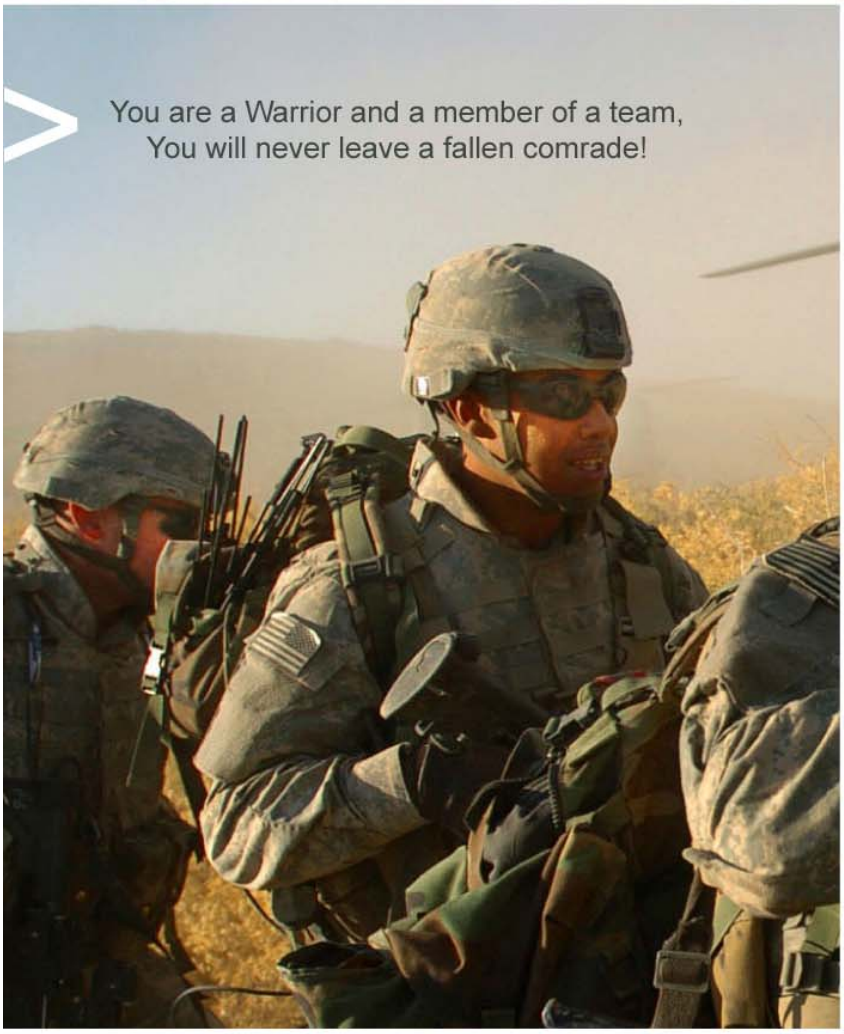

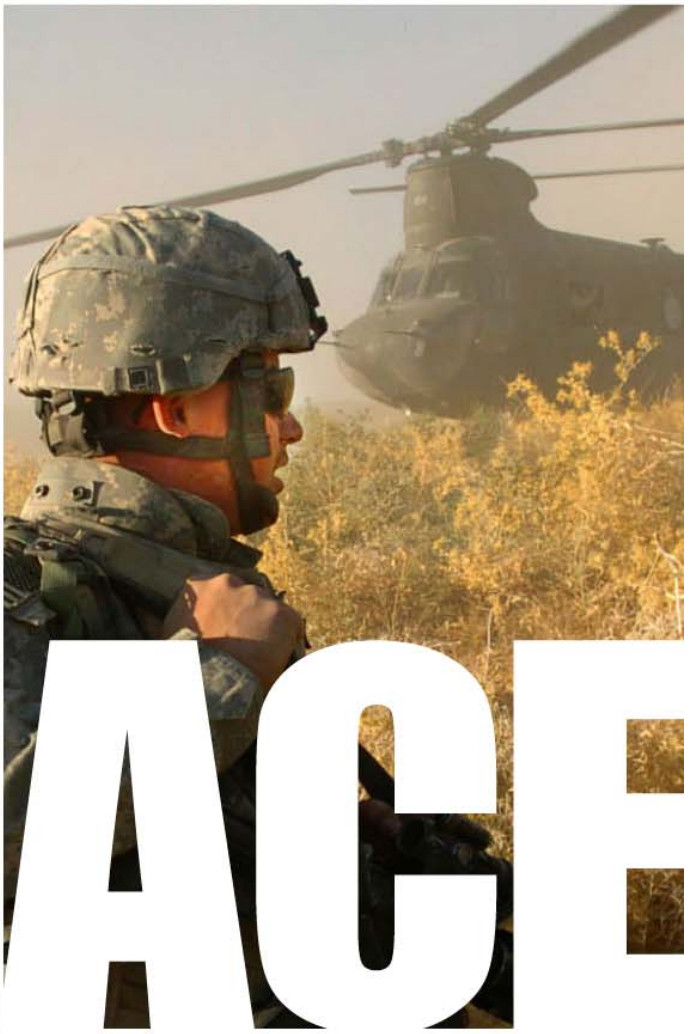

ACE

Army's ACE Suicide Intervention Program: Train-the-Trainers Manual

U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM)
31 January 2008

USACHPPM
Readiness thru Health

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Train –The-Trainer's Manual

Introduction: This manual is for training trainers on how to instruct the ***Army ACE Suicide Intervention Program*** with the goal of ensuring that all Warriors receive this training. This manual will be updated annually to reflect new changes to the program. Graphic training aids (Power Point visuals, DVD, handouts & training tip cards) are available for downloading at the USACHPPM web page, https://chppm-www.apgea.army.mil/dhpw/Readiness/suicide.aspx and the USACHPPM AKO web page, https://www.us.army.mil/suite/page/334798.

Content Overview: Topics in this training include suicide awareness, warning signs of suicidal thinking and behavior, and intervention skill's development. The acronym, ACE, will guide the actions to take with a buddy to prevent suicide. ACE stands for "ask," "care," and "escort." The training will show how a battle buddy should ask a fellow Warrior about suicidal ideation, care for the Warrior, and escort the Warrior to the source of additional help.

Purpose: With the advent of combat operations in Afghanistan and Iraq, completed suicides in theater increased during 2002-2007. To assess Soldiers' mental health issues and evaluate the unit's suicide prevention programs, OTSG deployed Mental Health Assessment Teams (MHAT) from 2003 - 2007 to the OIF/OEF Theaters. The 2005 MHAT report verified that suicide prevention training was being conducted at specific intervals during the deployment cycle, primarily conducted by Unit Ministry Teams (UMT) with occasional assistance from behavioral health assets. However, the report findings suggested that the Soldiers, who reported receiving suicide prevention training before and during deployments, perceived the training as insufficient in identifying fellow Soldiers at risk for suicide.[1] Given this perception, it was recommended that the Suicide Prevention Program be redesigned for more effectiveness. The Army G1 has requested that CHPPM: 1) develop an Army-specific suicide awareness and prevention training support package with accompanying DVD; and 2) develop a suicide intervention skills training support package (TSP) for Army wide distribution.[2] The ***Army's ACE Suicide Intervention Program*** is a response to the second directive indicated above.

General Research Findings re: Suicide: The latest national suicide data reported by the Centers for Disease Control and Prevention (CDC) Web-based Injury Statistics Query and Reporting System (WISQARS) contains data from 2004. The CDC reported that 32,439 people in the United States died by suicide in 2004.[3] "An estimated eight to 25 attempted suicides occur per every suicide death".[4] The national suicide rate for 2004 was 10.9 per 100,000. Since 1994, the rate has fluctuated from 12.0 to 10.9. Research reveals that 90% of those individuals who committed suicide had a Diagnostic and Statistical Manual of Mental Disorders, 4th. Edition (DSM-IV) diagnosis. It also shows that men are four times more likely to **complete** suicide while women are three times more likely to **attempt** suicide.

Specific Research Findings re: Army Suicide: The Army suicide rate for 2005 was 13.0 which were higher than the 2004 civilian rate but lower than the civilian demographically-adjusted rate of 19.9. The Army suicide rate has varied from 15.8 in 1985 to 9.2 in 2001 to. Eighty-eight Soldiers committed suicide in 2005. During CY 2006, the Army had 98 confirmed suicides with a rate of 17.3 per 100 K. Eighty-seven percent (87%) of those deaths were from the Active Component (AC), 42% were either deployed or had deployed within the previous 12 months.

Why the Army's ACE Suicide Intervention Program: Army Suicide Event Reports (ASERs) indicate that the Soldiers at the greatest risk for suicide are lower enlisted Soldiers who do not seek help. As a result, the Army's peer suicide intervention program was redesigned to make it as effective as possible in **targeting the Soldiers who are most at risk**. Therefore, the focus of attention will be on training at the lower unit levels of the company, platoon, squad, and team. Another focus of attention will be leadership training and community education. The benefit of leadership training is that it has a wider reach, and community education provides yet another layer of protection. These collective actions can save lives and ultimately reduce the Army suicide rate.

Key Element

A key element of suicide prevention is to train Warriors to recognize when a fellow Warrior may be at risk for suicide, ask about it, and assist the Warrior who is thinking about suicide to get specialized help. The assumption is that Warriors know each other best and are closest to the stage for problems. The Army's ACE Suicide Intervention program will train Warriors and leaders to identify Warriors in close proximity who may be at risk for suicide and then to effectively intervene ("Ask, Care, Escort"). If all Warriors develop requisite awareness and intervention skills at the individual level, then they become a competent and confident force for preservation of life within the integrity of the unit.

Recognition skills enable a fellow Warrior to be able to identify when a buddy is a suicide risk. Thus the **"Ask"** of *"ACE"* came about. By **asking** a fellow Warrior who shows signs of suicidal behavior about their situation, one can then assist **("Care"**) this Warrior who is thinking about suicide to get **("Escort"**) specialized help. Since it is logical that Warriors serving in the same unit know each other best, it stands to reason that they are the ones closest to, and are more apt to be able to identify, their battle buddy's suicide-related problems. So, the objective, then, is to train the "boots on the ground" to **recognize** when a fellow Warrior is in distress and **respond** effectively.

The Strength of ACE

ACE is based in a strengths perspective that is designed to empower Warriors to be part of the solution. This program is based on a belief that the average Warrior can be trained to act effectively to help a fellow Warrior. ACE will equip Warriors with the necessary skills to attack and defeat the negative effects of suicidal behavior in a battle buddy. In order to enable Warriors to follow such a directive, the stigma attached to seeking help must be eliminated. The ACE instructions will provide a complete explanation of the negative effects of stigma, and its negative impact on help-seeking behavior. Help-seeking and assisting others must be normalized and made compatible with the warrior ethos.

As SMA Kenneth O. Preston stated: "One suicide is one too many!" and "Not all wounds are visible. If you are feeling depressed or suicidal, seek help. We need you on the Army team."

The Goal of ACE

The overall purpose of the **"ACE"** suicide intervention program is to help Warriors in the ranks to learn that they can take necessary steps to prevent suicides. It is aimed at Warriors and leaders with a goal to make it easier for Warriors to help fellow Warriors who have thoughts of suicide. ACE will encourage Warriors to question directly and honestly any buddy who exhibits suicidal behavior. This training will help Warriors to avoid letting their fears of suicide govern their actions to prevent suicides. The long term goals are as follows:

1. Contribute to the decrease in individual-level stigma of suicide prevention;
2. Increase in the number of early identification referrals and follow-up made for potentially suicidal warriors;
3. Contribute to the decrease in the number of suicides and suicide attempts by Warriors.

The Training Focus of ACE

ACE training can play a role in the unit's resolve to help prevent suicide. Warriors will learn that they have a vested interest in helping their fellow Warrior. A unit member's suicide will negatively affect unit cohesion. A suicide can demoralize and seriously disrupt the unit's ability to sustain its mission. Given this perspective, Warriors and leaders have a vested interest in helping buddies who are thinking of suicide.

Overall, suicide intervention training using the acronym "ACE" focuses on equipping Warriors with skills necessary to help a suicidal buddy.

ACE:

- Is a gatekeeper (peer) early prevention/ intervention program that is evidence-based.
- Does not require training in formal counseling to be effective.
- Targets those Warriors most at risk for suicide and the least likely to seek help due to stigma.
- Teaches Warriors how to recognize suicidal behavior in fellow Warriors and the warning signs that accompany it.
- Increases a Warrior's confidence to ask if a buddy is thinking of suicide.
- Teaches Warriors skills in active listening.
- Increases the opportunity to secure early intervention before a suicidal crisis.
- Encourages Warriors to take a buddy directly to a Chaplain or behavioral health provider (Never leave a battle buddy alone.).

<u>ACE Training Objectives</u>:

- Foster individual and group responsibility for the well being of others.
- Raise the awareness of **stigma** and its negative effects on "help seeking."
- Build resiliency as a protective factor in the prevention of suicides.
- Teach participants the knowledge and skills for identifying, intervening, and referring suicidal Warriors for help.
- Develop competence and confidence in the application of these skills.
- Teach participants to identify military community resources and make referrals for Warriors in need of services.

How to Use This Manual

Getting Started: This manual contains all the necessary information to train leaders and Warriors about suicidal behavior and to help a battle buddy who may be suicidal.

Important Note: This manual is not a *treatment* manual. It only provides basic instructional guidance to trainers and leaders re: suicide *intervention* skills

What You Need to Teach Suicide Intervention Program Training

1. Equipment

DVD player, computer (laptop or desktop) with working internet connection, projector, projection screen, audio capabilities required, butcher block paper with stand, markers, gaffers tape, extension cords, adapters, and cable connectors.

2. Handouts

Handouts are to be place in individual folders for class participants. The handouts include the following nine attachments & vignettes:
Attachment 1: Suicide Prevention Questionnaire (2 copies)
Attachment 3: "Suicide in the U.S. Statistics and prevention"
Attachment 4: Myths and Facts about Suicide
Attachment 5: Suicide Prevention Training Tip Card
Attachment 6: ACE Training Tip Card
Attachment 7: Listening Skills Exercise
Attachment 8: Stigma: Myths and Facts
Attachment 10: Army ACE (Peer) Suicide Intervention Role-play Options
Attachment 11: Army's ACE Suicide Intervention Training Feedback

3. A 3-Hour Training Module

The material contained in this manual is designed to be delivered in approximately three hours, including completion of pre and post measurements and a satisfaction questionnaire. However, the trainer can take more time to expand the presentation by including other topics such as resiliency training, behavioral health issues/concerns, or other life cycle improvement classes.

4. **Suitable Teaching Environment**

This can include a traditional platform classroom, real time distance learning facility like a TNET or Distance training Facility.

The Training Process

1. Distribute "ACE" training pre-measurement instrument (Attachment 1) and training folders prior to arrival of class participants: place them each on seat or desk.

2. Teaching trainers and/or leaders ensure that class participants sign in.

(NOTE: The sign in sheet will help you to complete the participants' certificates. It will also be your record of those individuals who completed the class.)

3. As the participants enter the room, encourage them to complete the **anonymous pre measurement instrument (attachment 1)**, and return the completed instrument to you, immediately. Class participants will complete the same measurement at the end of the class, hence the post measurement.

Inform the participants that you will explain the rationale for completing the measurement during your classroom introduction.

CLASS Introduction

(Note to Instructor: Have PowerPoint visual #1, the title slide, up on the screen)

1. Setting the Tone.

Begin your class presentation by introducing yourself and any person who may be assisting you by stating name, rank, and position.

If you are a leader who is training your own unit, a formal introduction is your option.

As an instructor who is new to the audience, you may want to open with a "thank you" for their interest to become involved in the Army's efforts to reduce suicide.

Ensure your class is given logistical information such as rest room locations, break and lunch start and stop times, any classroom rules and regulations such as whether or not they can or cannot have food and/or drink, and the like.

Explain what they will accomplish in the next 3 hour period.

Include class content objectives such as:

a. Foster individual and group responsibility for the well being of others

b. Become aware of stigma and its negative effects on "help seeking"

c. Build resiliency as a protective factor in the prevention of suicides

d. Improve knowledge and skills for identifying, intervening, and referring suicidal Soldiers for help

f. Learn three critical actions to take to help buddies who are suicidal

e. Develop competence and confidence in the application of the stated skills and those additional ones you cover

g. Identify military community resources and how to make referrals to them for Warriors in need of services

State and emphasize that **the overall goal** of the Army Suicide Prevention Program (ASPP) and this training **is to reduce Soldier suicides**. This goal is based on the belief that many suicides are preventable.

>> The American Association of Suicidology estimates that approximately 80% of suicidal individuals give definite danger and warning signs of their intentions.

>>If the Army is vigilant, aware of and appreciates the significance of these danger and warning signs, and knows how to properly intervene, suicides will likely decrease.[5]

>>The **ACE** is designed to accomplish this mission.

2. Clearly State

Acknowledge to the audience in general terms that some individuals who are present today may have suffered individual losses, suspect a battle buddy is at risk for suicide, or suspect they are at risk.

Suicide is an emotionally charged subject!

Therefore, it is understandable that it may be difficult to learn now about things they wish they knew earlier.

Reassure the audience that by end of the class, they will have the necessary information and knowledge to deal with individuals who are at risk for suicide. Make sure to note that you or class assistant will be available after the training session to assist or further discuss any concerns that arise during today's class.

Ask them to write down on a slip of paper as they sit through the class any therapeutic-type questions and concerns that may require professional intervention so they can bring them to your attention after the training ("after" because some of your class content may answer their question[s]).

3. Measurement Instruments

Provide a brief explanation about the pre and post class measurement.

Emphasize the need for **ACE** program developers to determine whether the program is indeed meeting the objectives previously indicated.

By accurately filling out the class measurement, class attendees ensure that outcomes, i.e., effectiveness and satisfaction are measured correctly.

Based on the pre and post class measurement outcomes measuring effectiveness and satisfaction, the **ACE** program developers will evaluate and modify activities i.e., developers will make any necessary course modifications.

Inform the audience that at the end of this class session, they will be required to complete another test and a satisfaction questionnaire.

Lesson One:

Begin Instructing

Topic: Attitude Awareness – This lesson is a general group discussion on feelings and experiences.

Attitude awareness is a less obvious goal of this program.

How Warriors and leaders think and feel about the subject of suicide will influence the way Warriors deal with a suicidal buddy. The intent of this lesson is to encourage Warriors to openly discuss a subject that is generally considered taboo.

Those who feel suicidal fully understand that talking about suicide is often a taboo subject. As a result, the suicidal Warriors will further isolate themselves in order to avoid the rejection from fellow Warriors. It is anticipated an open discussion will dispel any misconception about this historically taboo subject.

Explain/identify to the class the historical attitudes that hinder countering and eliminating suicide in the Army. (e.g., how *stigma* "looks" in a unit)

Let them know you are going to ask questions that are designed to explore these foundational attitudes that need restructuring for the Army to see success in the reduction and elimination of suicide among their ranks.

Began Group Discussion: Be alert to the fact that, when you do start asking these questions, it is not unusual for audience members to begin sharing personal experiences about someone they know who attempted suicide or completed suicide. **This is a positive indication that the topic of suicide is now okay to discuss openly.**

To help facilitate the group discussion ask these questions:

1. Do you know any one who has died by suicide?
2. Do you know anyone who has attempted suicide?
3. What would you do to help someone who is suicidal?
4. How comfortable would you feel in helping someone who is suicidal?
5. How confident are you that you could help someone who is suicidal?
6. If your battle buddy was suicidal, to whom would you refer your battle buddy for help?
7. Who would you tell if you had thoughts of suicide?

++

(Note to Instructor: Regarding #7, remember, the "ACE" is about suicide awareness, early recognition of suicidal thinking and behavior in buddies, and escorting and taking a buddy who is suicidal for help; it is not *treatment* of suicidal behavior.

As the presenter, <u>you are not expected to provide the *treatment* when an audience member presents a situation that requires immediate intervention</u>. It is important only that you be *prepared* to refer someone who may need assistance. If an audience member needs immediate attention, your assistant could quickly meet with this person to evaluate the need.

++ (Back to your class members)

Wrap up the discussion of Question # 7 by gaining a general commitment from the audience to either help a buddy or seek help when suicidal behavior is detected.

The presenter should ask the audience if they are prepared to learn about how to help a buddy who is suicidal. If the presenter receives general agreement, the instructions should continue.

Ask your class these final two questions:

8. How widespread is stigma in your unit?

9. What are your thoughts about seeking help for emotional problems?

Next, explain to your class the following to **reinforce** the purpose for their being in attendance in this class today:

Class, the key element of suicide prevention is to train Warriors to **recognize** when a fellow Warrior may be at risk for suicide, **ask** about it, and **assist** the Warrior who is thinking about suicide to get specialized help. The assumption is that Warriors know each other best and, are closest to the stage for problems.

Therefore, the course objective is to train the "boots on the ground" to recognize when a fellow Warrior is in distress and respond effectively. "**ACE" specific purpose is to equip** Warriors and leaders with these skills necessary to identify Warriors in close proximity who may be at risk for suicide and then to act effectively to intervene.

If all Warriors develop requisite awareness and intervention skills at their personal level, then they become a competent and confident force for preservation of life within the integrity of the unit. It is known that the Warriors at the greatest risk for suicide are lower enlisted Soldiers **who do not seek help**.

This program is designed for you to become more effective at helping your buddy who may be at risk. When class participants provide a general agreement to help a buddy who maybe suicidal or seek help if they feel suicidal, it is time to start lesson two.

Note: The following discussion on the handouts is to be supplemental training. If time allows, the class facilitator may conduct a brief overview on any one of the documents that appears appropriate.

>>>Transition to Handout "Profile" (Attachment # 2)

Move the attention of your class to a review of the facts regarding high risk groups that are of particular concern to the Army

Review the ASER data on the handout title "Profile"[6] (Attachment #2)

>>>Transition to Handout "Suicide in the U.S.: Statistics and Prevention" (Attachment # 3)

Review the handout of "Suicide in the U.S.: Statistics and Prevention" (Attachment # 3)

(Note to Instructor: Only draw attention to this handout as it is for information purposes only. Highlight just relevant data based on any discussion up to this point.)

>>>Transition to Handout "Myths and Facts About Suicide" (Attachment # 4)

Give a brief overview of the Myths and Facts about suicide (Attachment # 4)

>>>Transition to a Discussion about "Suicide Warning Signs and Risk Factors"

Focus the next part of your class **[thirty minutes];** discuss suicide warning signs and risk factors.

Explain that there is no **definite** measure to predict suicide or suicidal behavior.

However, American Association of Suicidology fact sheet states that "the vast majority of individuals who are suicidal often display cues and warning signs".

Also, researchers have noted that suicide involves **aggression** and sometimes it is carried out **impulsively**. [7]

Note: Alcohol use or a history of traumatic brain injury may cause or worsen **impulsivity and disinhibited behavior**.

The additional stress of a traumatic event or bad situation can make a Soldier feel overwhelmed and trapped by the situation.

For this Warrior, suicide may be seen as a way of dealing with the strong negative emotions through escape. This is often an impulsive response - act of attempted or completed suicide- with very little warning to fellow Warriors.

The CY 2006 Army Suicide Event Report (ASER) indicated the motivational event for completed suicides was 43% unknown.[8] This could suggest that some of these unknown motivational event suicides could have been impulsive acts with very little or no warning signs.

However, it was reported that 6% of the completed suicides were acts of impulsivity.

Make a note that an observable risk factor for Warrior battle buddies to keep an eye out for is being aware when a "bad event", e.g., Dear John Letter, takes place and what is the observed reaction to this specific event. Reactions that can signal possible suicidal actions include aggressive behavior, anxiety, withdrawal, or agitation.

The ACE intervention is for Warriors to identify battle buddies who are experiencing problems and perhaps intervene before he or she impulsively attempts to kill self. Fellow Soldiers' vigilance and willingness to help a battle buddy can save lives.

[Note to Instructor: Share the following… If, in fact, your personal troubles are beginning to overwhelm you, then seek the type of help in the manner to be explained in this course immediately letting your Warrior buddies know how you are feeling. Part of the relief is sharing.]

>>>Transition to a Discussion about "Warning Signs and Risk Factors" (Attachment # 5)

There are factors that have been identified that place Warriors at higher risk for suicide, but very few Warriors with these risks actually attempt or complete suicide. At this point, refer to training tip cards: Warning Signs and Risk Factors (attachments 5).

Emphasize that suicide is a rare event, and it is difficult to use these risk factors to predict who will die from suicide. The assumption is that battle buddies are the closest and best equipped to notice warning signs or changes in behavior.

Explain that the best indicator that a Warrior is at increased risk for suicide is a history of prior suicidal attempt.

Also, research indicates the most significant predictor of suicidal risk for Warriors with **Post Traumatic Stress Disorder (PTSD)** is **combat related guilt**.

During post deployment, Warriors may experience highly intrusive thoughts and extreme guilt about acts committed during deployment. A Warrior may experience difficulties coping with these thoughts and commit suicide for relief.[9]

Regarding **Depression,** The National Institute of Mental Health (NIMH) reports that "the majority of people who have depression do not die by suicide, having major depression does increase suicide risk compared to people without depression.

The risk of death by suicide may, in part, be related to the severity of the depression. It is estimated that about 60 percent of people who commit suicide have a mood disorder (e.g., major depression).

"Younger persons who kill themselves often have a substance abuse disorder in addition to being depressed". [10] In the Army, about 20 to 30 % Soldiers who completed suicide were drinking at the time of the event.

>>>Transition to a Discussion about "Overview of Depression and Reasons Why Warriors Complete Suicide" (Attachment # 5)

Using training tip card attachment 5, provide a brief overview of reasons why Soldiers complete suicide and depression.
>>>Transition to Lesson Two

Lesson Two

Discuss Risk Factors

[Negative] Risk factors **increase** the probability that difficulties could result in serious behavioral or physical health problems. The risk factors only raise the risk of an individual being suicidal. Having negative risk factors does not mean that the individual is suicidal. Simply stated, Soldiers who possess negative risk factors are at greater potential for suicidal behavior.

Discuss Protective (or Positive) Risk Factors

On the other hand, Warriors' protective [or positive] factors **reduce** the likelihood of suicide. Protective factors "enhance resilience and may serve to counterbalance risk factors".[11]

Protective factors are quite varied and include a Warrior's attitudinal and behavioral characteristics, as well as attributes of the military environment and culture.

A Warrior's most important [or positive] factors are:

Individual Protective Factors
- Cultural and religious beliefs that discourage suicide and support self-preservation
- Coping/problem solving skills
- Support through ongoing health and mental health care relationships
- Resiliency, self esteem, direction, mission, determination, perseverance, optimism, empathy
- Reasons for living
- Family supports (spouse & extended family)
- Pride and patriotism

Unit Protective factors
- Unit cohesion
- Sense of social support and belonging in the unit
- Staying connected with friends – Buddy system
- Access to comprehensive health care
- Cultural values affirming life
- Caring Leadership

Military Community Protective factors
- Access to healthcare and mental health care

- Social support, close relationships, caring adults, participation and bond with school and church
- Respect for help-seeking behavior
- Skills to recognize and respond to signs of risk

>>>Transition to a Discussion of "Warrior Resiliency"

Warrior Resiliency

Warriors are expected to deal with **difficult events** that will change their lives.

Examples of **difficult events** are (1) the death of a battle buddy in combat, (2) the physical and emotional challenges of combat, (3) separations from love ones, (4) breakup of a relationship, and (5) other deployment-related traumatic events.

Other difficult events that can give resiliency a chance to blossom include problems arising from family relationships, legal issues, financial and serious health problems.

Many Warriors react to these challenges in very **adaptable** ways. While some Warriors react to these events with a flood of emotions and a sense of uncertainty, others **adapt** well and, over time, develop what is referred to as ***resiliency.***

[Note to Instructor: Ask the audience to provide a definition of resiliency and personal examples of resiliency before providing schoolhouse definition.]

Define Resiliency

Resiliency is the ability to recover and adapt well from the face of adversity, trauma, illness, changes or misfortunes.

Resiliency means "bouncing back" from difficult situations. [12]

Resiliency among Warriors are, generally, very **ordinary.**

Most Warriors **commonly** demonstrate resiliency during very difficult and stressful situations.

Resiliency can be birthed and nurtured by learning **adaptive behaviors**, thoughts, and actions that allow the individual to recover from difficult experiences.

Warrior resiliency is associated with a combination of factors.

These factors include:

1. A sense of belonging in the unit

2. Having the inner strength to face adversity and fears of combat

3. Having the capacity to connect with battle buddies

4. Having caring, healthy and supportive relationships within and outside of the family

5. A positive view of self

6. Confidence in strengths and abilities to function as a Warrior

7. The capacity to manage strong feelings and impulses.

>>>Transition to "How to Build Resiliency"

Building resiliency is a personal journey.[13]

There are a variety of strategies a Warrior can use to build resiliency.

This is because each individual Warrior, because of their uniqueness, will react to **difficult events** in different ways.

In other words, the method one Warrior uses to mange difficult events might not work for another Warrior.

There are a variety of different **strategies** to use to meet these challenging difficult events, i.e., **build resiliency**.

1. Make connections and reach out to unit members. Actively engage in developing good relationships with fellow Warriors. Be active in unit activities; join base social support groups, faith-based organizations, or other groups.

2. Accept and face your fears. Understand that being fearful is acceptable. Assess the risk and be confident in your ability to cope with the uncertainty.

3. Nurture good relationships with family and close friends. Accept the help and support from them when you need someone who cares and willing to listen.

4. Regulate your emotions and avoid impulsive behavior. Learn to stay calm under pressure. Think before you act--delay gratification.

5. Maintain realistic optimism. Believe in your ability to survive and function as a good Soldier. Given your training, know that you have the ability to handle any adversity or misfortune. Problems solve and worked toward positive outcomes.

6. Identify your strengths. Nurture positive views of yourself. Trust your instincts and ability to solve problems.

7. Having Faith in God and future - being connected.

8. Be willing to access social support.

9. Commit yourself to keeping in shape, maintaining physical health (diet, rest, exercise)

These resiliency strategies are very consistent with the **Army's values**:

Loyalty
Bear true faith and allegiance to the U.S. constitution, the Army, and other soldiers.
Be loyal to the nation and its heritage.

Duty
Fulfill your obligations.
Accept responsibility for your own actions and those entrusted to your care.
Find opportunities to improve oneself for the good of the group.

Respect
Rely upon the golden rule.
How we consider others reflects upon each of us, both personally and as a professional organization.

Selfless Service
Put the welfare of the nation, the Army, and your subordinates before your own.
Selfless service leads to organizational teamwork and encompasses discipline, self-control and faith in the system.

Honor
Live up to all the Army values.

Integrity
Do what is right, legally and morally.
Be willing to do what is right even when no one is looking.
It is our "moral compass" an inner voice.

Personal Courage
Our ability to face fear, danger, or adversity, both physical and moral courage.

(**Note to Instructor: Instructor is encouraged to solicit volunteers from the audience to share personal experiences about a stressful situation, and how the person recovered from that experience. What strategies the individual used to recover from the experience? What did the individual learn from the experience? If no volunteers, the instructor could discuss a personal experience for the class.)**

Lesson Two: **Hope Box Exercise:** Everyone take a few minutes and make a list of personal resiliency strategies that can help you to deal with a potentially bad situation or event.
Facilitator: Ask for a volunteer to share their list…lead a group discussion.
Now: Ask the group to pick their top three personal resiliency strategies and record on a small piece of paper. Recommend that they fold the paper and store in their wallet or purse.
State: When you are confronted with a bad situation or event, review your list. Use the strategies identified in order to help you cope with the situation.

>>>Transition to Lesson Three

Lesson Three

Present "ACE" Concepts and Skills (Time allotted: 30 minutes)
Note to Instructor: To avoid lecturing from the power point, instructor should encourage Soldiers to share personal experiences in helping a buddy who was struggling with a problem. Whenever possible, the instructor should allow the participants to process the information i.e. allow the participants to openly discuss the material in this lesson

"ACE" for Soldiers:
"Ask": Ask your battle buddy about his or her suicidal thoughts.

1. Know the **warning signs** you might see in yourself or battle buddy if he or she is suicidal.

2. Look for any outward sign that shows a deviation from your battle buddy's usual self.

Refer your students back to the discussion on **warning signs** and **[positive and negative] risk factors** which you should have already completed

(Note to instructor: Ensure you do not teach this section on "ACE" as a separate unit because the learning comprehension builds on what is previously taught in the lesson)

When the **warning signs** are present, it is imperative to ask your battle buddy directly; "Are you thinking about killing yourself?"

(Note to Instructor: Refer students to Training Card at Attachment # 6)

Teach How to "ASK"

Ask your battle buddy directly about thoughts or plans for suicide.

1. Say something like, “I can see that you feel distressed.” “Have you thought of hurting yourself or someone else?” or, “Do you wish you were dead?”

2. Then “Have you thought of how you could kill yourself?” (or whomever)

3. Talk openly about suicide. Be willing to listen and allow your battle buddy to express his or her feelings.

>>>Transition to Teach about the “C” in “ACE”, *“Care”*

Teach How to “Care”

1. Care for your battle buddy by understanding that your battle buddy may be in pain

2. Actively listening may produce relief. Calmly control the situation: do not use force

3. Take action by removing any lethal means, such as weapons or pills

(Note to Instructor: Teach the following at this point in your class)

>>>Transition to Teach about *What* to Listen for while “Active Listening”

What to Listen For:

1. It is important to understand with **what, where, and when** your battle buddy plans to kill himself or herself

2. If your battle buddy acknowledges his or her plans, it generally suggests that your buddy is accepting your help

3. If your battle buddy tells you his plan, try to determine what steps he or she planned to take in order to carry out the event

4. What were his or her preparations for dying (e.g., giving away personal possessions)

5. Find out the timing and location of the suicidal plan and the lethality of method

6. Ask about rehearsal behaviors (e.g., tying noose, loading gun)

7. Explore ambivalence (undecided), that is, asks your battle buddy, specifically, about his reasons to die versus the reasons to live

8. Determine your battle buddy’s access to lethal methods, including firearms

9. Disarm your buddy (lethal means). If your battle buddy is armed, say, "Let me unload your weapon and keep it safe for you while we talk".

10. If it is not safe for you to disarm your battle buddy, get help from your chain of command.

>>>Transition to Teach about How to Escort Your Battle Buddy **to Get Help**

Now it is time to take your battle buddy for help

The following will help:

1. Talking to your battle buddy

2. Encouraging your battle buddy to seek a helping professional now

3. Identifying support systems that can help your battle buddy

>>>Teach about the "E" in "ACE", *"Escort"*

Overview

Escort your battle buddy immediately to your chain of command, Chaplain, or behavioral health professional

1. Don't keep your battle buddy's suicidal behavior a secret

2. Adopting an attitude that you are going to help your battle buddy will save his or her life

3. Stay with your battle buddy until he or she receives appropriate help. Don't leave your buddy alone.

(Note to Instructor: Cover these teaching points during this section of the training)

1. Why it is important to stay with your battle buddy

2. Why being there with your battle buddy makes a difference

3. How to be available and supportive

4. How to reassure your battle buddy that you will be by his or her side no matter what

Review

1. Locate help for your battle buddy

2. Know where to get professional help from resources in the military and civilian community

3. Whatever you do, be sure to secure help and support for your buddy

>>>**Revisit "***Active Listening" (Conclude this lesson with the active listening exercise)*

Active Listening

1. The nuts and bolts of active listening in order to understand your buddy's problem

(Note to Instructor: promote active class discussion here on what they think is "Active Listening" then explain)

Active listening occurs when the listener is genuinely interested in the speaker's message. Clues or warning signs are missed because a potential helper either lacks the time or interest that causes the message not to be heard. Sometimes the helper is just too busy to actually listen or comprehend. This communication mishap occurs far too often and can lead to disastrous results (e.g., suicide).

The steps to active listening are:

1. Look your battle buddy in the eyes; suspend other things you are doing

2. Listen not merely to the words, but the feeling content

3. Be sincerely interested in what your battle buddy is talking about

4. Talk to your battle buddy alone in a private setting

5. Allow your battle buddy to talk freely

6. Restate what your battle buddy said

7. Ask clarification questions once in a while

8. Be aware of your own feelings and strong opinion

9. When talking to your battle buddy, give him and yourself plenty of time

10. Stay calm and objective

11. Don't criticize or argue with your battle buddy's thoughts and feelings, but listen and allow time for him/her to find words

12. Have your resources handy (i.e., know how to locate your chain of command, chaplain, or behavioral health)

(<u>Note to Instructor</u>: At this time, conduct the "Listening Skills" exercise at Attachment 7)

>>>Transition to Teach about *<u>"Stigma"(if time allows)</u>*

What are the Myths vs. Facts of seeking help, "stigma"?

Discussion Points re: *Stigma*. The MHAT 2 reports indicated that "among Soldiers who screened positive for depression, anxiety, or PTSD, 53% reported that their unit leadership might treat them differently, and 54% reported that they would be seen as weak."[14]Such evidence suggests that Army personnel continue to sanction the stigma of "help seeking," which ultimately acts as a barrier for access to preventive and stabilizing care. President George W. Bush responded to stigma by stating the following:

"... Americans must understand and send this message: mental disability is not a scandal - it is an illness. And like physical illness, it is treatable, especially when the treatment comes early." [15]

Stigma refers to a cluster of negative attitudes and beliefs that inadvertently motivate Warriors and leaders to fear, reject, avoid, and discriminate against military and civilian personnel with mental illnesses.[16]

Stigma is widespread in the Army.

Stigma leads Warriors and leaders to avoid and often discriminate against Warriors who are experiencing personal emotional problems. It leads to low self-esteem, isolation, and hopelessness for the Warrior who has a mental illness.[17]It deters the Warrior from seeking care.

In response to stigma, Warriors with mental health problems internalize others' attitudes and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment. When Warriors fail to seek help when it is necessary, the general outcome is emotional degeneration leading to poor work performance and suicidal behavior.

Note to Instructor: To conclude this lesson, ask the following three questions: 1) How do members of your unit view soldiers who seek help for behavioral or psychological problems? 2) How does command respond to soldiers who seek help for behavioral/ psychological problems? and 3) If needed, how can you change fellow Soldiers and command perceptions about help seeking behavior?

As more Soldiers seek help and share their stories with buddies and relatives, compassion will be the response, not ridicule.

(Note to Instructor: Conclude this discussion on <u>stigma and the importance of seeking help before problems become unmanageable</u> by reviewing the Myths and Facts training aid Attachment # 8.)

>>>Transition to Teaching Lesson Four

Lesson Four

ACE Role Play Activities

Introductory Teaching Points [for students]:

1. The Mental Health Advisory Team (MHAT) reports clearly demonstrate that Soldiers talk with other Soldiers about his or her own personal distress.

2. Given this situation, the Army is expecting that each Soldier care for buddies by ensuring suicidal Soldiers receive appropriate care and support.

3. It is every Soldier's responsibility to look out for his or her buddy which includes helping a buddy during times of trouble.

4. For the next hour, you will have the opportunity to practice what you have been taught thus far about the *ACE* intervention.

Please understand that some people will feel threatened by the role play experience. This is not unusual. Remember, you are "Army Strong" and your ability to face your fears of being embarrassed during the role play will require you to use your inner strength and moral courage, i.e., *Resiliency,* to help get through the process.

How to Facilitate the Role Playing [for the instructor]

Background

The learning process for ACE draws on the **experiential learning theory**.

Experiential learning has proven to be especially important in the acquisition of skills.

The learning is enhanced when class participants are encouraged to rehearse the skills identified in lesson three.

The **ACE** structured **role-play with feedback** enables class participants to work in all four environments.

How the ACE Role Playing works [for the instructor]

1. The actual role-play is a particular type of *simulation* that focuses attention on the Soldier's interaction with a buddy

2. The role play will provide classroom participants a chance to practice intervention skills and talk about suicidal thoughts with a fellow Soldier under various circumstances.

3. The *ACE* role-play asks Soldiers to imagine that they are either themselves or another person in a particular situation.

4. For example, the Soldier will be asked to behave exactly as an interviewer or someone who has suicidal thoughts would behave.

5. As a result of doing this, the Soldier, or the rest of the class, or both, will **learn more about early recognition of suicidal thinking and behavior in buddies and practice what they learned about** *ACE***.**

6. In essence, the role-play activities will provide each participant an opportunity to observe, discuss and assimilate information.

7. The role-play will allow Soldiers to practice what they learned in a **safe environment**.

Key Class Goal of *ACE* Role Playing: Soldiers will develop a higher level of comfort and confidence to ask, and intervene on behalf of, a fellow Soldier who is contemplating suicide

Note to the Instructor: Instructions about *ACE* **Role Playing (**review/provide a copy of Attachment 9 for class participants).

1. The incorporation of the modeling and role play into the training adds variety, a change of pace, and opportunities to reinforce learning

2. The classroom instructor is to model the intervention by inviting one of the Soldiers to act the role of a buddy by using one of the realistic scenarios developed for the class

3. The instructor is to illustrate and model the different functions or parts of ***ACE*.**

4. The instructor ensures class participants have training tip cards for reference.

5. The instructor uses a visual display of the acronym ***ACE*** and a descriptive meaning of each letter for Soldiers to read while role playing.

6. The instructor displays the PowerPoint slide of the ***ACE*** tip card during the role play exercise on the screen and/or TV monitors

Note to the Instructor: Instructions on *How* to Conduct the *ACE* Role Playing Activities

Background

1. There are **two** recommended ways to conduct the role-play activity.

2. **Number One:** Instructor creates small groups of 8 to 10 Soldiers allowing a few Soldiers to do the actual role play while the remaining group members observe the role play.

3. **Number Two:** The instructor creates small groups of 3 where each group member plays a different role.

Alternatively, give one Soldier (e.g., "battle buddy") a scenario/script of the "battle buddy" role while the other Soldier (e.g., "interviewer") applies what was learned in class so far by questioning the "battle buddy" based on the ***ACE*** functions. The instructor should provide a copy of **Attachment 9 & 10** to each small group. It may be best to pick a scenario for each group to role play

The third Soldier serves as an observer.

The players can rotate through roles within a single role-play (switching) with the intention of gaining insight into other roles or perspectives or players can be substituted at various points in the role-play by the observer.

The role play scenario provided to the buddy will be partially scripted (the realistic scenarios will have certain prompts for the player to act out his or her role).

The choice of the role-play activity will be dependent on time and group size.

Specifics

1. Ensure there is plenty of time for participants to switch roles so everyone has a chance to practice intervening

2. Ensure there is time for discussion and questions at the conclusion of the role play activities

3. Move around the room to help Soldiers along, as needed

4. Use the following questions to promote discussion and reflection in the large group:

Note to Instructor: Based on Soldiers responses to the following questions, you may want to record responses on the "Trainer feedback Questionnaire" (question #1).

a. How many of you asked your buddy directly if he or she was thinking about killing themselves?

b. Did your group encounter difficulties with following the ***ACE*** **acronym**?

c. Did the group encounter difficulties with information gathering (***Asking*** part)?

d. Did the group encounter difficulties with gaining a buddy commitment **(*Caring*** part)?

e. Did you provide each other feedback?

f. If so, was the feedback helpful?

g. Ask questions about the group's feelings, emotions, and current attitude about helping a buddy

h. Did you experience any difficulties in the role-play?

>>>Transition to Teach Lesson Five

Lesson Six

Army Resources

Background

If a buddy identifies a fellow Soldier who is suicidal by using the ***ACE*** method of intervention, **the Army behavioral health professional community must accept the referral for professional evaluation and/or care.**

It is a significant responsibility for the buddy to start this chain of events in order to help a fellow Soldier.

The chain of command, chaplains and behavioral health professionals are expected to help Soldiers by creating a community safety net for suicidal people.

Based on this concept, the professional community acknowledges and supports this notion by **providing an array of treatment options and resources for a Soldier who is suicidal.**

However, Soldiers are generally not very knowledgeable about the available treatment options or resources for a suicidal Soldier.

Purpose of Teaching about Army Resources

1. Identify local resources for a suicidal Soldier

2. To reassure Soldiers that the professional provider will respond when the ***ACE*** intervention is utilized and the buddy escorts and helps a fellow Soldier get connected with a professional provider

How to Teach about Army Resources

1. For this exercise, it is recommended to use the last 15 minutes of your training time.

2. Create small groups of 8 to 10 Soldiers

3. Provide each group with butcher block paper, stand, marker(s), gaffer or masking tape

4. Task each group to identify local resources that can help fellow Soldiers who are suicidal

5. Task each group to record their findings on the butcher block paper.

6. Have each small group appoint a group leader who will report these findings to the entire class

7. Explain to the class that the purpose of this exercise is to increase Soldiers' [their] awareness of the extended [professional] resources available to them and the appropriate mechanisms to utilize them

8. Reinforce their answers and ensure they include the following that are generally available in all tactical environments:

a. Organic medical assets to include medics and medical officers

b. Unit Chaplain & Unit Ministry Teams

c. Behavioral Health assets organic and attached to organization

d. Combat stress control team working in the unit's area of responsibility

>>>Transition to Teach Wrap-Up Activities Section

Wrap Up Activities Section

Instructor:

1. Summarize class using PowerPoint visuals

2. Have all of your class participants complete the post measurement and satisfaction questionnaires found at **Attachments # 1 and 11**

3. Hand out training completion certificates that have each class participant name on it correctly spelled

4. Take final questions

5. Dismiss and Goodbye

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Attachment 1: Suicide Prevention Questionnaire

43010

Suicide Prevention Questionnaire

Please answer all questions according to how you would react in a real-life situation.

Test ☐ Pre ☐ Post

Session ☐ Morning ☐ Afternoon

Date (mm/dd/yy) ☐☐ / ☐☐ / ☐☐

1. Imagine yourself in a situation where you might be able to help someone who is demonstrating signs of suicide. Please answer the questions by marking the box that best fits you.

	Not at all 1	2	3	4	Completely 5
a. How comfortable would you feel helping this suicidal person?	☐	☐	☐	☐	☐
b. Considering your current knowledge and skills, how competent would you feel helping this person?	☐	☐	☐	☐	☐
c. How competent would you feel in asking this person if he or she is suicidal?	☐	☐	☐	☐	☐
d. How competent would you feel in listening to this suicidal person's problems?	☐	☐	☐	☐	☐
e. How competent would you feel in escorting this person to help?	☐	☐	☐	☐	☐
f. Overall, how confident are you that you would try to help this person?	☐	☐	☐	☐	☐
g. Would you be willing to ask this person if he or she is suicidal?	☐	☐	☐	☐	☐
h. Would you be willing to care for this suicidal person by listening to his or her problems?	☐	☐	☐	☐	☐
i. Would you be willing to personally escort this suicidal person to a helping professional?	☐	☐	☐	☐	☐

2. Please rate your level of knowledge by marking the box that best fits you.

	VERY Low 1	2	3	4	VERY High 5
a. Facts about suicide prevention.	☐	☐	☐	☐	☐
b. Suicide warning signs.	☐	☐	☐	☐	☐
c. How to ask someone about suicide.	☐	☐	☐	☐	☐
d. How to get help for someone who may be suicidal.	☐	☐	☐	☐	☐
e. Information about local resources for help with suicide.	☐	☐	☐	☐	☐

3. The following questions are intended to assess your knowledge about suicide prevention and intervention. Please mark the box that best fits your answer.

	Strongly Agree 1	2	Neither 3	4	Strongly Disagree 5
a. It is harmful for me to engage in open communication when dealing with someone at risk of suicide.	☐	☐	☐	☐	☐
b. It is ok to leave someone alone who is thinking about suicide.	☐	☐	☐	☐	☐
c. If a buddy I knew told me that he or she was thinking of suicide, I would want to get more information about his or her plan.	☐	☐	☐	☐	☐
d. If a buddy I knew was showing signs of suicide, I would raise the question of suicide with him or her.	☐	☐	☐	☐	☐
e. If a buddy admits to feelings of suicide, I would refer the Soldier to a Chaplain or behavioral health professional.	☐	☐	☐	☐	☐

Attachment 2: Profile

Completed/attempted suicides: (Total ASER reports = 1032 for CY 06; total Completed = 84; total attempted = 943). G1 reported for CY 06 97 completed suicides.

- Completed suicides are common for young, Caucasian, junior enlisted male Soldiers with younger, lower-enlisted, female Soldiers overrepresented for suicide attempts compared to completions.
- Most completed suicides (74% n=52) did not have a reported prior psychiatric disorder. However, 26% (n=22) completed suicides had a history of one psychiatric disorder. Of those individuals who attempted suicide, 49% (n= 406) had a history of one psychiatric disorder.
- Firearms71% (n=60) were the most common method for completed suicides (non military weapon was higher).
- Overdose 53% (n = 495) and cutting 18% (n= 170) were the most common methods of self-harm not resulting in death.
- Majority of the completers and attempters occurred in personal residence with most place of residence being the barracks.
- Majority were in garrison vs. deployment
- Uses of alcohol and/or drugs were reported for 41% of the completed suicides and 47% of the attempts.
- 31% of the completed suicides were seen by the medical treatment facility within the last 30 days before the event; 37% of the attempted suicides were seen by the medical treatment facility within the last 30 days before the event.
- Failed relationships (spousal) were reported for 55% (n=46) of completed and 40% of attempted (n= 370).
- Other failed relationships (non-spousal) were reported for 14% (n =12) of completed and 16% (n =143) of the attempts.
- The most common motivations for the suicide were hopelessness 14 % (n=12); emotional relief* 14% (n = 12), and unknown 43% (n =36).
- The most common motivations for attempted suicides were emotional relief 31% (n =291); hopelessness 12% (n =109); and depression 10% (n =94);
- Caucasian unmarried enlisted less than 25 years old comprised the majority.

*Emotional relief - to stop bad feelings, self hatred, anxiety relief.

Note: "The most frequently reported stressors included failed or faulty relationships (especially marriage), legal problems, work related problems, and excessive debt". (p.29) "Almost two thirds of completions had a history of at least one OIF-OEF deployment. However, multiple OIF-OEF deployments were relatively rare among those with suicidal behaviors". Because there is no base rate data for OIF and non-OIF populations, this data was not further interpreted by the ASER.

Attachment 3: *Suicide in the U.S.: Statistics and Prevention*

Suicide is a major, preventable public health problem. In 2004, it was the eleventh leading cause of death in the U.S., accounting for 32,439 deaths.[1] The overall rate was 10.9 suicide deaths per 100,000 people.[1] An estimated 8 to 25 attempted suicides occur per every suicide death.[2]

Suicidal behavior is complex. Some risk factors vary with age, gender, or ethnic group and may occur in combination or change over time.

What are the risk factors for suicide?

Research shows that risk factors for suicide include:

• depression and other mental disorders, or a substance-abuse disorder (often in combination with other mental disorders). More than 90 percent of people who die by suicide have these risk factors.[2]

• stressful life events, in combination with other risk factors, such as depression. However, suicide and suicidal behavior are not normal responses to stress; many people have these risk factors but are not suicidal.

• prior suicide attempt

• family history of mental disorder or substance abuse

• family history of suicide

• family violence, including physical or sexual abuse

• firearms in the home, [3] the method used in more than half of suicides

• incarceration

• exposure to the suicidal behavior of others, such as family members, peers, or media figures.[2]

Research also shows that the risk for suicide is associated with changes in brain chemicals called neurotransmitters, including serotonin. Decreased levels of serotonin have been found in people with depression, impulsive disorders, and a history of suicide attempts, and in the brains of suicide victims. [4]

Are women or men at higher risk?

• Suicide was the eighth leading cause of death for males and the sixteenth leading cause of death for females in 2004.[1]

• Almost four times as many males as females die by suicide.[1]

• Firearms, suffocation, and poison are by far the most common methods of suicide, overall. However, men and women differ in the method used, as shown below.[1]

Suicide by:	Males (%)	Females (%)
Firearms	57	32
Suffocation	23	20
Poisoning	13	38

Is suicide common among children and young people?

In 2004, suicide was the third leading cause of death in each of the following age groups.[1] Of every 100,000 young people in each age group, the following number died by suicide:

- Children ages 10 to 14 – 1.3 per 100,000
- Adolescents ages 15 to19 – 8.2 per 100,000
- Young adults ages 20 to 24 – 12.5 per 100,000

As in the general population, young people were much more likely to use firearms, suffocation, and poisoning than other methods of suicide, overall. However, while adolescents and young adults were more likely to use firearms than suffocation, children were dramatically more likely to use suffocation.[1]

There were also gender differences in suicide among young people, as follows:

- Almost four times as many males as females ages 15 to 19 died by suicide.[1]
- More than six times as many males as females ages 20 to 24 died by suicide.[1]

Are older adults at risk?

Older Americans are disproportionately likely to die by suicide.

- Of every 100,000 people ages 65 and older, 14.3 died by suicide in 2004. This figure is higher than the national average of 10.9 suicides per 100,000 people in the general population. [1]
- Non-Hispanic white men age 85 or older had an even higher rate, with 17.8 suicide deaths per 100,000.[1]

Are Some Ethnic Groups or Races at Higher Risk?

Below are rates of suicide by ethnic group in 2004.[1]

- Highest rates:
  - Non-Hispanic Whites – 12.9 per 100,000
  - American Indian and Alaska Natives – 12.4 per 100,000
- Lowest rates:
  - Non-Hispanic Blacks – 5.3 per 100,000
  - Asian and Pacific Islanders – 5.8 per 100,000
  - Hispanics – 5.9 per 100,000

What are some risk factors for nonfatal suicide attempts?

- As noted, an estimated 8 to 25 nonfatal suicide attempts occur per every suicide death. Men and the elderly are more likely to have fatal attempts than are women and youth.[2]
- Risk factors for nonfatal suicide attempts by adults include depression and other mental disorders, alcohol abuse, cocaine use, and separation or divorce.[6,7]
- Risk factors for attempted suicide by youth include depression, alcohol or other drug-use disorder, physical or sexual abuse, and disruptive behavior.[7, 8]
- ***Most suicide attempts are expressions of extreme distress, not harmless bids for attention. A person who appears suicidal should not be left alone and needs immediate mental-health treatment.***

What can be done to prevent suicide?

Research helps determine which factors can be modified to help prevent suicide and which interventions are appropriate for specific groups of people. Before being put into practice, prevention programs should be tested through research to determine their safety and effectiveness.[9] For example, because research has shown that mental and substance abuse disorders are major risk factors for suicide, many programs also focus on treating these disorders. Studies showed that a type of psychotherapy called cognitive therapy reduced the rate of repeated suicide attempts by 50 percent during a year of follow-up. A previous suicide attempt is among the strongest predictors of subsequent suicide, and cognitive therapy helps suicide attempters consider alternative actions when thoughts of self-harm arise.[10]

Specific kinds of psychotherapy may be helpful for specific groups of people. For example, a recent study showed that a treatment called dialectical behavior therapy reduced suicide attempts by half, compared with other kinds of therapy, in people with borderline personality disorder (a serious disorder of emotion regulation).[11]

The medication clozapine is approved by the Food and Drug Administration for suicide prevention in people with schizophrenia.[12] Other promising medications and psychosocial treatments for suicidal people are being tested.

Research shows that older adults and female suicide victims likely saw a primary care provider in the year before death. Improving primary-care providers' ability to recognize and treat risk factors may help prevent suicide among these groups.[13] Improving outreach to men at risk is a major challenge in need of investigation.

What should I do if I think someone is suicidal?

If you think someone is suicidal, do not leave him or her alone. Try to get the person to seek immediate help from his or her doctor or the nearest hospital emergency room, or call 911. Eliminate access to firearms or other potential tools for suicide, including unsupervised access to medications.

For More Information About Suicide

- **For Immediate help**, call this toll-free number, available 24 hours a day, every day: 1-800-273-TALK (8255). You will reach the National Suicide Prevention Lifeline, a service available to anyone. You may call for yourself or for someone you care about. All calls are confidential.

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Attachment 4: Myths and Facts about Suicide

Myth: People who talk about suicide don't commit suicide.
Fact: Of any ten persons who kill themselves, eight have given definite warnings of their suicidal intentions.

Myth: Suicide happens without warning.
Fact: Studies reveal that the suicidal people give many clues and warnings regarding their suicidal intentions.

Myth: Suicidal people are fully intent on dying.
Fact: Most suicidal people are undecided about living or dying and they "gamble with death", leaving it to others to save them. Almost no one commits suicide without letting others know how they are feeling.

Myth: Improvement following a suicidal crisis means the suicidal risk is over.
Fact: Most suicides occur within about 3 months following the beginning of "improvement", when the individual has the energy to put their thoughts and feelings into effect.

Myth: All suicidal individuals are mentally ill and suicide is always the act of a psychotic person.
Fact: Studies of hundreds of genuine suicide notes indicate that although the suicidal person is extremely unhappy they are not necessarily mentally ill.

Myth: Most suicide attempts are during the winter holiday season.
Fact: Most suicide attempts occur in the spring- time when some individuals feel that new life is beginning for everyone except them.

Myth: Clinical depression is something that a person can just "snap out of."
Fact: It is a serious health problem that affects the total person physically, emotionally, and biochemically.

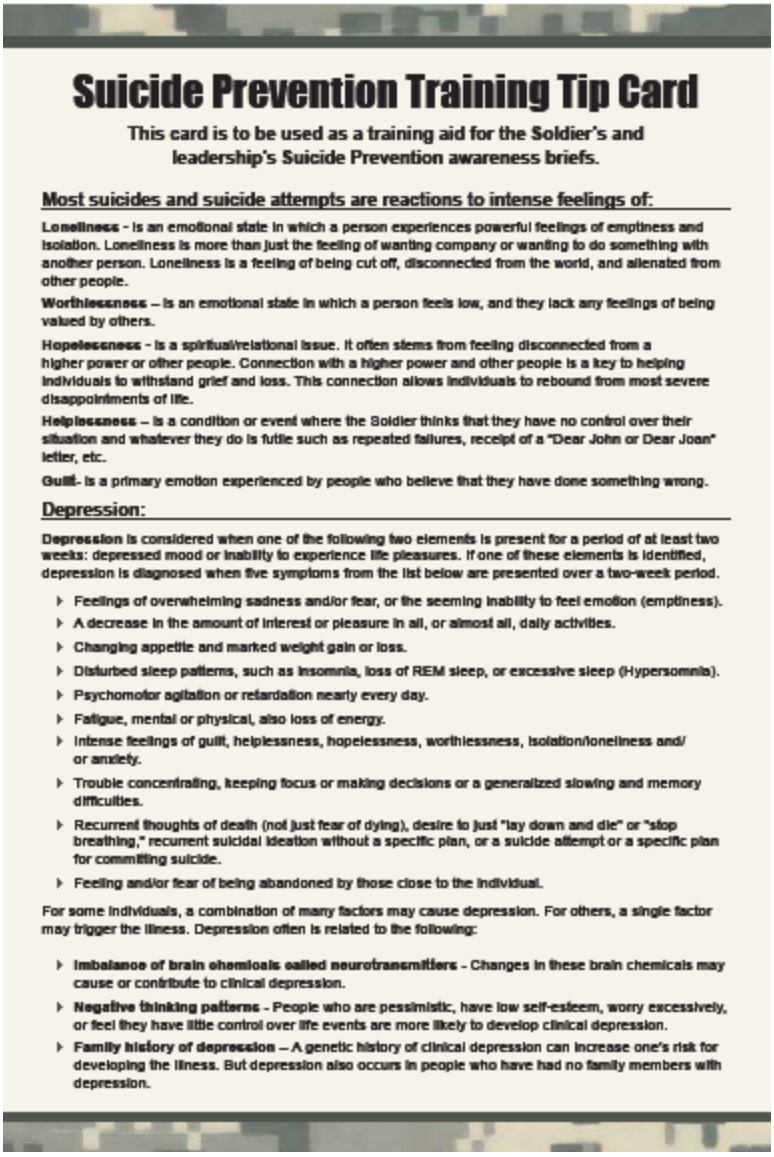
Myth: Depression is rare in young people.
Fact: The rate of depression in this group may be as high as one in eight. Also, it is estimated that two-thirds of young people will not get the help they need.

Myth: Suicide victims want to end their life.
Fact: Suicide victims want to end the terrible pain they feel. Death can seem like the only way out.

Myth: Talking about depression or suicide only makes things worse.
Fact: Talking is the first step toward help.

Myth: Telling someone that a friend might be depressed is betraying a trust.
Fact: True friends care enough about someone's well-being to get them help.

Attachment 5: Training Tip Card



Suicide Prevention Training Tip Card

This card is to be used as a training aid for the Soldier's and leadership's Suicide Prevention awareness briefs.

Most suicides and suicide attempts are reactions to intense feelings of:

Loneliness - is an emotional state in which a person experiences powerful feelings of emptiness and isolation. Loneliness is more than just the feeling of wanting company or wanting to do something with another person. Loneliness is a feeling of being cut off, disconnected from the world, and alienated from other people.

Worthlessness – is an emotional state in which a person feels low, and they lack any feelings of being valued by others.

Hopelessness - is a spiritual/relational issue. It often stems from feeling disconnected from a higher power or other people. Connection with a higher power and other people is a key to helping individuals to withstand grief and loss. This connection allows individuals to rebound from most severe disappointments of life.

Helplessness – is a condition or event where the Soldier thinks that they have no control over their situation and whatever they do is futile such as repeated failures, receipt of a "Dear John or Dear Joan" letter, etc.

Guilt- is a primary emotion experienced by people who believe that they have done something wrong.

Depression:

Depression is considered when one of the following two elements is present for a period of at least two weeks: depressed mood or inability to experience life pleasures. If one of these elements is identified, depression is diagnosed when five symptoms from the list below are presented over a two-week period.

- Feelings of overwhelming sadness and/or fear, or the seeming inability to feel emotion (emptiness).
- A decrease in the amount of interest or pleasure in all, or almost all, daily activities.
- Changing appetite and marked weight gain or loss.
- Disturbed sleep patterns, such as insomnia, loss of REM sleep, or excessive sleep (Hypersomnia).
- Psychomotor agitation or retardation nearly every day.
- Fatigue, mental or physical, also loss of energy.
- Intense feelings of guilt, helplessness, hopelessness, worthlessness, isolation/loneliness and/or anxiety.
- Trouble concentrating, keeping focus or making decisions or a generalized slowing and memory difficulties.
- Recurrent thoughts of death (not just fear of dying), desire to just "lay down and die" or "stop breathing," recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- Feeling and/or fear of being abandoned by those close to the individual.

For some individuals, a combination of many factors may cause depression. For others, a single factor may trigger the illness. Depression often is related to the following:

- **Imbalance of brain chemicals called neurotransmitters** - Changes in these brain chemicals may cause or contribute to clinical depression.
- **Negative thinking patterns** - People who are pessimistic, have low self-esteem, worry excessively, or feel they have little control over life events are more likely to develop clinical depression.
- **Family history of depression** – A genetic history of clinical depression can increase one's risk for developing the illness. But depression also occurs in people who have had no family members with depression.

- **Difficult life events** – Events such as the death of a loved one, divorce, financial strains, history of trauma, moving to a new location or significant loss can contribute to the onset of clinical depression.
- **Frequent and excessive alcohol consumption** – Drinking large amounts of alcohol on a regular basis can sometimes lead to clinical depression. Excessive alcohol consumption is also sometimes a symptom of depression.

Warning Signs:

When a Soldier presents with any combination of the following, the buddy or chain of command should be more vigilant. It is advised that help should be secured for the Soldier.

- Talk of suicide or killing someone else
- Giving away property or disregard for what happens to one's property
- Withdrawal from friends and activities
- Problems with girlfriend/boyfriend or spouse
- Acting bizarre or unusual (based on your knowledge of the person)
- Soldiers in trouble for misconduct (Art-15, UCMJ, etc.)
- Soldiers experiencing financial problems
- Soldiers who have lost their job at home (reservists)
- Those soldiers leaving the service (retirements, ETSs, etc.)

When a Soldier presents with any one of these concerns, the Soldier should be seen immediately by a helping provider.

- Talking or hinting about suicide
- Formulating a plan to include acquiring the means to kill oneself
- Having a desire to die
- Obsession with death (music, poetry, artwork)
- Themes of death in letters and notes
- Finalizing personal affairs
- Giving away personal possessions

Risk Factors:

Risk factors are those things that increase the probability that difficulties could result in serious adverse behavioral or physical health. The risk factors only raise the risk of an individual being suicidal, it does not mean they are suicidal.

The risk factors often associated with suicidal behavior include:

- Relationship problems (loss of girlfriend/boyfriend, divorce, etc.)
- History of previous suicide attempts
- Substance abuse
- History of depression or other mental illness
- Family history of suicide or violence.
- Work related problems
- Transitions (retirement, PCS, discharge, etc.)
- A serious medical problem
- Significant loss (death of loved one, loss due to natural disasters, etc.)
- Current/pending disciplinary or legal action
- Setbacks (academic, career, or personal)
- Severe, prolonged, and/or perceived unmanageable stress
- A sense of powerlessness, helplessness, and/or hopelessness

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Suicidal Risk Highest When:

- The person sees no way out and fears things may get worse.
- The predominant emotions are **hopelessness and helplessness.**
- **Thinking is constricted** with a tendency to perceive his or her situation as all bad.
- Judgment is impaired by use of **alcohol or other substances.**

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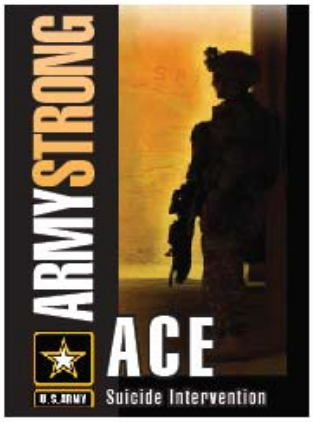
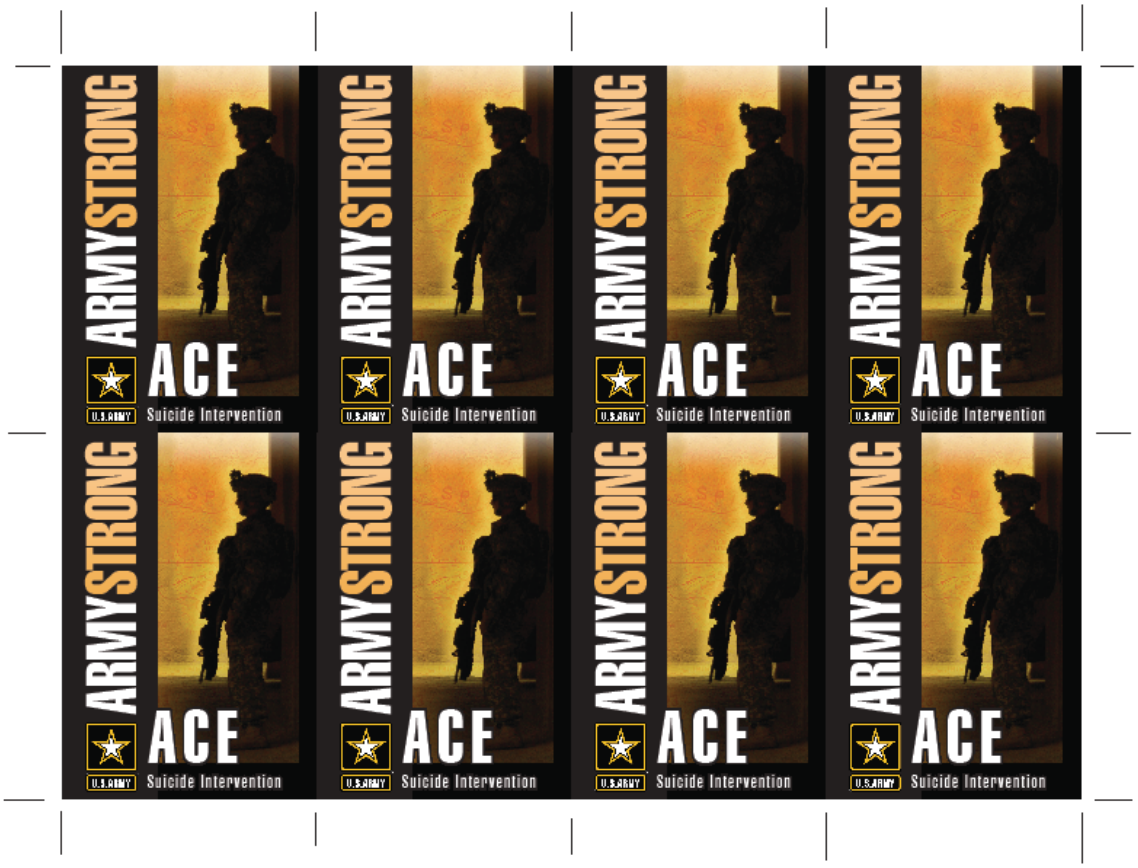
Attachment 6: ACE Training Tip Card





Attachment 7 Listening Skills Exercise
Minimal Encourages

Directions: The group should be divided into subgroups of three. There will be three roles in each subgroup: speaker, listener, and observer. Everyone will take each role once in this practice, so divide into your subgroup and decide who is going to take which role first.

Objective-- The point of the practice session is to give each person the opportunity to learn how to use verbal and non-verbal minimal encouragers and become a better listener.

To the speaker--Your task is to talk about something that is important to you: your job, your family, a decision, or a question. The practice will be more helpful if you talk about something you really care about, although role-playing is possible. You may find yourself in the midst of discussing something important when the allotted time runs out. If this happens, you could make an agreement with the person listening to carry on later, after work or during a break.

To the listener--Your task is to practice the skills of the session: eye contact, body language, silences, and verbal minimal encouragers. Don't panic! Just concentrate on following the speaker's train of thought. Try to limit your responses to the skills discussed in this session.

To the observer--Your task is to observe the listener's verbal and non-verbal skills. Observe and count only as many behaviors (eye contact, body posture, verbal minimal encouragers, topic jumps) as you can manage and still be relatively accurate.

Procedure:

The first speaker will talk with the listener for three or four minutes. The listener will then discuss the listening experience with the two other members of the subgroup. (To the listener: What was comfortable? Difficult? Did you stay with the speaker?) Then the speaker will share his or her feelings about the listener's listening. (To the speaker: Did you feel listened to? Was it helpful? Did the listener have any habits you found distracting?) The observer will then share observations. This sharing process should take about three or four minutes.

Now everyone change places. Have the listener become the speaker, the speaker the observer, and the observer the listener. Go through the five minutes of talking and listening and five minutes of exchanging remarks twice more so that each person takes each role once. The entire practice session should take about 25 minutes.

When you are finished, form the large group. Your facilitator will help you share your practice experiences. How are these skills relevant to your work? Where else would they be useful? Go around the group so that participants have a chance to share at least one thing they have learned about themselves in this practice session.

Source: Interactive Skills Program: Helping Through Listening and Influencing, Hedlund and Freedman, Cornell University Cooperative Extension Service, l981.

Attachment 8: Stigma: Myths and Facts

A. Myths & Facts of Seeking Help: Battlemind Training II

Myth 1: Only weak Soldiers have mental health problems.
Fact: Everyone is affected by combat.

Myth 2: If a Soldier has a problem, he/she will get help.
Fact: Most Soldiers do not get help because of stigma.

Myth 3: A fellow Soldier's mental health problems are none of my business.
Fact: Soldiers most often turn to other Soldiers when they need help. Leaders are responsible for helping Soldiers.

Myth 4: The Army doesn't support Soldiers with mental health problems.
Fact: There are multiple ways to get help.

Myth 5: No one can help me if I have a mental health problem.
Fact: Professional treatment helps, the earlier the better.

B. Myths and Facts: National Mental Health Awareness Campaign

Myth: Mental illness is not real and cannot be treated.
Fact: Mental disorders are as easy to diagnose as asthma, diabetes and cancer with a range of effective treatments for most conditions.
- Surgeon General's Report on Mental Health

Myth: We're good people. Mental illness doesn't happen to my family.
Fact: One in four families is affected by a mental health problem.
— National Alliance for the Mentally Ill

Myth: It's not depression; you're just going through a phase.
Fact: Nineteen million adults in the United States suffer from some form of depression every year.
— National Institute of Mental Health

Myth: Doctors are too busy treating physical problems to deal with mental health.
Fact: Up to one-half of all visits to primary care physicians are due to conditions that are caused or exacerbated by mental illness.
— Collaborative Family Healthcare Coalition

Myth: Mental illness is a personal problem not a business concern.
Fact: Depression is the leading cause of disability in the United States over back problems, heart disease and liver failure.
— World Health Organization

Myth: Mental illness is not a legitimate medical condition but rather something that results from your own doing and your own choices.
Fact: Researchers have determined that many mental illnesses are probably the result of a chemical imbalance in the brain. These imbalances may be inherited or may develop because of excessive stress or substance abuse. With proper care and treatment, a person can recover and resume normal activities.

Myth: Mental illness is an indication of weakness and laziness (That you are a moral failure or you just can't cut it.)
Fact: Mental illness is a diagnosable condition that can be treated with a wide range of effective treatments. Soldiers seldom fake a mental illness in order to shirk his or her military responsibility.

Myth: If you have a mental illness, you are dangerous and unpredictable.
Fact: "The vast majority of people with mental illness are not violent. In the cases when violence does occur, the incidence typically results from the same reasons as with the general public such as feeling threatened or excessive use of alcohol and/or drugs".
- MHA: "Stigma: Building Awareness and Understanding" fact sheet.

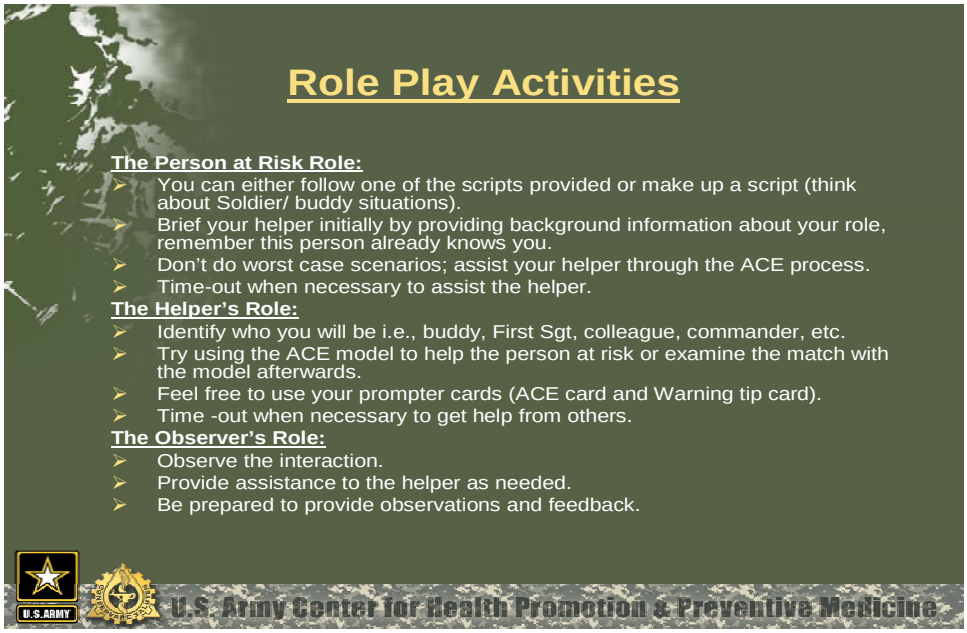
C. Myths and Facts: Army Suicide Prevention

Myth: Soldiers who experience mental health problems are treated with compassion by fellow Soldiers and leadership.
Fact: Soldiers who experience mental health problems routinely face discrimination in the workplace and become socially isolated within the unit. They may lose their Army career, be subject to gossip by fellow Soldiers, and get passed over for promotions.

Myth: If the Soldier seeks help at mental health, this will end his/her career.
Fact: If a Soldier has problems and these problems interfere with work performance and unit mission, the Soldier could be discharged for allowing his/her problem to get out of control.

Myth: Soldiers will lose their security clearance for mental health problems.
Fact: Soldiers who have mental health problems that are not effectively treated may lose security clearance. Most Soldiers who are seen at mental health maintain their security clearance.

Attachment 9: Role Play Training Aid



Attachment 10: Army ACE (Peer) Suicide Intervention Role-play Options

Ten role-play scenes are presented in this attachment. The role plays are designed to take place with you and one other individual. It may feel awkward at first; however, practicing ways to talk to a suicidal buddy is one of the best ways to help a buddy in real life. The text below provides key phrases that you should mention during the role-play and also includes information that the other individual in the role play does not know.

1. You are a twenty four year old active duty SGT (E-5). You are three months in your first deployment to Iraq. Your spouse of three years just wrote you a text message requesting a divorce. Your spouse ends the text message with, "I am sorry…I didn't expect to fall in love with someone else."

You are talking with a fellow NCO.

What he/she does not know.

Your spouse has a history of being unfaithful.
Your spouse requested a divorce once before that triggered a past suicidal attempt.
You wrote your spouse a text message to indicating you will die if she/he divorces you.
You are now having thoughts of killing yourself by using your own rifle.

The conversation starts by you saying: "My wife/husband wants to divorce me." "I can't stand being here." "If I were home, I could change her/his mind."

2. You are a nineteen year old active duty PFC (E-3). You are six months in your first deployment to Iraq. You just came back from a patrol in Baghdad. Your close battle buddy was killed by an IED during this patrol. Your squad leader is talking to you. Your squad leader was suggesting that you were not adequately focused during this recent mission. You are already feeling responsible for your friend's death.

You are still talking to your squad leader:

What he does not know:

You blame yourself for your buddy's death.
You feel that he was the only friend you had in the unit.
You now feel very alone.
You are thinking about dying…no plan.

Sometime during the discussion you say: "I know Sarge…I let him down." "My best friend was killed because of me."

3. You are a thirty year old National Guard SPC (E-4). You have just returned from your first deployment in Afghanistan. During this deployment, you received an article 15 for insubordination. You just discovered that your girlfriend/boyfriend has been unfaithful. She/He

no longer wants to see you. You were very embarrassed by the article 15, and now you are feeling quite sad about losing your girlfriend/boyfriend.

You are talking to a fellow Soldier:

What your friend does not know:

You are feeling sad and taking medication to help you sleep.
Until the article 15, you wanted to make the Army your career.
You have been diagnosed with depression in the past.
You are feeling like you did three years ago when you tried to kill yourself.
You are considering killing yourself by overdosing on sleeping pills.

Sometime during the conversation you say: "I can't take it anymore".

4. You are a twenty year old active duty PVT (E2). You are preparing for your first deployment to Iraq. You just received an article 15 for being AWOL. Your spouse of one year had "maxed out" the credit cards. Your home mortgage company just sent a letter demanding immediate house payment. The bank threatens to start foreclosure proceedings. You are feeling quite powerless and overwhelmed.

You are talking to the First SGT about your financial problems.

What the First SGT does not know:

You are fighting daily with your spouse about the finances.
Your drinking has increased.
You just increased the amount of death benefits on your insurance.
You have been thinking about volunteering for any dangerous mission to end your life.

During your discussion, you tell the First SGT: "I love my wife/husband, and I have a plan to make sure she/he is taken care of after I am gone."

5. You are a twenty five year old active duty SGT (E-5). You are in your third month of your second deployment. This deployment has brought back many terrible memories from the first deployment. Up to this point, you have been able to cope. On a recent patrol, two guys in your unit were gunned down by insurgents. You failed to fire back at the enemy. You are now safe back at your rear area. You are obsessed with this incident. You can not understand why they were killed and you are still alive.

You are talking to your buddy.

What your buddy does not know:

You are struggling with intrusive thoughts from the first deployment.
You failed to fire back at the enemy during the firefight.
You are feeling guilty about the deaths of your fellow Soldiers.
You now have frequent thoughts about joining your dead comrades.

Sometime during the discussion say, "I should have died with my friends."

6. You are a thirty year old NGR deployed SSG (E-6). Prior to deployment, you had a violent verbal argument with your husband. After three months, you continue to have haunting memories of this argument. There is no relief from your husband…each time you call home he starts to argue. During the last phone call, he shared that the children really miss her. He states, "You are a bad mother for leaving your babies like this." "You are useless as a mother." You are already feeling powerless about your situation. Your husband's last comment really hurt.

You are talking to your buddy.

What your buddy does not know:

You are feeling quite guilty about being separated from your two young children.
Your husband has on several occasions threatened to divorce.
Since deployment, you have not slept or ate well.
Several times you thought about killing yourself by using your own weapon.

Sometime during the discussion say, "I'm useless to my family. My children would be better off if I were dead."

7. You are a twenty year old active duty SPC (E-4). You are 5 months into a second deployment in Iraq. Yesterday, you met an old friend who just deployed to Iraq. He tells you that your girlfriend/boyfriend has been cheating. On several occasions, your friend had seen her/him at the bar with another gal/guy. You are very upset. You want to confront her/him now.

Your squad leader notices that you are upset. You are fusing with your rifle. Your squad leader began to talk to you.

What your squad leader does not know:

He/she does not know about your relationship problems.
You feel hopeless about your situation because you are unable to confront her/him about alleged cheating.
You are confused about what to do next.
You are thinking about killing yourself.

The conversation starts by you saying: "I just learned that my girlfriend/boyfriend is cheating on me."

8. You are a 23-year old active duty SPC (E-4). You are now in a rehab hospital. One month ago, you lost your leg to an IED in Iraq. Additionally, you received a mild concussion from the blast. Your recovery has been difficult because of an infection. Prior to the loss of your leg, you were a marathon runner. You loved to run.

Your buddy is visiting you in the hospital.

What your buddy does not know:

You are feeling very hopeless about your future.
You told your girlfriend/boyfriend to stop visiting you.
You are feeling that you are a burden to your family.
You attempted suicide by drug overdose 2 weeks ago.
You have been stock piling your pain medications; however, you are undecided about killing yourself.

Sometime during the conversation you say, "I can't live this way."

9. You are a34-year old reserve SSG (E-6). You were passed over for a promotion. You are preparing to deploy to Iraq. This was an unexpected call-up to deploy. You can not afford to leave your job due to a huge mortgage payment. If you are deployed, you will need to sell your house because your Army pay is not enough to cover the mortgage. You may lose the house. Your spouse thinks you volunteer for deployment. If you sell the house, your spouse threatens to leave you.

You are talking to your buddy.

What your buddy does not know:

You are feeling very hopeless about your situation.
You recently increased your Life Insurance.
You have frequent thoughts about dying in combat so your family can collect the Life Insurance.

Sometime during the conversation you say: "If I die, my life insurance will pay off the mortgage on my house. My family will always have a place to live."

10. You are a 23-year old active duty SPC (E-4). You have been deployed to Afghanistan for 8 months. You are home on R&R. This was to be a surprise visit home for your family and girlfriend. You planned to propose to your girlfriend of 4 years. When you visited her, you learned that she had been cheating. She is now pregnant. You are devastated.

You are talking to a friend.

What your friend does not know:

You are very depressed.
You are abusing alcohol.
You feel like there is nothing else to live for.
You purchased a weapon.

Sometime during the conversation you say, "While in Afghanistan, thinking about her helped me to cope. I can't see myself living without her."

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Attachment 11: Army's ACE Suicide Intervention Training Feedback

Thank you for attending today's ACE Suicide Intervention training. We're interested in what you thought of the training session and how we can improve the content. *Your feedback is anonymous. Your name on this form is not necessary.* We greatly appreciate your feedback.

Please take a few minutes to complete this evaluation form. Please only evaluate the training organization, DVD presentation, content, talking points, and slides.

Your comments will assist us in further development of our Suicide Intervention training program.

Please answer the following questions by marking the box that most represents your answer.

	Not at All 1	2	3	4	Very Much 5
1. How effective was this training for increasing your awareness of suicide risk?	☐	☐	☐	☐	☐
2. How effective was this training for improving your ability to talk about suicide?	☐	☐	☐	☐	☐
3. How clear was this training about what to do if you are the one thinking about suicide?	☐	☐	☐	☐	☐
4. How clear was the training about what to do if your buddy is thinking about suicide?	☐	☐	☐	☐	☐
5. How satisfied are you with the training?	☐	☐	☐	☐	☐

6. List three aspects of the training session that you found especially useful?

7. List three aspects of the training session that could be improved?

8. What other feedback would you like to give us?

9. Next time we provide suicide training, what should we try that is different from today and past training you received on suicide prevention?

Attachment 12: Army's ACE Suicide Intervention Program for Soldiers (TSP)

The Army's ACE Suicide Intervention Training for Soldiers can play a role in the unit's resolve to help prevent suicide. Soldiers will learn that they have a vested interest in helping their fellow Soldier. Unit cohesion can be negatively affected by the suicide of a unit member. A suicide can demoralize and seriously disrupt the unit's ability to sustain its mission. Given this perspective, Soldiers and leaders have a vested interest in helping battle buddies who are thinking of suicide.

Overall, suicide intervention training using the acronym "ACE" focuses on equipping Soldiers with skills necessary to help a suicidal buddy. What follows is a standardize lesson plan with presenting instruction on the Army's ACE Suicide Intervention Training to Soldiers.
Instructor: Recommend chaplain, senior NCO chaplain assistant, or behavioral health professionals **(**i.e. senior behavioral health NCO: licensed professional counselor: social worker, psychologist, or psychiatrist) conduct this training.

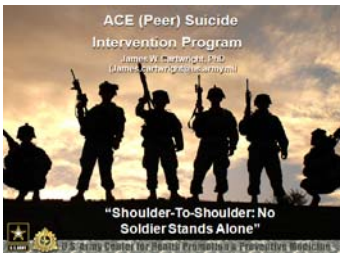
Additional Personnel Support Requirements: Due to the fact that many Soldiers have had personal experience with suicidal thoughts or behavior (either themselves or someone they know), either a chaplain or behavioral health professional should be available to speak with students during or after this briefing.

Equipment Required: DVD player, laptop, projector and projection screen, audio capabilities and butcher block paper.

Materials Required INSTRUCTOR MATERIALS:
DVD
VGT 1- 51
Handouts are to be place in individual folders for class participants. The handouts include the following nine attachments & vignettes:
Attachment 3: "Suicide in the U.S. Statistics and prevention"
Attachment 4: Myths and Facts about Suicide
Attachment 5: Suicide Prevention Training Tip Card
Attachment 6: ACE Training Tip Card
Attachment 7: Listening Skills Exercise
Attachment 8: Stigma: Myths and Facts
Attachment 9: Army's ACE Suicide Intervention Training Feedback
Printed copies of vignettes
2 pieces of butcher block paper & markers

NOTE: Attachments #s 3, 4 & 8 are supplemental readings. They will not be discuss during training.

Instructional Guidance: Before presenting this lesson, instructors must thoroughly prepare by studying the lessons and identified reference materials in the Army's ACE Suicide Intervention Program: Train- the-Trainers Manual.



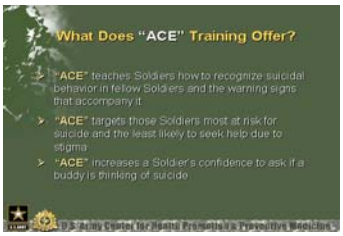
Slide 1: The class facilitator should do introductions, pass out booklets/handouts, and gather pre-measurement questionnaires (facilitator should place their name on the title slide).

Slide 2: All class participants should complete a pre measurement before class starts. Send all pre and post measurements to CHPM for further analysis. The hard copies can be sent to James W. Cartwright, PhD, 5158 Blackhawk Rd., APG, MD 21010-5403. The measurements can also be sent electronically to the following e-mail: james.cartwright@us.army.mil.

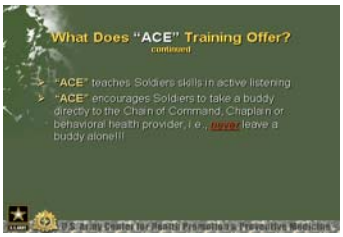
Slide 3: Army Goal: The loss of even one Soldier by suicide is catastrophic, and the goal of the Army is zero! The main objective is to minimize the risk of suicide and suicidal behavior through proactive actions. The Sergeant Major of the Army (SMA) is a true believer in the ASPP. He is currently assisting the U.S. Army Center for Health Promotion and Preventive Medicine in presenting a coin for the suicide prevention poster competition. The SMA endorses proactive measures by Soldiers and leaders to minimize risk and suicidal behavior.

Slide 4: Show PSA from SGM Preston.

Slide 5: Introduction of the ACE acronym. Overall, suicide intervention training using the acronym "ACE" focuses on equipping Soldiers with skills necessary to help a suicidal buddy. What follows is a standardize lesson plan with presenting instruction on the Army's ACE Suicide Intervention Training to Soldiers. Topics in this training include suicide awareness, warning signs of suicidal thinking and behavior, and intervention skill's development. The acronym, ACE, will guide the actions to take with a buddy to prevent suicide. ACE stands for "ask", "care", and "escort". The training will show how a buddy should ask a fellow Soldier about suicidal ideation, care for the Soldier, and escort the soldier to the source of additional help.



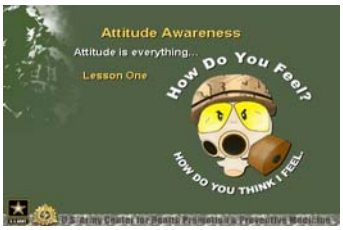
Slide 6: The ACE Learning Objectives.



Slide 7: Continue discussion on learning objectives.

Slide 8: In the next three hours we will be covering five lessons:

1) Attitude Awareness
2) Protective factors/resiliency
3) ACE concepts
4) Role play exercise
5) Resource development



Slide 9: Start Lesson number One, **"Attitude Awareness".**
Suicide is an emotionally charged subject!
Therefore, it is understandable that it may be difficult to learn now about things they wish they knew earlier. Reassure the audience that by end of the class, they will have the necessary information and knowledge to deal with individuals who are at risk for suicide. Make sure to note that you will be available after the training session to assist or further discuss any concerns that arise during today's class. Ask them to write down on a slip of paper as they sit through the class any therapeutic-type questions and concerns that may require professional intervention so they can bring them to your attention after the training ("after" because some of your class content may answer their question[s]).

<u>Slide 10: (Show clip):</u> Kevin Hines Video Clip.
<u>Lesson One:</u>

Begin Instructing

Topic: Attitude Awareness (general group discussion on feelings and experiences)

Attitude awareness is a less obvious goal of this program.

How Soldiers and leaders think and feel about the subject of suicide will influence the way Soldiers deal with a suicidal buddy. The intent of this lesson is to encourage Soldiers to openly discuss a subject that is generally considered taboo.

Those who feel suicidal fully understand that talking about suicide is taboo. As a result, the suicidal Soldiers will further isolate themselves in order to avoid the rejection from fellow Soldiers. It is anticipated an open discussion will dispel any misconception about this historically taboo subject.

Explain/identify to the class the historical attitudes that hinder countering and eliminating suicide in the Army. (e.g., how *stigma* "looks" in a unit)

Let them know you are going to ask questions that are designed to explore these foundational attitudes that need restructuring for the Army to see success in the reduction and elimination of suicide among their ranks.

Be alert to the fact that, when you do start asking these questions, it is not unusual for audience members to begin sharing personal experiences about someone they know who attempted suicide or completed suicide. **This is a positive indication that the topic of suicide is now okay to discuss openly.**

Ask these questions:

1. Do you know anyone who has died by suicide?
2. Do you know anyone who has attempted suicide?
3. What would you do to help someone who is suicidal?
4. How comfortable would you feel in helping someone who is suicidal?
5. How confident are you that you could help someone who is suicidal?
6. If your buddy was suicidal, to whom would you refer your buddy for help?
7. Who would you tell if you had thoughts of suicide?

++

(Note to Instructor: Regarding #7, remember, the "ACE" is about suicide awareness, early recognition of suicidal thinking and behavior in buddies, and escorting and taking a buddy who is suicidal for help; it is not *treatment* of suicidal behavior.

As the presenter, you are not expected to provide the *treatment* when an audience member presents a situation that requires immediate intervention. It is important only that you be *prepared* to refer someone who may need assistance.

++ (Back to your class members)

Wrap up the discussion of Question # 8 & 9 by gaining a general commitment from the audience to either help a buddy or seek help when suicidal behavior is detected.

The presenter should ask the audience if they are prepared to learn about how to help a buddy who is suicidal. If the presenter receives general agreement, the instructions should continue.

Ask your class these final questions:

8. How widespread is stigma in your unit?

9. What are your thoughts about seeking help for emotional problems?

Next, explain to your class the following to **reinforce** the purpose for their being in attendance in this class today:

Class, the key element of suicide prevention is to train Soldiers to **recognize** when a fellow Soldier may be at risk for suicide, **ask** about it, and **assist** the Soldier who is thinking about suicide to get specialized help. The assumption is that Soldiers know each other best and, are closest to the stage for problems.

Therefore, the course objective is to train the "boots on the ground" to recognize when a fellow Soldier is in distress and respond effectively. "**ACE" specific purpose is to equip** Soldiers and leaders with these skills necessary to identify Soldiers in close proximity who may be at risk for suicide and then to act effectively to intervene.

If all Soldiers develop requisite awareness and intervention skills at their personal level, then they become a competent and confident force for preservation of life within the integrity of the unit. It is known that the Soldiers at the greatest risk for suicide are lower enlisted Soldiers **who do not seek help**.

This program is designed for you to become more effective at helping your buddy who may be at risk.

>>>Transition to Lesson Two

Slide 11:

Lesson Two: **Discuss Risk Factors**

[Negative] Risk factors **increase** the probability that difficulties could result in serious behavioral or physical health problems. The risk factors only raise the risk of an individual being suicidal. Having negative risk factors does not mean that the individual is suicidal. Simply stated, Soldiers who possess negative risk factors are at greater potential for suicidal behavior.

Discuss Protective Risk Factors

On the other hand, Soldiers' protective factors **reduce** the likelihood of suicide. Protective factors "enhance resilience and may serve to counterbalance risk factors".[11]

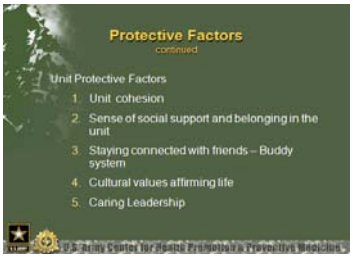
Protective factors are quite varied and include a Soldier's attitudinal and behavioral characteristics, as well as attributes of the military environment and culture.

A Soldier's most important factors are:

<u>Slide 12</u>: Individual Protective Factors

<u>Slide 13:</u> Individual Protective Factors (continue)

<u>Slide 14:</u> Individual Protective Factors (continue)



<u>Slide 15</u>: Unit Protective factors

<u>Slide 16:</u> Military Community Protective factors

<u>Slide 17</u>: Drew Carey Video Clip

>>>Transition to a Discussion of "Soldier Resiliency"

Soldier Resiliency

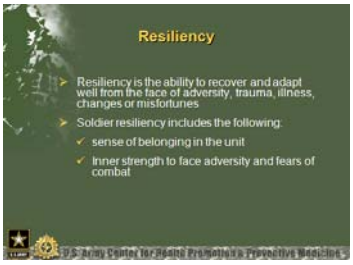
Soldiers are expected to deal with **difficult events** that will change their lives.

Examples of **difficult events** are (1) the death of a buddy in combat, (2) the physical and emotional challenges of combat, (3) separations from love ones, (4) breakup of a relationship, and (5) other deployment-related traumatic events.

Other difficult events that can give resiliency a chance to blossom include problems arising from family relationships, legal issues, financial and serious health problems.

Many Soldiers react to these challenges in very **adaptable** ways. While some Soldiers react to these events with a flood of emotions and a sense of uncertainty, others **adapt** well and, over time, develop what is referred to as ***<u>resiliency.</u>***

[Note to Instructor: Ask the audience to provide a definition of resiliency and personal examples of resiliency before providing schoolhouse definition.]



<u>Slide 18:</u> Define Resiliency
<u>Resiliency</u> <u>is the ability to recover and adapt well from the face of adversity, trauma, illness, changes or misfortunes.</u>

<u>Slide 19:</u> Resiliency (continue)

>>>Transition to "How to Build Resiliency"

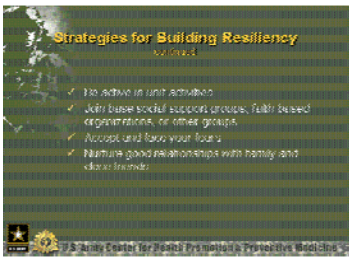
Slide 20: Building resiliency is a personal journey.[13]

There are a variety of strategies a Soldier can use to build resiliency.

This is because each individual Soldier, because of their uniqueness, will react to **difficult events** in different ways.

In other words, the method one Soldier uses to mange difficult events might not work for another Soldier.

There are a variety of different **strategies** to use to meet these challenging difficult events, i.e., **build resiliency**.



Slide 21: Strategies (continue)

Slide 22: Strategies (continue)

Slide 23: Strategies (continue)

Note to Instructor: Encourage Soldiers to share personal Strategies. What follows is an expanded explanation of the strategies indentified on the slides:

1. Make connections and reach out to unit members. Actively engage in developing good relationships with fellow Soldiers. Be active in unit activities; join base social support groups, faith-based organizations, or other groups.

2. Accept and face your fears. Understand that being fearful is acceptable. Assess the risk and be confident in your ability to cope with the uncertainty.

3. Nurture good relationships with family and close friends. Accept the help and support from them when you need someone who cares and willing to listen.

4. Regulate your emotions and avoid impulsive behavior. Learn to stay calm under pressure. Think before you act--delay gratification.

5. Maintain realistic optimism. Believe in your ability to survive and function as a good Soldier. Given your training, know that you have the ability to handle any adversity or misfortune. Problems solve and worked toward positive outcomes.

6. Identify your strengths. Nurture positive views of yourself. Trust your instincts and ability to solve problems.

7. Be willing to access social support.

8. Commit yourself to keeping in shape, maintaining physical health (diet, rest, exercise)

These resiliency strategies are very consistent with the **Army's values**:

Loyalty

Bear true faith and allegiance to the U.S. constitution, the Army, and other soldiers.
Be loyal to the nation and its heritage.

Duty
Fulfill your obligations.
Accept responsibility for your own actions and those entrusted to your care.
Find opportunities to improve oneself for the good of the group.

Respect
Rely upon the golden rule.
How we consider others reflects upon each of us, both personally and as a professional organization.

Selfless Service
Put the welfare of the nation, the Army, and your subordinates before your own.
Selfless service leads to organizational teamwork and encompasses discipline, self-control and faith in the system.

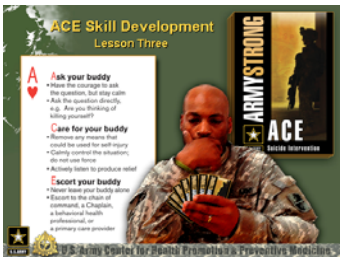
Honor
Live up to all the Army values.

Integrity
Do what is right, legally and morally.
Be willing to do what is right even when no one is looking.
It is our "moral compass" an inner voice.

Personal Courage
Our ability to face fear, danger, or adversity, both physical and moral courage.

(**Note to Instructor: Instructor is encouraged to solicit volunteers from the audience to share personal experiences about a stressful situation, and how the person recovered from that experience. What strategies the individual used to recover from the experience? What did the individual learn from the experience? If no volunteers, the instructor could discuss a personal experience for the class.)**

>>>Transition to Lesson Three



Slide 24: Lesson Three, ACE Concepts and Skills.

Present "ACE" Concepts and Skills (Time allotted: 30 minutes)
Explain that every intervention is different. It is important to remember that helping a buddy will require that you remain calm, determine, and flexible.

Slide 25: Show Eric Hipple video clip. Refer to the training tip card titled, **"Suicide Prevention Training Tip Card" (Attachment # 5).**
"Focus the next part of your class **[thirty minutes];** discuss suicide warning signs and risk factors. The reminder of the following material is for information only…share if time allows.
Explain that there is no **definite** measure to predict suicide or suicidal behavior.
However, American Association of Suicidology fact sheet states that "the vast majority of individuals who are suicidal often display cues and warning signs".
Also, researchers have noted that suicide involves **aggression** and sometimes it is carried out **impulsively**. [7]
Note: Alcohol use or a history of traumatic brain injury may cause or worsen **impulsivity and disinhibited behavior**.
The additional stress of a traumatic event or bad situation can make a Soldier feel overwhelmed and trapped by the situation.
For this Soldier, suicide may be seen as a way of dealing with the strong negative emotions through escape. This is often an impulsive response - act of attempted or completed suicide- with very little warning to fellow Soldiers.
The CY 2006 Army Suicide Event Report (ASER) indicated the motivational event for completed suicides was 43% unknown.[8] This could suggest that some of these unknown motivational event suicides could have been impulsive acts with very little or no warning signs. However, it was reported that 6% of the completed suicides were acts of impulsivity.
Make a note that an observable risk factor for Soldier battle buddies to keep an eye out for is being aware when a "bad event", e.g., Dear John Letter, takes place and what is the observed reaction to this specific event. Reactions that can signal possible suicidal actions include aggressive behavior, anxiety, withdrawal, or agitation.
The ACE intervention is for Soldiers to identify battle buddies who are experiencing problems and perhaps intervene before he or she impulsively attempts to kill self. Fellow Soldiers' vigilance and willingness to help a battle buddy can save lives.

[Note to Instructor: Share the following… If, in fact, your personal troubles are beginning to overwhelm you, then seek the type of help in the manner to be explained in this course immediately letting your Soldier buddies know how you are feeling. Part of the relief is sharing.]

There are factors that have been identified that place Soldiers at higher risk for suicide, but very few Soldiers with these risks actually attempt or complete suicide. At this point, refer to training tip cards: Warning Signs and Risk Factors (attachments 5).

Emphasize that suicide is a rare event, and it is difficult to use these risk factors to predict who will die from suicide. The assumption is that battle buddies are the closest and best equipped to notice warning signs or changes in behavior.

Explain that the best indicator that a Soldier is at increased risk for suicide is a history of prior suicidal attempt.

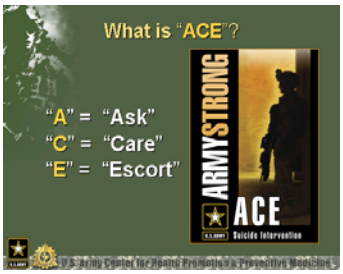
Also, research indicates the most significant predictor of suicidal risk for Soldiers with **Post Traumatic Stress Disorder (PTSD)** is **combat related guilt**.

During post deployment, Soldiers may experience highly intrusive thoughts and extreme guilt about acts committed during deployment. A Soldier may experience difficulties coping with these thoughts and commit suicide for relief.[9]

Regarding **Depression,** The National Institute of Mental Health (NIMH) reports that "the majority of people who have depression do not die by suicide, having major depression does increase suicide risk compared to people without depression.

The risk of death by suicide may, in part, be related to the severity of the depression. It is estimated that about 60 percent of people who commit suicide have a mood disorder (e.g., major depression).

"Younger persons who kill themselves often have a substance abuse disorder in addition to being depressed". [10] In the Army, about 20 to 30 % Soldiers who completed suicide were drinking at the time of the event.



Slide 26: "ACE" for Soldiers:
"Ask": Ask your buddy about his or her suicidal thoughts.

1. Know the **warning signs** you might see in yourself or buddy if he or she is suicidal.

2. Look for any outward sign that shows a deviation from your buddy's usual self.

Refer your students back to the discussion on **warning signs** and **negative risk factors** which you should have already completed

(Note to instructor: Ensure you do not teach this section on "ACE" as a separate unit because the learning comprehension builds on what is previously taught in the lesson)

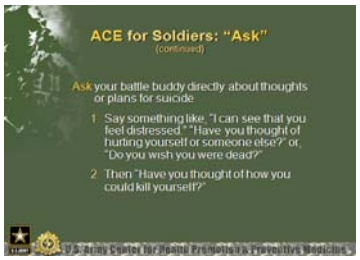
When the **warning signs** are present, it is imperative to ask your buddy directly; "Are you thinking about killing yourself"

(Note to Instructor: Refer students to Training Card at Attachment # 6)

<u>Slide 27:</u> Teach How to "ASK"

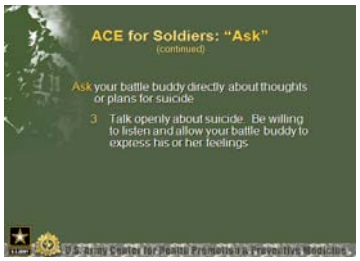
Ask your buddy directly about thoughts or plans for suicide.

1. Say something like, "I can see that you feel distressed." "Have you thought of hurting yourself or someone else?" or, "Do you wish you were dead?"
2. Then "Have you thought of how you could kill yourself?" (or whomever)
3. Talk openly about suicide. Be willing to listen and allow your buddy to express his or her feelings.

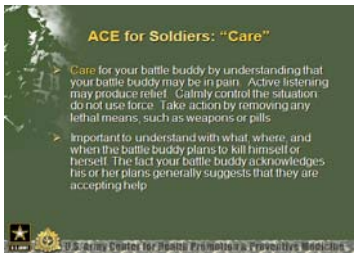


<u>Slide 28:</u> ASK (continue)

The Instructor may want to encourage a volunteer to brief the slides in this section.

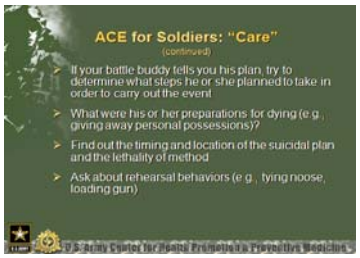


Slide 29: ASK **(continue)**



<u>Slide 30:</u> Teach How to "Care"

1. Care for your buddy by understanding that your buddy may be in pain
2. Active listening may produce relief. Calmly control the situation: do not use force
3. Take action by removing any lethal means, such as weapons or pills.



<u>Slide 31:</u> Care (continue)

<u>Slide 32</u>: Care (continue)

Slide 33: (<u>Note to Instructor</u>: Teach the following at this point in your class)

What to Listen For:

1. It is important to understand with **what, where, and when** your buddy plans to kill himself or herself

2. If your buddy acknowledges his or her plans, it generally suggests that your buddy is accepting your help

3. If your buddy tells you his plan, try to determine what steps he or she planned to take in order to carry out the event

4. What were his or her preparations for dying (e.g., giving away personal possessions)

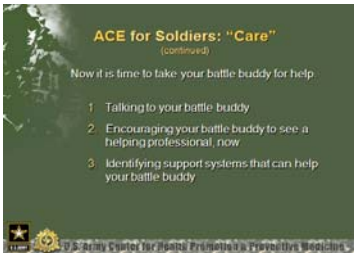
5. Find out the timing and location of the suicidal plan and the lethality of method

6. Ask about rehearsal behaviors (e.g., tying noose, loading gun)

7. Explore ambivalence, that is, asks your buddy, specifically, about his reasons to die versus the reasons to live

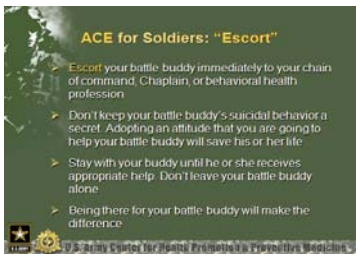
8. Determine your buddy's access to lethal methods, including firearms

9. Disarm your buddy (lethal means). If your buddy is armed, say, "Let me unload your weapon and keep it safe for you while we talk".



<u>Slide 33:</u> Transition to Teach about How to Escort Your Buddy **to Get Help**

Now it is time to escort your buddy



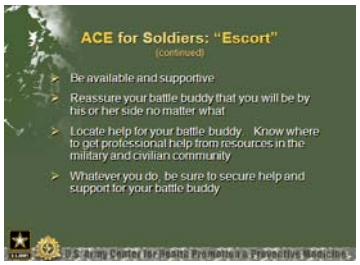
<u>Slide 34:</u> Teach about the "E" in "ACE", <u>*"Escort"*</u>
Overview

Escort your buddy immediately to your chain of command, Chaplain, or behavioral health professional

1. Don't keep your buddy's suicidal behavior a secret

2. Adopting an attitude that you are going to help your buddy will save his or her life

3. Stay with your buddy until he or she receives appropriate help. Don't leave your buddy alone.



<u>Slide 35: (Note to Instructor</u>: Cover these teaching points during this section of the training)

1. **Why it is important to stay with your buddy**
2. **Why being there with your buddy makes a difference**
3. **How to be available and supportive**
4. **How to reassure your buddy that you will be by his or her side no matter what.**

Review: (if needed)

1. Locate help for your buddy

2. Know where to get professional help from resources in the military and civilian community

3. Whatever you do, be sure to secure help and support for your buddy

<u>Slide 36:</u> Transition to Teach about How to *<u>"Care"</u>* Through *<u>"Active Listening"</u>*

(<u>Note to Instructor</u>: promote active class discussion here on what they think is "Active Listening" then explain)

Active listening occurs when the listener is genuinely interested in the speaker's message. Clues or warning signs are missed because a potential helper either lacks the time or interest that causes the message not to be heard. Sometimes the helper is just too busy to actually listen or comprehend. This communication mishap occurs far too often and can lead to disastrous results (e.g., suicide). Active listening requires patience. The patience listener will learn the reasons why his/her buddy wants to die, and eventually your buddy will see that death is not all that is there. It is important to listen long enough so that your buddy feels understood and the reason for living are found.

<u>Slide 37</u>: Note to Instructor: If time is allowed, prepare the class to break into groups of three in order to complete the Active Listening exercise (attachment 7).

Slide 38: If short of time, the instructor can do the following exercise (large group exercise):

LISTEN!

We have a twenty five year old active duty SGT (E-5). He is in his third month of a second deployment. This deployment has brought back many terrible memories from the first deployment. Up to this point, he had been able to cope. On a recent patrol, two guys from his unit were killed by an IED. A gun battle started with a group of insurgents. He failed to fire back at the enemy. He is now safe back in the rear area. He is obsessed with this incident. He can not understand why his buddies were killed and he is still alive.

You are talking to him.

He states: "A part of me wants to die with my friends but I am also glad I survived the IED." "The only thing I want right now is to be with my friends but I want to live."

Reflect back to me about what he actually stated.
Group needs to state back what the Soldier said.

What did you also hear?

He is struggling with intrusive thoughts from the first deployment.
He failed to fire back at the enemy during the firefight.
He is feeling guilty about the deaths of his fellow Soldiers.
He now has frequent thoughts about joining his dead comrades.

How would you know if you were correct?

What was it like to do this exercise?
Reflecting back is a powerful tool in any intervention.

>>>Transition to Teaching Lesson Four

Slide 39: Lesson Four: Role Play

If time allows, you can prepare class for role play by doing the following in the large group:

Class Role Play

Use same scenario as stated in previous lesson on active listening. Now get the group to interview you using ACE.

Start: "The only thing I want right now is to be with my friends". Someone should **ASK**: Are you thinking about killing yourself. Your response: "Yes I am thinking about killing myself". If someone **CARE**, the individual will ask about your plan. Your response: "I thought about taking this bottle of drugs". You can also add any of the following comments in the dialogue: "I froze when we were fighting. I never fired my weapon. Seeing my buddies lying in the street was awful for me. …I could not get their images out of my mind". "I'm not sleeping …I think about it all the time". Finally, someone

should suggest that they want to **ESCORT** you to a helping provider. When the class completes the group interview, it is now time to break the class up into groups of three.

<u>Slide 40:</u> ACE Role Play Activities
Introductory Teaching Points [for students]:
1. The Mental Health Advisory Team (MHAT) reports clearly demonstrate that Soldiers talk with other Soldiers about his or her own personal distress.
2. Given this situation, the Army is expecting that each Soldier care for buddies by ensuring suicidal Soldiers receive appropriate care and support.
3. It is every Soldier's responsibility to look out for his or her buddy which includes helping a buddy during times of trouble.
4. For the next hour, you will have the opportunity to practice what you have been taught thus far about the *ACE* intervention.

<u>Slide 41:</u> Please understand that some people will feel threatened by the role play experience. This is not unusual.

<u>Slide 42:</u> How to Facilitate the Role Playing [for the instructor]
Highlight the ground rules.

Slide 43: How the ACE Role Playing works [for the instructor]
1. The actual role-play is a particular type of *simulation* that focuses attention on the Soldier's interaction with a buddy

2. The role play will provide classroom participants a chance to practice intervention skills and talk about suicidal thoughts with a fellow Soldier under various circumstances.

3. The *ACE* role-play asks Soldiers to imagine that they are either themselves or another person in a particular situation.

4. For example, the Soldier will be asked to behave exactly as an interviewer *[interviewee?}* or someone who has suicidal thoughts would behave.

5. As a result of doing this, the Soldier, or the rest of the class, or both, will **learn more about early recognition of suicidal thinking and behavior in buddies and practice what they learned about** *ACE***.**

6. In essence, the role-play activities will provide each participant an opportunity to observe, discuss and assimilate information.

7. The role-play will allow Soldiers to practice what they learned in a **safe environment**.

Key Class Goal of *ACE* Role Playing: Soldiers will develop a higher level of comfort and confidence to ask, and intervene on behalf of, a fellow Soldier who is contemplating suicide

Note to the Instructor: Instructions about *ACE* Role Playing

1. The instructor ensures class participants have training tip cards for reference.

2. The instructor uses a visual display of the acronym ***ACE*** and a descriptive meaning of each letter for Soldiers to read while role playing.

3. The instructor displays the PowerPoint slide of the ***ACE*** tip card during the role play exercise on the screen and/or TV monitors

Note to the Instructor: Instructions on *How* to Conduct the *ACE* Role Playing Activities

Background

1. There are **two** recommended ways to conduct the role-play activity.

2. **Number One:** Instructor creates small groups of 8 to 10 Soldiers allowing only a few Soldiers to do the actual role play while the remaining group members observe the role play.

3. **Number Two:** The instructor creates small groups of 3 where each group member plays a different role.

Alternatively, one Soldier (e.g. "buddy") is given a scenario/script of the "buddy" role while the other Soldier (e.g. "interviewer") applies what was learned in class so far by questioning the "buddy" based on the ***ACE*** functions.

The third Soldier serves as an observer.

The players can rotate through roles within a single role-play (switching) with the intention of gaining insight into other roles or perspectives or players can be substituted at various points in the role-play by the observer.

The role play scenario provided to the buddy will be partially scripted (the realistic scenarios will have certain prompts for the player to act out his or her role).

The choice of the role-play activity will be dependent on time and group size.

Specifics

1. Ensure there is plenty of time for participants to switch roles so everyone has a chance to practice intervening

2. Ensure there is time for discussion and questions at the conclusion of the role play activities

3. Move around the room to help Soldiers along, as needed

4. Use the following questions to promote discussion and reflection in the large group:

a. How many of you asked your buddy directly if he or she was thinking about killing themselves?

b. Did your group encounter difficulties with following the ***ACE*** **acronym**?

c. Did the group encounter difficulties with information gathering (***Asking*** part)?

d. Did the group encounter difficulties with gaining a buddy commitment **(*Caring*** part)?

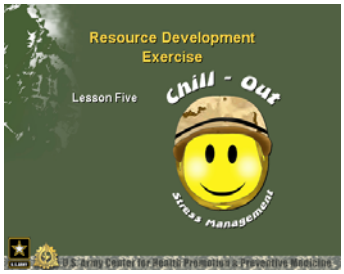
e. Did you provide each other feedback?

f. If so, was the feedback helpful?

g. Ask questions about the group's feelings, emotions, and current attitude about helping a buddy

h. Did you experience any difficulties in the role-play?

>>>Transition to Teach Lesson Five



Slide 44: Lesson Five, Army Resources.
Background: If a buddy identifies a fellow Soldier who is suicidal by using the ***ACE*** method of intervention, **the Army behavioral health professional community must accept the referral for professional evaluation and/or care.** It is a significant

responsibility for the buddy to start this chain of events in order to help a fellow Soldier.

The chain of command, chaplains and behavioral health professionals are expected to help Soldiers by creating a community safety net for suicidal people. Based on this concept, the professional community acknowledges and supports this notion by **providing an array of treatment options and resources for a Soldier who is suicidal. However, Soldiers are generally not very knowledgeable about the available treatment options or resources for a suicidal Soldier.**

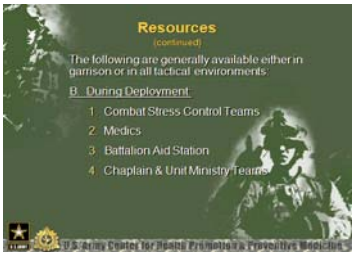
Purpose of Teaching about Army Resources

1. Identify local treatment options and resources for a suicidal Soldier
2. To reassure Soldiers that the professional provider will respond when the ***ACE*** intervention is utilized and the buddy escorts and helps a fellow Soldier get connected with a professional provider

How to Teach about Army Resources

1. Create small groups of 8 to 10 Soldiers
2. Provide each group with butcher block paper, stand, marker(s), gaffer or masking tape
3. Task each group to identify local resources that can help fellow Soldiers who are suicidal
4. Task each group to record their findings on the butcher block paper.
5. Have each small group appoint a group leader who will report these findings to the entire class
6. Explain to the class that the purpose of this exercise is to increase Soldiers' [their] awareness of the extended [professional] resources available to them and the appropriate mechanisms to utilize them
7. Reinforce their answers and ensure they include the following that are generally available in all tactical environments:
    a. Organic medical assets to include medics and medical officers
    b. Unit Chaplain
    c. Behavioral Health assets organic and attached to organization
    d. Combat stress control team working in the unit's area of responsibility

Slide 45: After the exercise is completed , show slides 45 & 46 to determine if the groups captured most of the available resources.



Slide 46:

Slide 47: Highlight the availability of Military One Source

>>>Transition to Teach Wrap-Up Activities Section

Slide 48: Wrap Up Activities Section
Instructor: Summarize class using Power Points visuals.

Slide 49:
Have all of your class participants complete the post measurement and satisfaction questionnaires found at **Attachments # 1 and 9.**
Hand out training completion certificates that have each class participant name on it correctly spelled.
Take final questions.

Slide 50: The class participants should complete post measurement and Army' Ace Suicide Intervention Training Feedback before being dismissed. See slide # 2 above for additional instructions.

Ensure that all participants hand in the post measurement questionnaires.

Dismiss and Say Goodbye **(Slide 51).**

Certificate of Completion

presented to:

_____

has successfully completed the

ACE Suicide Intervention Training Program

Center for Health Promotion and Preventive Medicine, Aberdeen Proving Ground, MD

DR. JAMES W. CARTWRIGHT

_____

Signature Date

Trainer Feedback Questionnaire

We're interested in what you think about the ACE Suicide Intervention Training Program and how we can improve the content. *Your feedback is greatly appreciated*.

Please take a few minutes to complete this evaluation form and return with pre/post measurements and feedback questionnaires (attachment 11) to the US Army Center for Health Promotion and Preventive Medicine (CHPPM). ***Question number 1 should be completed as part of wrapping up lesson number 4(role play lesson). Questions 2 through 5 can be completed at the end of the class.***

Your comments will assist us in the further development of the ACE Suicide Intervention Training Program.

1. Use the following questions to promote discussion and reflection in the large group (record the groups' responses):

   a. How many of you asked your buddy directly if he or she was thinking about killing themselves?

   b. Did your group encounter difficulties with following the ***ACE*** **acronym**?

   c. Did the group encounter difficulties with information gathering (***Asking*** part)?

   d. Did the group encounter difficulties with gaining a buddy commitment **(*Caring*** part)?

   e. Did you provide each other feedback?

   f. If so, was the feedback helpful?

   g. Ask questions about the group's feelings, emotions, and current attitude about helping a buddy.

2. List three aspects of the training session that you found especially useful?

3. List three aspects of the training session that could be improved?

4. What other feedback would you like to give us?

5. Next time you provide suicide training, what should you try that is different from today and past training you provided on suicide prevention?