



DEPARTMENT OF THE NAVY

NAVY RECRUITING DISTRICT NEW YORK
990 STEWART AVENUE
2ND FLOOR, SUITE 220
GARDEN CITY, NY 11530-4858

NAVCRUITDISTNYINST 1720.1B
00

12 Apr 16

NAVCRUITDIST NEW YORK INSTRUCTION 1720.1B

Subj: SUICIDE PREVENTION PROGRAM

Ref: (a) OPNAVINST 1720.4A
(b) OPNAVINST 6100.2A
(c) SECNAVINST 6320.24A
(d) MILPERSMAN 1770
(e) OPNAVINST F3100.64H

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

1. Purpose. To provide policy, procedures and assign responsibilities for the Suicide Prevention Program per references (a) through (e).
2. Cancellation. NAVCRUITDISTNYINST 1720.1A
3. Applicability. Provisions of this instruction apply to all military, civilian and contract personnel assigned to Navy Recruiting District (NRD) New York.
4. Background

a. Suicide is a preventable personnel loss that impacts unit readiness, morale and mission effectiveness. Relationship disruption, substance abuse, financial, legal and mental health problems (such as depression) can interfere with individual efficiency and unit effectiveness and also increase a person's suicide risk. Factors including positive attitude, solid spirituality, good problem solving skills and healthy stress control can increase individual efficiency and unit effectiveness and reduce risk of intentional self harm. As such, preventing suicide in the Navy begins with promotion of health and wellness consistent with keeping command personnel ready to accomplish the mission. Enclosure (1) contains a list of suicide risk factors, protective factors and resources for assistance.

b. Navy suicide prevention programs consist of four elements:

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

APR. 12 2016

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

(3) Response – assisting families, units and command members affected by suicide behaviors.

(4) Reporting – reporting incidents of suicide and suicide-related behaviors.

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

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

a. Training

(1) Suicide prevention training shall be conducted at least annually. General Military Training (GMT) materials may fulfill part of this training requirement but must be supplemented with information on local action plans and support resources. Suicide prevention training should include, but is not limited to:

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

(b) Recognition of specific risk factors for suicide;

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

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

(e) Contact information for local support services.

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

APR 12 2016

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

b. Intervention

(1) Enclosure (1) is the command's suicide prevention and crisis intervention plan that includes the process for identification, referral, access to treatment and follow-up procedures for personnel who indicate a heightened risk of suicide.

(2) NRD New York will foster a command climate that supports and promotes psychological health consistent with operational stress control principles. For example:

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

(3) NRD New York will provide support for those who seek help with personal problems. Access must be provided to prevention, counseling and treatment programs and services

APR. 12 2016

supporting the early resolution of mental health and family and personal problems that underlie suicidal behavior.

(4) If a command member's comments, written communication or behaviors lead the command to believe there is imminent risk that the person may cause harm to self or others, command leadership must take safety measures that include restricting access of at-risk personnel to means that can be used to inflict harm and seek emergent mental health evaluation consistent with reference (c).

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

d. Reporting

(1) Suicides and suicide-related behaviors shall be reported per references (d) and (e).

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

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

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

APR 12 2016

e. Suicide Prevention Coordinator. The SPC will aid the Commanding Officer in ensuring that the suicide prevention program is fully implemented and fully compliant with all aspects of reference (a). These responsibilities include ensuring:

- (1) Annual suicide prevention training for all command personnel.
- (2) Suicide prevention is part of life-skills/health promotions training.
- (3) Written suicide prevention and crisis intervention plan is in place (e.g., standard operating procedures, duty office checklist).
- (4) Local support resource contact information is easily available. For example:
 - Chaplain/Religious Services
 - Fleet and Family Support Center
 - Medical
 - Security
 - Local Emergency Room
- (5) Personnel and supervisors have ready access to information about how to get help with personal problems (e.g., wallet card info, posters, plan of the day, e-mails).
- (6) Procedures are in place to facilitate personnel accessing needed services (e.g., time for appointments, access to transportation, overcoming logistical barriers, discouragement of stigmatizing).
- (7) Supervisors are active in identifying personnel potentially in need of support (e.g., relationship problems, financial problems, recent loss, legal problems or loss of status, change in behavior or performance, showing warning signs).
- (8) Safety plan is in place for dealing with high-risk command members (e.g., suicidal/homicidal/bizarre thoughts and behaviors) until mental health services are available. In the absence of guidance from a mental health professional, recommend:
 - (a) Removal of personal hazards (no weapons, belt, shoes, boot straps, draw strings, shirt stays and personal hygiene items such as toothbrush or razor).
 - (b) Removal of environmental hazards from room (room free of sheets, elastic bands, mirrors, pencils, pens, window dressings (such as blinds), shoelaces, strings, alcohol, weapons, medication, cleaning supplies, razors, metal eating utensils, telephones, tools, or any other rope, breakable, or sharp-edged object).

APR 12 2016

- (c) Line of sight supervision.
- (9) Mental health contact information is readily available.
- (10) Follow-up plan for personnel after acute evaluation.

5. Resources

www.suicide.navy.mil
www.med.navy.mil
www.militaryonesource.com
www.militarymentalhealth.org



J. W. STICHT

APR 12 2016

Suicide Prevention Crisis Response Plan

Important Phone Numbers

NRDNY Command Duty Officer	516-250-3656
Fort Hamilton	718-630-4101
WestPoint family advocacy	718-938-3369
Fort Hamilton Emergency Service	718-630-HELP
NWS Earle Branch Medical Clinic	732-866-2300
NWS Earle Navy Fleet and Family Support Center (FFSC)	732-866-2115
Suicide Prevention Hotline	800-273-TALK (Option 1)
Naval Criminal Investigation Service (NCIS)	732-866-2235
American Association of Poison Control Centers	800-222-1222

Action – What will the First Responder do?

1. If a command member presents suicidal behavior during working hours:
 - a. Ensure the person is safe and is not left alone.
 - b. If no injuries, contact Command Suicide Prevention Coordinator (SPC). If unable to reach SPC, contact the Command Master Chief (CMC), the Commanding Officer (CO), and immediate supervisors.
 - c. If injured call 911.
2. If a person presents suicidal behavior during non-working hours:
 - a. Ensure the person is safe and not in immediate danger.
 - b. If not safe or injured, call 911 immediately.
 - c. If no injuries contact SPC. If unable to reach the SPC, contact the CDO, CMC and immediate supervisors.

APR 12 2016

“Do’s” and “Don’ts”

1. If a person reports suicide related behavior to a command member:

DO:

- Ensure someone is with them.
- Remove all hazards in immediate surroundings (weapons, scissors, etc.)
- Treat the person with respect. Remember the acronym ACT – Ask, Care, Treat.
- Be yourself. “The right words” are unimportant. If you are concerned, your voice and manner will show it.
- Listen attentively, stay calm, be supportive and kind.
- Focus on the person, not the rules.
- Do not be judgmental or invalidate the person’s feelings. Let the person express emotions without negative feedback.

DO NOT:

- Tell the person how they are feeling.
- Make decisions for the person.
- Say anything that would cause the person to feel that you disbelieve what they are saying.

APR 12 2016

CHECKLIST FOR SUICIDE RELATED BEHAVIOR

1. Identify the caller:

Name: _____

Phone Number: _____

Date/Time: _____

2. Identify the Facts:

Location of person: _____

Where did the incident occur? _____

Approximate age of person? _____

Is there a Weapon? _____

Who else is there? _____

Who is the person? _____

Have you/they taken drugs or alcohol? _____

3. Ask: Has the Command Suicide Prevention Coordinator been notified?

Yes _____ No _____

Yes _____ No _____

4. Ask: Has Medical Assistance been called?

If yes, who was contacted?

Name: _____

Phone _____

number: _____

Yes _____ No _____

5. Ask: Has Security/police been called?

If yes, who was contacted?

Name: _____

Phone _____

number: _____

*** The Suicide Prevention Coordinator will maintain a copy. ***

APR 12 2016

SUICIDE RISK FACTORS, PROTECTIVE FACTORS AND RESOURCES

1. Risk Factors and Stressors Associated with Navy Suicides

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

2. Protective Factors that Reduce Risk of Suicide

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

APR 12 2016

- g. Spiritual support
- h. Beliefs counter to suicide that support self-preservation

3. Resources

- a. www.suicide.navy.mil
- b. www.nmcphc.med.navy.mil
- c. www.militaryonesource.com
- d. www.militarymentalhealth.org (Funded by Department of Defense Office of Health Affairs) provides anonymous online mental health screenings
- e. www.usmc-mccs.org/leadersguide

APR 12 2016

DEFINITIONS OF SUICIDE RELATED BEHAVIORS

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