



DEPARTMENT OF THE NAVY
OFFICE OF THE CHIEF OF NAVAL OPERATIONS
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OPNAVINST 1720.4A
N135
4 Aug 09

OPNAV INSTRUCTION 1720.4A

From: Chief of Naval Operations

Subj: SUICIDE PREVENTION PROGRAM

Ref: (a) OPNAVINST 6100.2A
(b) SECNAVINST 6320.24A
(c) MILPERSMAN 1770
(d) OPNAVINST F3100.6H (NOTAL)

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

1. Purpose. To provide policy, procedures and assign responsibilities for the Navy's Suicide Prevention Program per references (a) through (d).

2. Cancellation. OPNAVINST 1720.4.

3. Applicability. Provisions of this instruction apply to all Active and Reserve Navy units within the Department of the Navy (DON).

4. Background

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

ready to accomplish the mission. Enclosure (1) contains a list of suicide risk factors, protective factors and resources for assistance.

b. Navy suicide prevention programs consist of four elements:

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

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

(3) Response - assisting families, units and service members affected by suicide behaviors.

(4) Reporting - reporting incidents of suicide and suicide-related behaviors (procedures outlined in subparagraph 5d below).

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

d. Terms used in this instruction are included in enclosure (2).

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

a. Training

(1) Suicide prevention training shall be conducted at least annually for all Active Component (AC) and Reserve Component (RC) Service members and for all Navy civilian

employees and full-time contractors who work on military installations. General Military Training (GMT) materials may fulfill part of this training requirement but must be supplemented with information on local action plans and support resources. Suicide prevention training should include, but is not limited to:

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

(b) Recognition of specific risk factors for suicide;

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

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

(e) Contact information for local support services.

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

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

b. Intervention

(1) Commanding Officers (COs) shall have written suicide prevention and crisis intervention plans that include the process for identification, referral, access to treatment and follow-up procedures for personnel who indicate a heightened risk of suicide.

(2) COs shall foster a command climate that supports and promotes psychological health consistent with operational stress control principles. For example:

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

(3) COs shall provide support for those who seek help with personal problems. Access must be provided to prevention, counseling and treatment programs and services supporting the early resolution of mental health, and family and personal problems that underlie suicidal behavior.

(4) If a Service member's comments, written communication or behaviors lead the command to believe there is imminent risk that the person may cause harm to self or others, command leadership must take safety measures that include restricting

access of at-risk personnel to means that can be used to inflict harm and seek emergent mental health evaluation consistent with reference (b).

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

d. Reporting

(1) Suicides and suicide-related behaviors shall be reported per references (c) and (d). Definitions for various suicide-related behaviors are provided in enclosure (2).

(2) A suicide is a self-inflicted death with evidence (either implicit or explicit) of intent to die. In instances of suicide and undetermined deaths for which suicide has not been excluded by the medical examiner, commands shall complete the Department of Defense Suicide Event Report (DoDSER) (available at <https://dodser.amedd.army.mil/dodser>) within 60 days of notification of death. Commands are advised to maintain copies of medical, dental and service records for 6 to 8 weeks after the member's death in order to complete the DoDSER and respond to unforeseen questions.

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

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

e. SPC. Each CO will appoint an SPC. The SPC will aid the CO in ensuring that the suicide prevention program is fully implemented.

6. Responsibilities

a. Deputy Chief of Naval Operations (Manpower, Personnel, Training and Education) (CNO (N1)) shall establish a suicide prevention program policy. As executive agent, the Office of the Chief of Naval Operations (OPNAV), Personal Readiness and Community Support Branch (N135) shall:

(1) Develop policy guidance for the Navy's Suicide Prevention Program;

(2) Provide educational support to commands for suicide prevention elements;

(3) Provide information to, and establish training for, SPCs;

(4) Monitor the number of suicides and track trends of all suicides in the Navy total force. Coordinate the development and maintenance of a database to monitor suicides in coordination with OPNAV, Navy Casualty Office (N135C), the Office of the Armed Forces Medical Examiner, the Department of Defense Center of Excellence for Psychological Health, and Bureau of Medicine and Surgery's (BUMED's) Director of Psychological Health for Navy Reserve;

(5) Maintain statistical data on suicide prevention training;

(6) Provide ongoing program evaluation to the chain of command.

b. Chief, BUMED shall:

(1) Develop procedures and policy to ensure service members who exhibit suicide-related ideations, communications or behaviors are properly evaluated and treated;

(2) Develop written procedures and policy to ensure that medical personnel execute their responsibilities regarding suicide prevention in an appropriate and consistent manner throughout DON to include communicating and coordinating with Service member's command;

(3) Provide technical assistance to COs and Navy leaders in support of commands;

(4) Ensure all MTFs have written protocols on suicide prevention maintained in acute care areas and emergency rooms;

(5) Develop written procedures and policy to ensure completion of the DoDSER for suicide attempts for service member patients covered in each MTF's area of responsibility.

c. OPNAV, Chief of Chaplains (N097) shall:

(1) Consult with BUMED in the development of procedures and policies to ensure service members who exhibit suicide-related behaviors (including ideations and communications) are properly evaluated;

(2) Develop written procedures to ensure that chaplains/religious program specialists execute their suicide prevention program responsibilities throughout the Navy;

(3) Provide assistance with implementation and evaluation of the suicide prevention program upon request of commands.

d. Commander, Navy Installations Command shall:

(1) Consult with BUMED in the development of procedures and policies for FFSCs to ensure service members who exhibit suicide-related behaviors (including ideations and communications) are properly evaluated;

(2) Develop written procedures to ensure that personnel routinely responsible for installation emergency response including security, fire and rescue personnel execute their suicide prevention program responsibilities throughout the Navy;

(3) Ensure that installation emergency response personnel receive annual training, which reviews safety precautions and procedures and de-escalation techniques, when responding to situations of potential suicide-related behaviors and psychiatric emergencies.

e. Commander, Naval Education and Training Command shall:

(1) Provide GMT, or similar annual training, curricula on suicide prevention;

(2) Include suicide prevention training at basic accession points and leadership courses of instruction, e.g., Officer Candidate School, Officer Development School, Naval Reserve Officer Training Corps, Command Leadership School, Senior Enlisted Academy and Recruit Training Command;

(3) Include rate specific suicide intervention training at "A" schools and "C" schools for hospital corpsman, religious program specialists and master-at-arms rates.

f. Commander, Navy Recruiting Command shall ensure all recruits meet minimum entry-level physical and mental readiness standards.

g. Commander, Navy Reserve Forces Command shall:

(1) Implement a suicide prevention program as outlined in paragraph 5 of this instruction;

(2) Ensure all drilling Reservists, including voluntary training unit members, complete annual suicide prevention training.

h. COs shall:

(1) Ensure an effective suicide prevention program is established and maintained, consistent with requirements of this

instruction. Enclosure (3) provides a sample command suicide prevention/crisis response plan checklist;

(2) Designate, in writing, an SPC to assist in implementing the installation/unit suicide prevention program. Whenever possible, the SPC should be E7 or above. Designate, in writing, assistant SPCs (as necessary), appropriate to command size and structure;

(3) Ensure suicide prevention training is conducted on an annual basis for all command personnel and maintain records of the training;

(4) Distribute health and fitness materials in support of OPNAV health promotion initiatives.

i. SPCs shall:

(1) Become thoroughly familiar with the contents of this instruction and advise the chain of command on all suicide prevention program matters;

(2) Receive SPC training as established by OPNAV (N135) as soon as possible after designation;

(3) Schedule and announce suicide prevention training and be prepared, as needed, to conduct training.

j. Individual service members shall:

(1) Learn and practice skills for maintaining a healthy lifestyle that promotes psychological health, physical readiness, and positive stress control;

(2) Provide assistance and immediately notify the chain of command if a shipmate is observed to be experiencing distress or difficulty in addressing problems or exhibiting behavior consistent with suicidal ideation;

(3) Seek assistance through the chain of command for support resources when experiencing distress or difficulty in addressing problems;

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(4) Participate in suicide prevention training on an annual basis as a minimum.

7. Records Management. Records created as a result of this instruction, regardless of media and format, shall be managed per Secretary of the Navy (SECNAV) Manual 5210.1 of November 2007.

8. Reports Control The reporting requirements contained in this instruction are exempt from reporting requirements per SECNAV Manual 5214.1 of December 2005.



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SUICIDE RISK FACTORS, PROTECTIVE FACTORS AND RESOURCES

Risk Factors and Stressors Associated with Navy Suicides

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

2. Protective Factors that Reduce Risk of Suicide

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

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

3. Resources

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

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DEFINITIONS OF SUICIDE RELATED BEHAVIORS

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

6. Self-Inflicted Death with Undetermined Intent. Self-inflicted death for which intent is either equivocal or unknown.

7. Suicide Attempt. A self-inflicted potentially injurious behavior with a non-fatal outcome for which there is evidence (either explicit or implicit) of intent to die. A suicide attempt may or may not result in injury.

8. Suicide. Self-inflicted death with evidence (either explicit or implicit) of intent to die.

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SAMPLE COMMAND SUICIDE PREVENTION/CRISIS RESPONSE PLAN CHECKLIST

Each command and environment is unique, as will be each command's suicide prevention and crisis intervention plan, but the following sample checklist may help in establishing or assessing the state of a program.

1. Appropriate annual suicide prevention training conducted for all Service members, including those in the Reserve, and for all Navy civilian employees and full time contractors?

Yes No

2. Suicide prevention part of life-skills/health promotions training? Yes No

3. Messages of concern sent by the senior leadership team to provide current information and guidance to all personnel on suicide prevention? Yes No

4. Written suicide prevention and crisis intervention plan in place (e.g., standard operating procedures, duty office checklist)? Yes No

5. Local support resource contact information easily available?

Yes No

For example:

Chaplain/Religious Services
Fleet and Family Support Center
Medical
Security
Local Emergency Room

6. Personnel and supervisors have ready access to information about how to get help with personal problems (e.g., wallet card info, posters, plan of the day, e-mails)? Yes No

7. Procedure in place to facilitate personnel accessing needed services (e.g., time for appointments, access to transportation, overcoming logistical barriers, discouragement of stigmatizing)?

Yes No

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8. Supervisors active in identifying personnel potentially in need of support (e.g., relationship problems, financial problems, recent loss, legal problems or loss of status, change in behavior or performance, showing warning signs)? Yes No

9. Safety plan for dealing with high-risk Service members (e.g., suicidal/homicidal/bizarre thoughts and behaviors) until mental health services are available. In the absence of guidance from a mental health professional, recommend:

a. Removal of personal hazards (no weapons, belt, shoes, boot straps, draw strings, shirt stays, and personal hygiene items such as toothbrush or razor).

b. Removal of environmental hazards from room (room free of sheets, elastic bands, mirrors, pencils, pens, window dressings (such as blinds), shoelaces, strings, alcohol, weapons, medication, cleaning supplies, razors, metal eating utensils, telephones, tools, or any other rope, breakable, or sharp-edged object).

c. Line of sight supervision.

10. Mental health contact information readily available?
 Yes No

11. Follow-up plan for personnel after acute evaluation?
 Yes No