the management of suicidal clients.

(4) Serves as liaison with DCP regarding EAP training for civilian employees.

q. USAFACFS directors, chiefs of special staff sections, and civilian supervisors—

(1) Review and adapt for their own use the Suicide Prevention Plan checklists at appendices A and B.

(2) Ensure that supervisors and key personnel are scheduled for training.

(3) Ensure that if an employee or soldier makes an actual attempt while on duty, the individual will be escorted to RACH ER. ER personnel will contact CMHS for an evaluation. CMHS will assess the situation and refer to an appropriate resource for follow-up.

(4) Call the MPs if the employee or soldier is threatening to harm him/herself, others, or government property. The MPs will escort the individual to RACH ER. The ER physician will contact CMHS for assessment, Emergency Order of Detention if necessary, or follow-up referral.

(5) Talk to the civilian employee if there is no overt gesture or attempt, and refer to the EAP or Occupational Health for evaluation. The individual will be assessed for related personal problems and referred to an appropriate agency. All civilian evaluations and referrals are voluntary. Supervisors should ensure that employees are not sent to the EAP or Occupational Health for clinical counseling.

r. MSCs—

(1) Ensure that caring leadership is practiced and that an early warning enrollment and follow-up system is embedded in chain of command suicide prevention procedures.

(2) Alert those ASPP agencies that may be providing assistance to the soldier so that a coordinated effort is made to treat the soldier.

(3) Develop supporting command wellness and suicide prevention plans as appropriate.

(4) Ensure that all commanders, staff, CSMs, and 1SGs are scheduled for suicide prevention training by unit ministry teams.

(5) Recommend the appointment of AR 15-6 investigations or conduct Fatality Review Boards as appropriate to determine if anything could have been done to prevent the suicide and to pass "lessons learned" on to commanders, staff, and the SPTF.

s. Commanders-

(1) Create and nurture a command climate in which command wellness is stressed and the act of seeking professional help is perceived as a sign of character strength.

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

(3) Ensure that subordinates are aware of assistance agencies.

(4) Refer individuals who are identified as having personal or emotional problems to the unit chaplain and other appropriate officials for help and follow through to ensure the problem is either resolved or continuing help is provided.

t. School Liaison Officer-coordinates training for school personnel in identifying and referring individuals at risk of suicide.

6. PROCEDURES. The Fort Sill Suicide Prevention Plan consists of three parts: Part 1, Primary Prevention; Part 2, Post-Gesture/Attempt; and Part 3, Post-Suicide. Refer also to paragraph 5, Responsibilities, above.

a. Part 1, Primary Prevention (education, identification, and training).

(1) SPTF will-

(a) Collect data on attempted suicides to develop profiles and highlight problem units/organizations.

(b) Hold quarterly meetings to ensure continuity of services and training and to ensure that all policies and procedures are adequate and updated as needed.

(c) Review status of program and report to the command through the CofS annually.

(2) CMHS will-

(a) Conduct as needed regular in-service training for helping professionals and military police in suicide prevention and crisis intervention. Chaplains may provide this training to ACS personnel.

(b) Certify civilian instructors in suicide prevention.

(c) Provide command wellness curriculum consultation to directors of PLDC, FAOAC, FAOBC, NCO Academy Warrant Officer Course (FAS), and 41B/DCP Course.

(d) Review and update command wellness lesson plans annually.

(e) Maintain liaison with off-post agencies and inform unit commanders about at risk personnel as appropriate.

(3) Unit Chaplains will-

(a) Conduct FMSPP education with focus on parents, teens, and spouses through briefings, classes, workshops, seminars, and similar settings. This phase of the FMSPP seeks to educate family members generally in command wellness and particularly in suicide risk identification and procedures for intervention and referral to community helping agencies. See appendices C and D.

(b) Maintain listings of local military resources and points of contact for the referral process.

(c) Ensure that family members receive appropriate community assistance.

(4) CID will-

(a) Maintain sensitivity to behavior of subjects charged with offenses; and in the event that a subject is suspected to be a suicide risk, notify the battery/company commander immediately.

(b) Establish liaison with local civilian police agencies to obtain information regarding off-post suicide-related events and provide the task force with such information.

(5) Military Police will--

(a) Maintain sensitivity to behavior of subjects charged with wrongdoing.

(b) Notify the unit commander immediately whenever a subject is suspected to be a suicide risk.

(c) Sensitize commanders to risks inherent with all soldiers facing adverse personnel actions.

(6) Unit commanders will-- (Command responsibility under this paragraph shall extend to and include soldiers known to be in the geographical area who have outprocessed from their unit or who may be waiting to inprocess to their unit.)

(a) Refer any soldier who exhibits behavior that indicates suicide risk to CMHS.

(b) Give confidential written notice of a suicide risk to any unit to which the at-risk soldier is to be assigned, to ensure that appropriate follow-up services are provided.

(7) SPTF Support Staffs (such as ADAPCP, ACS, Chaplains, family practice physicians, CMHS) will--

(a) Notify the unit commander of any soldier who exhibits behavior that indicates suicide risk.

(b) Except for ADAPCP, notify an individual's battalion commander (or equivalent supervisor) if the individual becomes a threat to self or others. The intent of battalion commander notification in these critical situations is to allow the battalion commander (1) to mentor the unit commander, (2) to ensure appropriate unit action and follow up, and (3) to involve the battalion chaplain.

(c) Refer family members who appear "at risk" to CMHS for evaluation.

(d) Ensure that helping professionals within their organization receive regular in-service training in suicide prevention and crisis intervention.

(8) The PLDC, FAOAC, FAOBC, NCO Academy, Warrant Officer Course (FAS), and 41B/DCP course directors will implement

command wellness training and in particular suicide education and identification instruction IAW AR 600-63, paragraph 5-5.

b. Part 2, Post-Gesture/Attempt.

(1) CMHS will-

(a) Act as primary agency to assist or prescribe assistance to the soldier and his/her family.

(b) Evaluate each soldier who has attempted suicide or exhibited behavior that establishes suicide risk, such as notes or comments about intent or severe depression.

(c) Establish a treatment plan and determine appropriateness of a profile (such as a "no weapons" profile).

(d) Notify unit commanders and chiefs of SPTF Support Staffs of "at risk" individuals (i.e., an individual in the acute phase of suicidal ideation/behavior).

(e) Maintain, at least weekly, consultation with the unit commander to advise of progress for soldiers considered "at risk."

(f) Telephonically notify the battery commander or first sergeant of missed appointments, including routine appointments, of soldiers identified "at risk."

(g) Notify an individual's battalion commander (or equivalent supervisor) if the individual becomes a threat to self or others.

(2) Other SPTF Support Staffs-

(a) Will telephonically notify the battery commander or first sergeant of missed appointments, including routine appointments, of soldiers identified "at risk."

(b) Ensure that helping professionals within their organization notify an individual's battalion commander (or equivalent supervisor) if the individual becomes a threat to self or others.

(3) Unit commanders or activity chiefs, within 24 hours of a potentially lethal suicide attempt, will- (Command responsibility under this paragraph shall extend to and include

soldiers known to be in the geographical area who have outprocessed from their unit or who may be waiting to inprocess to their unit.)

- (a) Notify CMHS.
- (b) Notify the Unit Chaplain.
- (c) Notify the battalion commander (or comparable equivalent).
- (d) Notify other SPTF Support Staffs who are providing assistance to the individual.
- (e) Ensure that the soldier surrenders all privately-owned weapons maintained on Fort Sill for storage in Unit Arms Room.
- (f) Notify PM regarding action on privately-owned weapons.
- (g) Notify the unit S2 (or unit security manager) of the attempt, who will ensure compliance with AR 380-67.
- (h) Coordinate with local law enforcement agencies to obtain any reports in cases of off-post suicide attempts or gestures. CID, MPI, and OSJA may be contacted for assistance.

(4) Suicide Risk Management Team. Battalion commanders (or comparable equivalent within the MSC), in coordination with CMHS, may immediately convene a Suicide Risk Management Team (SRMT) during a suicide crisis. The SRMT will actively monitor the progress of the soldier(s) identified as suicidal and at high-risk. The SRMT is charged with the responsibility of addressing the medical and administrative needs presented by high-risk cases referred to it by the battalion commander. The SRMT will not become involved in rescue or emergency lifesaving operations with respect to suicide attempts.

(a) The purpose of the SRMT is to assist the commander in assessing the situation, determining appropriate courses of action, directing immediate interagency and interstaff actions, and advising the commander. The role of the SRMT is to address those problems and issues that precipitated the suicide attempt and to deal expeditiously with them. SRMT intervention will include taking actions necessary to provide for the immediate welfare of families who have suffered a suicide or suicide attempt.

(b) The SRMT will be composed of a representative from the following:

- (1) MEDDAC
- (2) CMHS
- (3) Battalion Commander, Command Sergeant Major
- (4) Unit Chaplain
- (5) G1/AG
- (6) SJA
- (7) Provost Marshall
- (8) ADCO
- (9) ACS

(c) Function of the SRMT members.

(1) MEDDAC commander's designee (an LTC or higher)–

(aa) Assumes primary responsibility as the SRMT Coordinator.

(ab) Develops and manages case files on identified high-risk individuals.

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

(ad) Serves as primary point of contact during a suicide crisis for battalion commanders to convene the SRMT.

(2) CMHS Representative–

(aa) Serves as the alternate coordinator in crisis situations in the absence of the MEDDAC Commander's Designee. Meets with the SRMT Coordinator during a suicide crisis.

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

(ac) Battalion commander—

(1a) Convenes, through the SRMT Coordinator, the SRMT when a soldier is identified as at high-risk for suicide, the situation is at crisis, and the Battalion Commander deems that the resources of the SRMT may help the soldier and the soldier's family members through the crisis.

(1b) Maintains an active and close liaison with other members of the SRMT on matters affecting members of the command.

(1c) Coordinates any necessary administrative action required by members of the command who have attempted suicide.

(ad) Unit Chaplain—

(1a) Meets with the SRMT Coordinator during a suicide crisis.

(1b) Actively monitors high-risk soldiers and provides intervention during a suicide crisis as needed.

(1c) Provides immediate pastoral assistance to families who have suffered a suicide or suicide attempt.

(ae) G1/AG representative—

(1a) Meets with the SRMT Coordinator upon request during a suicide crisis.

(1b) Advises other SRMT members on career implications and courses of action available regarding soldiers identified as potential suicides.

(1c) Coordinates with the Battalion Commander to provide advice or administrative assistance as required.

(af) SJA Representative—

(1a) Meets with the SRMT Coordinator upon request during a suicide crisis.

(1b) Provides advice to the SRMT and coordinates legal services as needed.

(ag) Provost Marshall Representative—

(1a) Meets with the SRMT Coordinator upon request during a suicide crisis.

(1b) Coordinates with medical treatment facilities and law enforcement agencies as needed.

(1c) Provides for immediate protection and well being of soldiers or family members at high-risk for suicide until unit or medical personnel are on the scene.

(ah) ADCO—

(1a) Serves as the second alternate coordinator. Meets with the SRMT Coordinator upon request during a suicide crisis.

(1b) Provides advice and assistance to the SRMT as needed.

(ai) ACS Representative—

(1a) Meets with the SRMT Coordinator upon request during a suicide crisis.

(1b) Provides advice and assistance to the SRMT as needed.

c. Part 3, Post-Suicide.

(1) AR 15-6 Investigations. Deaths of soldiers assigned or attached to Fort Sill may be investigated using informal procedures IAW AR 15-6. The purpose of the investigation is to determine the facts surrounding the death and to otherwise facilitate the Fatality Review Board, if one is deemed necessary. In cases involving death, AR 15-6 requires the appointing authority for AR 15-6 investigations be a general court-martial convening authority (GCMCA).

(a) MSC Appointing Authority. In investigating suicides, if the MSC Appointing Authority decides that an informal AR 15-6 would be appropriate, the MSC Appointing Authority will request that the GCMCA appoint an investigation IAW AR 15-6. The MSC Appointing Authority is encouraged to request that the GCMCA use the informal AR 15-6 investigation process but may choose to conduct a Fatality Review Board in addition to or in lieu of the

AR 15-6 investigation. The MSC Appointing Authority should consult with the SJA to assist in this decision. The MSC Appointing Authority in IIIId ACA cases shall be the IIIId ACA DCO; the Appointing Authority in USAFAS cases shall be the USAFAS CofS; and the Appointing Authority in all other cases shall be the Garrison Commander.

(b) GCMCA. In cases of suicide, the GCMCA is encouraged to consult with the SJA concerning whether to appoint an AR 15-6 investigation. If an AR 15-6 investigation is appointed, the GCMCA shall forward a copy of the completed investigation report (including DD Form 1574) to the MSC Appointing Authority and the SPTF chair.

(c) Investigating Officer (IO). The IO shall receive a briefing by a legal advisor from the SJA office. Once appointed, the IO will coordinate with both CID and the person from CMHS performing the psychological autopsy. The purpose of this coordination is to reduce duplication of effort and unnecessary imposition on family members of the decedent. The investigation will usually have a suspense of 10 working days. An IO may request and the Appointing Authority may grant extensions in 3-day increments.

(2) Fatality Review Board. The MSC Appointing Authority (as defined in subparagraph (1)(a), above) shall convene a Fatality Review Board as appropriate in cases of suicide or suspected suicide. Once the GCMCA approves the report of investigation or once the GCMCA or the MSC Appointing Authority decides that an AR 15-6 investigation is inappropriate, the MSC Appointing Authority shall convene a Fatality Review Board IAW subparagraph (2), below, within 7 working days of the discovery of the death or, if a Fatality Review Board would be inappropriate, shall refer the case to the IG or other appropriate mechanism as necessary. In cases of fatalities not involving suicide, the MSC Appointing Authority shall convene a Fatality Review Board as appropriate under this paragraph.

(a) Composition. The Board will consist of the Appointing Authority (or designee) from the decedent's MSC, who serves as chairperson; the MSC G1/S1 (or equivalent); the decedent's chain of command from immediate supervisor to brigade commander (or equivalent supervisory chain); the unit chaplain (or Post Chaplain); Surgeon; Chief, CMHS; ADCO; Provost Marshal; SJA; IG; CID; Post Safety Officer, and other personnel as determined by the Appointing Authority.

(b) Intent and Format.

(1a) The intent of the Fatality Review Board is to review the facts and circumstances of a fatality using a leadership forum. In all cases, the Board will examine the command climate, unit safety, and quality of life. In the case of a suicide, the board will also examine suicide prevention programs, the individual soldier's duty performance, and possible distress signals shown by the decedent. The forum should help the Board look for ways to minimize/eliminate preventable deaths and better serve the people within the military community. The Board should also serve to facilitate the unit leadership in their role in the healing process of individuals and in restoring unit morale and readiness. Assigning blame is not a goal of the Board.

(1b) The format of the Board will be an After Action Review (AAR). The goal is to attempt to determine the whys and wherefores of the fatality and to develop a written synopsis, which can be used to provide information and help prevent similar incidents.

(c) Questions to Consider. The board will pursue any questions and concerns derived from the facts of the case consistent with the intent and format of a Fatality Review Board. At minimum, the board will address the following questions in the case of a suicide:

(1a) Why did the individual commit suicide? When the manner of death is clear and unequivocal, the Board can serve to enhance understanding of the factors that led to the act. When the manner of death is clear, but the reasons for the suicide remain unclear, the Board will attempt to reconstruct the motivations, philosophy, psychodynamic, and existential crisis of the decedent.

(1b) What is the most probable manner of death? When the cause of death can be clearly established but the manner of death is equivocal, the purpose of the Board is to establish the manner of death with as much accuracy as possible.

(1c) Did command actions contribute to suicidal behavior?

(1d) In what ways did command act to prevent the suicide?

(1c) What is the most probable reason for victim's decision to commit suicide?

(1d) Are there suggestions derived from the suicidal incident that would improve prevention training?

(1e) Were procedures for management of soldiers previously referred to CMHS followed?

(1f) What are the lessons learned?

(d) Responsibilities.

(1a) The MSC Chief of Staff will coordinate and convene the board. Board members are listed in subparagraph (a), above.

(1b) The G1 will act as recorder, review administrative documents for accuracy, provide personnel information of deceased, prepare the final report for the MSC commander, and forward copies to principal agencies involved and to the members of the SPTF.

(1c) The PM will provide facts and circumstances on the fatality, any previous criminal background or incidents involving the deceased, or any other pertinent information.

(1d) SJA will provide information and legal guidance concerning present and suggested policies and regulations. SJA will ensure that any possible or appropriate disciplinary actions are not compromised and that all individual rights are preserved.

(1e) CID will provide details of the fatality for the purpose of gathering information.

(1f) ADCO will provide information concerning any alcohol/drug-related circumstances involved in the fatality.

(1g) The Post Safety Officer will provide information on current command trends and suggestions for improvement.

(1h) The MSC Surgeon will--

(aa) Recommend attendance by clinical support staff to include psychiatrists, social workers, drug and alcohol counselors, etc., as appropriate.

(ab) Provide medical interpretation and guidance necessary for understanding the death of the soldier.

(ac) Provide suggestions in the identification of distress signals.

(1i) The Post Chaplain will--

(aa) Provide information concerning command support programs available for use by commanders.

(ab) Assist the chain of command with development of soldier's character profile.

(1j) The chain of command (from immediate supervisor to brigade commander) will--

(aa) Be prepared to address command policies, accident and suicide prevention, safety and quality of life programs.

(ab) Establish a character profile for the deceased soldier. Be prepared to discuss the soldier's past duty performance, education and family background, military training, signals of distress, and any other information that may aid in understanding the soldier command climate and the incident.

(ac) Discuss the chronology of events leading to the fatality.

(ad) Be prepared to make recommendations to improve policies and programs.

(e) The MSC Appointing Authority will brief the first general officer in the chain of command on the results of the board within 10 days after convening the inquiry. The MSC Appointing Authority will be prepared to brief the CG on the results of the board within 14 days after convening the inquiry.

(3) The SPTF will--

(a) Review, in coordination with the MSC concerned, results and lessons learned as reported by Fatality Review Boards and update the Fort Sill ASPP accordingly.

(b) Explore ways to mobilize the complete resources of the military community to assist the surviving family members (and soldier, if applicable) to the extent permitted by applicable law and regulation.

(4) CMHS will-

(a) Conduct a psychological autopsy IAW DA Pam 600-24, chapter 5. The psychological autopsy is required for any suicide or suspected suicide of any AC soldier, RC soldier on active duty or active duty for training, or any active member of other armed forces of the United States assigned or attached to the installation. Mental Health Officers should seek opportunities to provide bereavement counseling through the psychological autopsy process.

(b) Provide assistance as required to an organization, its members, and its family members following a suicide of a soldier or civilian employee to facilitate the healing process and reverse the adverse impact a suicide has on the morale and readiness of the organization.

(c) Prepare and submit to the DCA, CID, HQDA, and TRADOC the completed psychological autopsy.

(5) Chaplains will provide assistance as required to an organization, its members, and its family members following a suicide of a soldier or civilian employee to facilitate the healing process and reverse the adverse impact a suicide has on the morale and readiness of the organization.

(6) AG will advise as to notification procedures for next-of-kin/family requests for assistance. Procedures will be IAW AR 600-8-1. AG will further advise as to nature of informal inquiries to include any special requirements of the case.

(7) PM will report fatalities of AC soldiers, RC soldiers, and Army civilians to HQDA by means of Serious Incident Report (SIR) IAW AR 190-40.

(8) Requests for Release of Information.

(a) Requests from the Media. All media requests for release of information will be referred to PAO. Upon media requests for information, PAO will confirm "suicide" or "attempted suicide" when CID has so confirmed. Any public release of additional information (name, rank, unit, etc.) about the noncombat death of an active duty servicemember not medically determined to be from natural causes will state that the cause and manner of death are undetermined, unless an official determination has been made. After the official

determination has been made, releases to the public will state the official determination of the cause of death and avoid speculation about the means if not substantiated in connection with the determination. All releases will be coordinated in advance among CID, the casualty assistance officer, and the SJA. No information will be released to the public before the family of the deceased member has been notified. PAO will follow standard coordination procedures outlined in AR 360-5 for active duty deaths and incidents under investigation.

(b) Requests from Family Members. The Casualty Office will assist family members who desire to request information concerning the death of a servicemember who dies in the line of duty. Without excluding other types of information permissible for release, such information may include a copy of any completed investigative report or any other completed fatality report. Such assistance will be provided until a copy of each such report is obtained or until access to any such report is denied by competent authority within DoD. Within thirty days of the notification of next of kin, the Casualty Office will inform family members of any investigation into the cause or circumstances of the death IAW Appendix E of AR 600-8-1. The Casualty Assistance Officer should consult with the SJA concerning the existence of investigations into the death and when family member requests are made under the Freedom of Information Act.

APPENDIX A

COMMANDER'S PROTOCOL FOR A SUICIDAL SOLDIER

Listed below are steps to take in the event of a suicide attempt or whenever you suspect a soldier may be a suicide risk.

I. When soldier has ATTEMPTED SUICIDE:

A	Step 1	Immediately call Emergency Room, RACH, 458-2770/2773
B	Step 2	Immediately notify chain of command to battalion level
C	Step 3	Immediately notify unit chaplain
D	Step 4	After establishing control of the soldier and arranging counseling in conjunction with proper medical/psychiatric support, then have a joint case study with first-line leader, appropriate members of the chain-of-command, unit chaplain, and medical/psychiatric staff to develop a problem-solving plan
E		Commanders will, within 24 hours of a suicide attempt to--
	1	Contact/notify CMHS. Ascertain what feedback the command can expect in this soldier's case.
	2	Notify other support staffs who are providing assistance to the individual.
	3	Ensure that the soldier surrenders privately-owned weapons maintained for storage in unit arms room.
	4	Notify PM regarding action on privately-owned weapons.
	5	Notify the unit S2 (or unit security manager) of the attempt, who will ensure compliance with AR 380-67.
	6	Coordinate with local law enforcement agencies to obtain any reports in case of off-post suicide attempts or gestures. CID, MPI, and OSJA may be contacted for assistance.

II. What to do when a soldier is IDENTIFIED AS A SUICIDE RISK:

A	Step 1	The person aware of the situation should immediately notify the chain-of-command. (Do not leave the soldier alone!).
---	--------	--

B	Step 2	Have the soldier seen by the unit chaplain (or duty chaplain) and with the chaplain advising the unit commander on appropriate action to be taken or Call Community Mental Health Service (CMHS) at 442-4833/4832 and have the soldier escorted by a leader to CMHS with FS Form 821 or, if after hours, RACH Emergency Room.
C	Step 3	Have a joint case study with first-line leader, appropriate members of the chain-of-command, chaplain, and input from all involved agencies to develop a problem-solving plan.
D	Step 4	Conduct a weekly follow-up review of the case by contacting and receiving input from all agencies involved. until the soldier is no longer "at risk."
E	Step 5	Continue to be sensitive to and watch for the possibility of a future recurrence.

III. WARNING SIGNS FOR SUICIDE:

A	Step 1	Know the warning signs. Be alert for the following signs in fellow soldiers.
		Talking or hinting about suicide.
		Making specific plans to commit suicide and access to lethal means.
		Preoccupation with death; sad music or sad poetry; themes of death in letters or artwork.
		Giving away possessions, making a will.
		Buying a gun.
		Depression.
		Decreased functioning at work.
		Withdrawing/isolating.
		Drug or alcohol problems.
		Previous suicide attempt.
		Feeling hopeless, helpless, or worthless.
		Relationship problems with spouse, boy/girlfriend.
		Enormous stress in life. For example, legal, financial or job-related problems.
		Sudden changes in behavior or drastic mood changes

B	Step 2	If you believe a soldier may be suicidal:
		Ask: "Have you been thinking of hurting yourself?" "Have you been thinking of killing yourself?"
		Notify the chain-of-command immediately if a soldier expresses any suicidal feelings. Even if the soldier denies being suicidal, there may be enough signs that you should still be concerned. If you have any doubts, notify your chain-of-command and get help.
		Take all threats seriously.
		Do not leave the soldier alone.

APPENDIX B

SUPERVISOR'S SUICIDE PROTOCOL FOR DA CIVILIANS

Listed below are steps to be taken in the event of a suicide attempt or whenever a supervisor suspects a civilian employee may be a risk for suicide.

I. If an employee ATTEMPTS suicide while on duty:

A	Step 1	Immediately notify RACH Emergency Room (ER), 458-2770/2773.
B	Step 2	If the employee poses a threat to others or to government property, immediately notify the Military Police at 442-2101.
C	Step 3	Notify the next level supervisor.
D	Step 4	As soon as possible, notify the Occupational Health Office to explain the situation at 458-2237.
E	Step 5	When the employee returns to duty, check to see if the employee has entered into a counseling program. Contact Occupational Health at 458-2237.
F	Step 6	Consult with Employee Assistance Program at 442-4205 for further evaluation/assessment and referral to a counseling program.

II. When an employee has threatened suicide or whenever a supervisor suspects a civilian employee may be a risk for suicide:

A	Step 1	Do not leave the employee alone. Notify the Occupational Health Office immediately at 458-2237. Explain the current situation and respond to his/her guidance. After hours, call the RACH emergency Room at 458-2770/2773.
B	Step 2	If the employee poses a threat to others or government property, immediately notify the military police at 442-2101.
C	Step 3	The employee may need to be escorted to Community Mental Health Service or RACH ER for assessment and disposition.
D	Step 4	When the employee returns to work, find out what treatment they are involved with to resolve their problem. Occupational Health at 458-2237 can be helpful for referrals.

III. Warning Signs for Suicide:

A	Step 1	Know the warning signs. Be alert for the following in your employees:
		Talking or hinting a lot about suicide.

		Making specific plans to commit suicide and access to lethal means.
		Preoccupation with death, sad music or sad poetry. Themes of death in letters or artwork.
		Giving away possessions, making a will.
		Buying a gun.
		Depression.
		Decreased functioning at work.
		Withdrawing/isolating.
		Drug or alcohol problems.
		Previous suicide attempt.
		Feeling hopeless/helpless/worthless.
		Relationship problems with spouse, boy/girlfriend.
		Sudden behavior changes.
		Multiple stressors. For example, job insecurity, problems at work, financial difficulties, etc.
		Dramatic mood swings.
B	Step 2	If you believe an employee may be suicidal:
		Ask: "Have you been thinking of hurting yourself?" "Have you been thinking of killing yourself?"
		Notify your next level supervisor.
		Take all threats seriously.
		Do not leave the employee alone.

APPENDIX C

FAMILY MEMBER SUICIDE PROTOCOL

Listed below are steps to be taken in the event of a suicide attempt or when it is suspected a military family member may be a suicide risk.

I. When a family member has ATTEMPTED SUICIDE:

A	Step 1	Immediately notify RACH Emergency Room (ER), 458-2770/2773 for the appropriate medical/psychiatric support.
B	Step 2	If the family member poses a threat to others or to government property, notify the military police at 442-2101 if on post, or the Comanche County Sheriff's Department at 353-4280 or Lawton Police Department at 911 if off-post.
C	Step 3	Notify unit chaplain.
D	Step 4	Refer to Community Mental Health Services (CMHS) to help, if CMHS is not already involved in arranging follow-up.

II. When a family member has threatened suicide or may be a RISK FOR SUICIDE:

A	Step 1	Do not leave the family member alone.
B	Step 2	Contact the RACH ER at 458-2720/2773 or CMHS at 442-4832/4833 for evaluation and disposition.
C	Step 3	If the family member poses a threat to others or to government property, immediately notify the Military Police at 442-2101 if on post, or the Comanche County Sheriff's Department at 353-4280 or Lawton Police Department at 911 if off-post.
D	Step 4	Continue to be sensitive to and watch for future recurrence. Establish and conduct follow-up, as needed, with input from a mental health professional.

III. Warning Signs for Suicide:

A	Step 1	Know the warning signs. Be alert for the following in family members:
		Talking or hinting a lot about suicide.
		Making specific plans to commit suicide and access to lethal means.
		Preoccupation with death; sad music or sad poetry; themes of death in letters or artwork.
		Giving away possessions, making a will.
		Buying a gun.
		Depression.

		Decreased functioning at school, work, or home.
		Withdrawing/isolating.
		Drug or alcohol problems.
		Previous suicide attempt.
		Feeling hopeless/helpless/worthless.
		Relationship problems with spouse, family member, friends, or significant others.
		Enormous stress in life. For example, legal, school, work, or problems with peers.
		Sudden changes in behavior.
		Drastic mood changes.
B	Step 2	If you believe a family member may be suicidal:
		Ask: "Have you been thinking of hurting yourself?" "Have you been thinking of killing yourself?"
		Get professional help. (see II A, B, C, D)
		Take all threats seriously.
		Do not leave the family member alone.

APPENDIX D

GUIDE TO THE PREVENTION OF SUICIDE

(Excerpts from DA Pam 600-70)

D-1. A GUIDE TO THE PREVENTION OF SUICIDE AND SELF-DESTRUCTIVE BEHAVIOR.

Suicide among young adults is a serious and growing problem. In the past 25 years, there has been a 300 percent increase in the adolescent suicide rate. More than 6,500 young Americans kill themselves each year. Taking all age groups into account, nearly 30,000 Americans die by their own hand each year. There are over 1000 suicide attempts in the United States daily or one every minute of every day. Nationally, suicide is the tenth leading cause of death. In persons 14 to 25 years of age, it is the third leading cause of death and, among college students, it is second.

a. Why Suicide? There is no simple answer as to why people choose to kill themselves. Usually, the emotional upset is so great that the person "just wants to stop the pain." The suicidal person feels a tremendous sense of loneliness and isolation. They feel helpless, hopeless and worthless. Often they believe that it does not matter if they live or die and that no one would miss them. Suicidal people feel that they cannot cope with their problems and that suicide is the only possible way to escape unbearable pain.

b. What Causes Suicide? In trying to understand why people kill themselves, it is tempting to look at the source of stress in their lives. An analysis of life stressors is not, however, the answer. Stress is a normal part of life and people are usually able to cope. Actually, most people think about suicide at sometime during their lives. Usually they find that these thoughts are temporary and that things do get better. Generally, it is a combination of events that lead a person to believe that suicide is the only way out. One common thread is that the person feels hopeless about life. Feelings of hopelessness and low self-esteem can have many causes.

- Break up a close relationship with a loved one or difficulties in interpersonal relationships with family or close friends.

- Death of a loved one, spouse, child, parent, sibling, friend, or pet.

- Worry about job or school performance and concerns about failure or doing less well than one hoped or expected.

- Loss of "support systems" or "emotional safety" which comes from moving to a new environment.

- Loss of social or financial status of the family.

- The compounding and disorienting effects of drugs and/or alcohol.

D-2. SUICIDE IS A NEEDLESS AND PERMANENT SOLUTION TO SHORT-TERM PROBLEMS.

a. What are the Facts? An encounter with a suicidal person is always a deeply emotional experience. There is a fear of not knowing what to do or doing the wrong thing. However, just telling someone "I care about you" indicates that there is hope and help. Misinformation often prevents potential helpers from becoming involved for fear of making a situation worse. There are many myths about suicide which keep us from becoming involved. What are the myths and what are the facts?

Myth: People who talk about suicide rarely attempt or commit suicide.

Fact: Nearly 80 percent of those who attempt or commit suicide give some warning of their intentions. When someone talks about committing suicide, he may be giving a warning that should not be ignored.

Myth: Talking to someone about their suicidal feelings will cause them to commit suicide.

Fact: Asking someone about their suicidal feelings usually makes the person feel relieved that someone finally recognized their emotional pain, and they will feel safer talking about it.

Myth: All suicidal people want to die and there is nothing that can be done about it.

Fact: Most suicidal people are undecided about living or dying. They may gamble with death, leaving it to others to rescue them. Frequently they call for help before and after a suicide attempt.

Myth: Suicide is an act of impulse with no previous planning.

Fact: Most suicides are carefully planned and thought about for weeks.

Myth: Once a person is suicidal, he is suicidal forever.

Fact: Most suicidal people are that way for only a brief period in their lives. If the attempter receives the proper assistance and support, he will probably never be suicidal again. Only about 10 percent of attempters later complete the act.

Myth: A person who attempts suicide will not try again.

Fact: Most people who commit suicide have made previous attempts.

Myth: Improvement in a suicidal person means the danger is over.

Fact: Most suicides occur within about three months following the beginning of improvement, when the individual has the energy to act on his morbid thoughts and feelings. The desire to escape life may be so great that the idea of suicide represents relief from a hopeless situation. Often a period of calm may follow a decision to commit suicide.

Myth: Suicidal persons are mentally ill.

Fact: Studies of hundreds of suicide notes indicate that, although the suicidal person is extremely unhappy, he is not necessarily mentally ill.

Myth: Because it includes the holiday season, December has a high suicide rate.

Fact: Nationally, December has the lowest suicide rate of any month. During the holiday season, the depressed person feels some sort of belonging and feels things may get better. As spring comes and their depression does not lift, the comparison of the newness and rebirth of spring and their own situation can produce overt self-destruction behavior.

b. What Are the Signs?

(1) Depression. Depression is often associated with suicide. In 75 to 80 percent of all suicides, depression is a contributing factor. Sadness and an occasional "case of the blues" are normal emotions common to everyone. However, depression, an abnormal emotional state, is a profound sadness which is present nearly everyday for at least two weeks. Depression is characterized by:

- Poor appetite or significant weight loss or increased appetite or significant weight gain.
- Change in sleep habits, either excessive sleep or inability to sleep.
- Behavioral agitation or a slowing of movement.
- Loss of interest or pleasure in usual activities or decrease in sexual drive.
- Loss of energy, fatigue.
- Complaints or evidence of diminished ability to think or concentrate.
- Feelings of worthlessness, self-reproach, or excessive guilt.
- Withdrawal from family and friends.
- Drastic mood swings.
- Sudden change in behavior.

(2) Other Signs of Suicide. Historical factors have been identified which, when present, should cause us to increase our vigilance. Any person is at greater risk of suicide if they have:

- Made a previous suicide attempt.
- A family history of suicide.
- Lost a friend through suicide.
- Been involved with drugs or alcohol.
- Alcoholics in the family.

(3) When one or more of the following are observed in a person (especially someone who is or has experienced some of the life stress events associated with suicide, who appears to be depressed, and has a history known to cause increased risk of suicide) suicidal behavior may be imminent:

- Talking about or hinting at suicide.
- Giving away possessions; making a will.
- Obsession with death; sad music or sad poetry. Themes of death in letters or art work.
- Making specific plans to commit suicide and access to lethal means.
- Buying a gun.

c. What To Do? If you believe that someone may be suicidal, it is important to remember:

- Take threats seriously. Trust your suspicions. It is easy to predict suicidal behavior when a person shows most of the factors given above. However, the warning signs from many people are very subtle. Something like telling loved ones "goodbye" instead of "good night" may be the only clue.

- Answer cries for help. Once you are alerted to the clues that may constitute a "cry for help" from a loved one, friend, or co-worker, you can help in several ways. The most important thing is not to ignore the issue. It is better to offer help early than to regret not doing so later. The first step is to offer support, understanding, and compassion, no matter what the problems may be. The suicidal person is truly hurting.

- Confront the problem. If you suspect that a person is suicidal, begin by asking questions such as, "Are you feeling depressed?" "Have you been thinking of hurting yourself?" leading up to the question "Are you thinking of killing yourself?" Be direct. Don't be afraid to discuss suicide with the person. Getting him to talk about it is a positive step. Be a good listener, and a good friend. Don't make moral judgements, act shocked, or make light of the situation. Offering advice such as, "Be grateful for what you have," or "you're so much better off than most," may only deepen the sense of guilt the person probably already feels. Discussing it may

help lead the person away from actually doing it by giving him the feeling that someone cares.

- Tell them you care. Persons who attempt suicide most often feel alone, worthless, and unloved. You can help by letting them know that they are not alone, that you are always there for them to talk to. Tell loved ones how much you care about them, and offer your support and compassion. By assuring the person that some help is available, you are literally throwing them a lifeline. Remember, although a person may think he wants to die, he has an innate will to live and is more likely hoping to be rescued.

- Get professional help. The most useful thing you can do is to encourage the person who is considering suicide to get professional help. If necessary, offer to go with them or take them to help. The Army community offers many sources of help. The Community Mental Health Service or hospital departments of psychiatry as well as psychology or social work services and division mental health services should be considered first in looking for help. After duty hours, the hospital emergency room would be the best source. When the danger is less immediate, the Family Life Center and the chaplaincy offer compassionate counseling services. Other sources of help include the alcohol and drug community counseling center, Army Community Service (ACS) and the chain of command.

d. What Not To Do.

- Don't leave anyone alone if you believe the risk for suicide is imminent.

- Don't assume the person isn't the suicidal "type."

- Don't act shocked at what the person tells you.

- Don't debate the morality of self-destruction or talk about how it may hurt others. This may induce more guilt.

- Don't keep a deadly secret. Tell someone what you suspect.

D-3. There Are Alternatives. Suicide is a traumatic event for the individual and for all those people who have some connection with the person. Edwin Schneidman, Ph.D., founding president of the American Association of Suicidology, has stated:

"Human understanding is the most effective weapon against suicide. The greatest need is to deepen the awareness and sensitivity of people to their fellow man."

(ATZR-J)

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