STRATEGY RESEARCH PROJECT

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THE ARMY SUICIDE PREVENTION PROGRAM AND WHERE DO WE GO FROM HERE?

BY

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The Army Suicide Prevention Program and Where Do We Go From Here?

by

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ABSTRACT

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TITLE: The Army Suicide Prevention Program and Where Do We Go From Here?

FORMAT: Strategy Research Project

DATE: 07 April 2001 PAGES: 30 CLASSIFICATION: Unclassified

One of the greatest challenges facing commanders in the Army today is the increased rate of suicide by soldiers. Currently, the Army suicide rate is between 14.79 and 15.49 per 100,000. This statistic is staggering and one that most would find hard to accept in a military system that is based on self-discipline and a high level of physical and emotional training. The Army Chief of Staff General Eric Shinseki has stated, "It is our responsibility to help our soldiers and civilians understand how to identify at risk individuals, recognize warning signs and know how to take direct action." This is the reason for the Army's Suicide Prevention Program. This paper will make the case that prevention is not enough, but intervention must play a role in the commanders suicide prevention program.

One of the best sources to help identify not only prevention issues, but also intervention ideas, is the soldier. A survey of approximately 300 soldiers was done as part of the research to support this paper. This research included both the active and reserve components. The results of this survey show that the Army has a need for an intervention plan within the current suicide prevention program. This program will consist of a person to talk to i.e. a hotline, a staff psychologist or chaplain available on call 24 hours. By having a person willing to listen the soldier knows someone cares about him/her in their time of crisis. This phone call is a means to provide help in a hopeless situation and helps diffuse a potential full-blown crisis.

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PREFACE

Suicide in the Army is a problem of utmost concern to the commanders' and the chaplains' corps. A human being capable of infinite worth and dignity who doesn't feel worthy or loved is a human being who doesn't know God's infinite love for us. The chaplains' corps wants to do whatever it can to help alleviate this monumental problem. The current statistics used were provided by the Chief of Chaplain's Office in Washington D.C. The support and encouragement to research and develop an intervention plan came from the many soldiers who came to me wanting to take their own life. My peer support came from LTC Glen Bloomstrom my good friend and mentor. Finally, thank you to the Army War College for allowing me the privilege and opportunity to research this very complex and delicate issue in hopes of developing a plan of intervention.

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THE ARMY SUICIDE PREVENTION PROGRAM AND WHERE DO WE GO FROM HERE?

> What can you do when you call for help and no one listens? When your hopelessness is so overwhelming that you feel like taking your own life? Your family can't relate to your problem and your friends are too involved in their own lives to listen. One solution is to find a "bystander" to talk to. Sometimes someone who doesn't know you is one of the easiest people to talk to. This could be a counselor, chaplain or a suicide hotline. They will take your problem seriously without criticizing.

Intervention is the key to suicide prevention. Intervention takes place when someone reaches out to ask for help, and someone is there to listen. But the current Army Suicide Prevention Program isn't working as well as we would like it to work. Suicide rates among soldiers are increasing. As of this date (November 2000) the civilian suicide rate is 12-13 per 100,000 compared to the Army's rate of between 14.79 and 15.49 per 100,000. Augmenting the current Army Suicide Prevention Program with an intervention program would bring about a decrease in these numbers.

HISTORY OF THE ARMY SUICIDE PREVENTION PROGRAM

In the spring of 1984 the Chief of Staff of the Army, General John A. Wickham, initiated a suicide prevention program for the Army.[1] General Wickham's motivation stemmed from a desire to reduce the numbers of suicide deaths from the Army. In developing the Army Suicide Prevention Program, certain essential tasks were identified. First, leaders and supervisors at all levels needed to be taught to recognize warning signs of personal crisis and to know where to refer someone for help. An educational process to teach these signs began. Second, the data-gathering mechanisms in place at that time were not giving an accurate picture of the problem and needed to be improved. In fact, cross-referencing data from the Army Casualty Branch, the Military Police, and the (Army Medical Department) AMEDD, there was no general agreement of who was even dead, much less how the death occurred. Third, because little was known about the circumstances of persons committing suicide in the Army from the basic demographic data that was available, a mechanism was needed to investigate each death in depth to understand factors which contributed to the decision to commit suicide so that prevention programs could be targeted on the underlying causes. These three tasks became the basis of the Army's suicide prevention program.

From the beginning of planning for the Army Suicide Prevention Program, the role of military chaplains' was thought to be critical. Therefore the chaplain and his or her assistant from the Unit Ministry Team (UMT) working with the Army Mental Health Team became the primary trainers of suicide prevention in their own units and would be the most visible person to first line supervisors to get help for themselves and their soldiers.

ARMY STRUCTURE HELPS PREVENT SUICIDE

The Army provides a structural framework within which levels of suicide prevention take place. Army leadership, from unit to highest command levels, assisted by a vast network of helping agencies, attempts to prevent suicide by use of "gate keepers." Gatekeepers identify and refer at-risk individuals for treatment. They come from all aspects of the military community, both within and outside the chain-of-command. Others in the military perform secondary and tertiary suicide prevention. All gatekeepers must be trained in their varying responsibilities according to their gatekeepers level.[2] Chaplains perform primary suicide prevention. They can perform screenings to help soldiers identify signs of distress in themselves and seek support from helping agencies. Secondary suicide prevention occurs as The Army structure facilitates follow-up of well being screenings. The gatekeepers identify and refer at-risk individuals for treatment. When warning signs appear, primary and secondary suicide prevention gives way to the tertiary suicide prevention, crisis intervention and medical treatment.[3]

Army structural support continues even after someone has attempted suicide. Hope is realized best through primarily a trusting relationship rather than by intellectual means

The Army has in place and teaches soldiers specific actions to take to help prevent suicide. Department of the Army (TRADOC) regulations 350-6 states: Commanders and Chaplains orientations in "initial entry training" units will include instructions on what actions soldiers must take in the event a fellow soldier talks to them about suicide. The orientation will direct the soldier to immediately notify the chain of command when he or she has such information. The soldier is to notify the first member of the chain of command who is available whether that is the commander, first sergeant or drill sergeant. Commanders must counsel soldiers who are reported to have discussed or alluded to suicide. The commander must refer any soldiers suspected of contemplating suicide to mental health personnel for evaluation and counseling. The commander will provide an escort of greater rank than the soldier, but at least an NCO, to accompany the soldier until mental health personnel assume control. At no time will the soldier be left alone and unsupervised.[4]

But the chain of command response doesn't work as well as it is intended to work. Chaplains who counsel soldiers will repeatedly hear those being counseled state dogmatically, " I would not talk to my sergeant or supervisor about my problem because they would think I'm crazy, can't perform my job, therefore I would lose my job and any means of supporting myself or my family." Most of them will say, " I am not crazy, just out of solutions and I can't control my situation any longer." By intervention, the chaplain or mental health professional will give a deliberate avenue of approach for change. Hope is introduced with ideas for a new way of thinking with a change towards present thoughts, feelings, and behaviors

INDICATORS AND ILLUSTRATIONS OF ARMY SUICIDES

Soldiers experience distress caused by downsizing, financial problems, absence from home due to increased deployments and re-deployments and potential combat scenarios. These stressors can lead to a downward cycle, which will almost always affect family or relational problems. The break down of the marriage, if married, is usually first, then the home, financial problems and eventually problems on the job. If these circumstances continue without intervention many will begin to lose hope and the spiral effect of these feelings are loss of hope and growth of despair, which can then lead to thoughts of suicide. In 1999 there were 7,673 substantiated allegations of family violence within Army ranks. Women and children suffered the most injuries, and researchers emphasize that these numbers include only cases that were reported and cannot be inclusive of violence that occurred unnoticed or was ignored. The total number of spouse abuse reported was an alarming 8,286 with 4,810 of those reports being substantiated by evidence. Studies reveal that spouse abuse is most frequent among young couples that have not yet developed joint coping and communications skills. The age group between 22-26 has the highest rate of soldiers abusing their spouses.[5]

Research has shown that the number of suicides have increased since 1990. They also demonstrate that the highest rate of suicide is age 21-25. This age group correlates with the Army rates of domestic violence. Domestic violence is one of the major traumatic trigger events leading to depression and hopelessness. It has been proven there is a communication break down which leads to domestic violence. There is also an inability for that same age group to deal with their emotional problems because they are unable to communicate their need for help.

The following illustrations depict the current Army suicide demographics

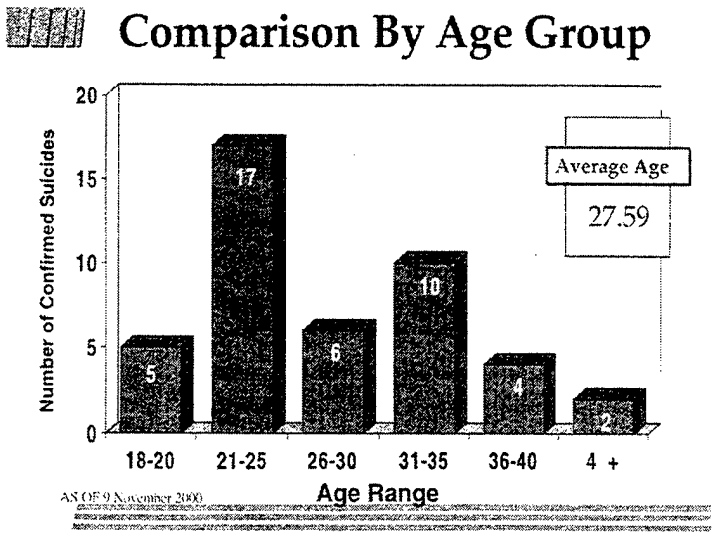


FIGURE 1 COMPARISON BY AGE GROUP, NOVEMBER 2000

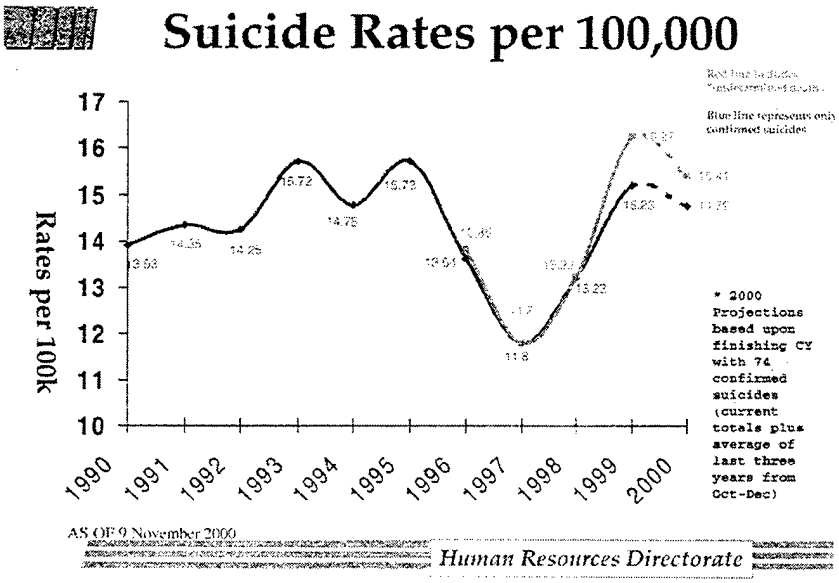


FIGURE 2 SUICIDE RATES PER 100,000, NOVEMBER 2000

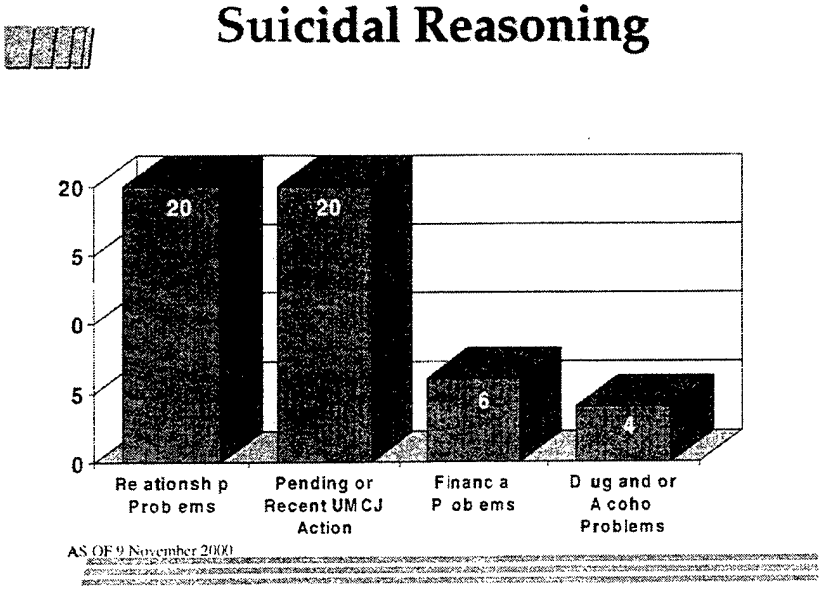


FIGURE 3 SUICIDAL REASONING, NOVEMBER 2000.

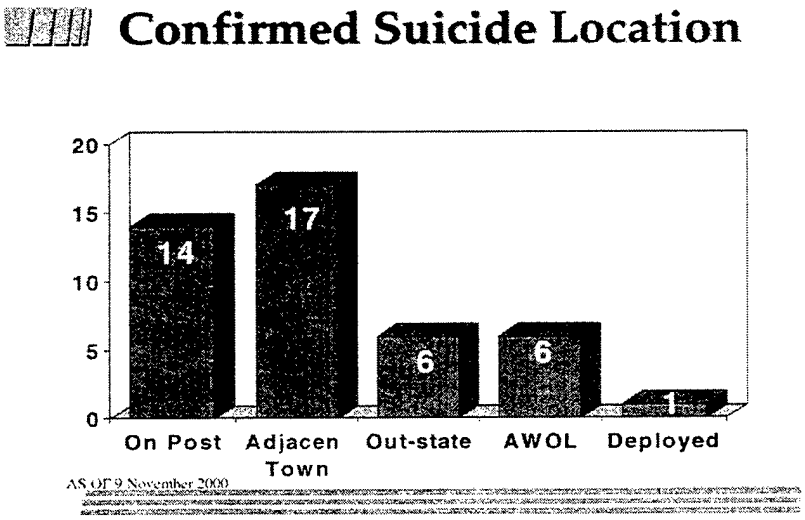


FIGURE 4 CONFIRMED SUICIDE LOCATION, NOVEMBER 2000.

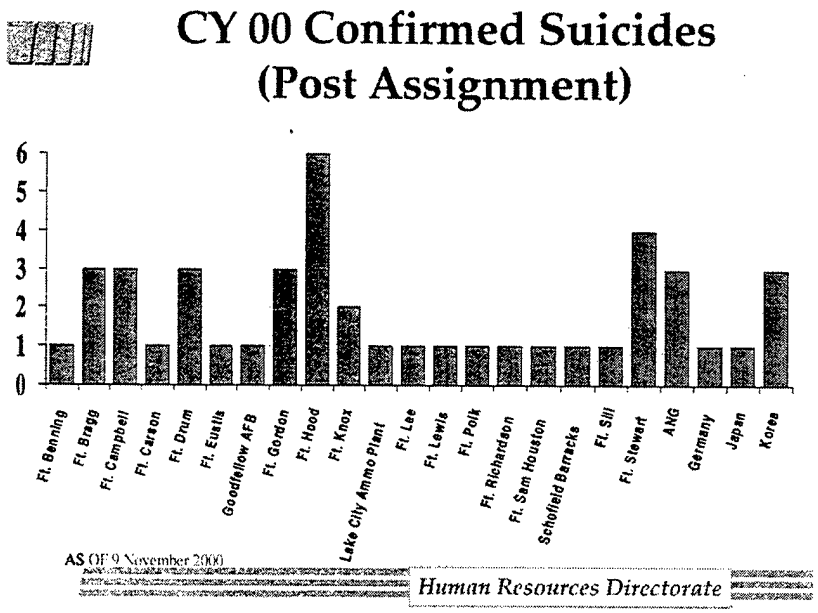


FIGURE 5 CONFIRMED SUICIDES BY POST ASSIGNMENT, NOVEMBER 2000.

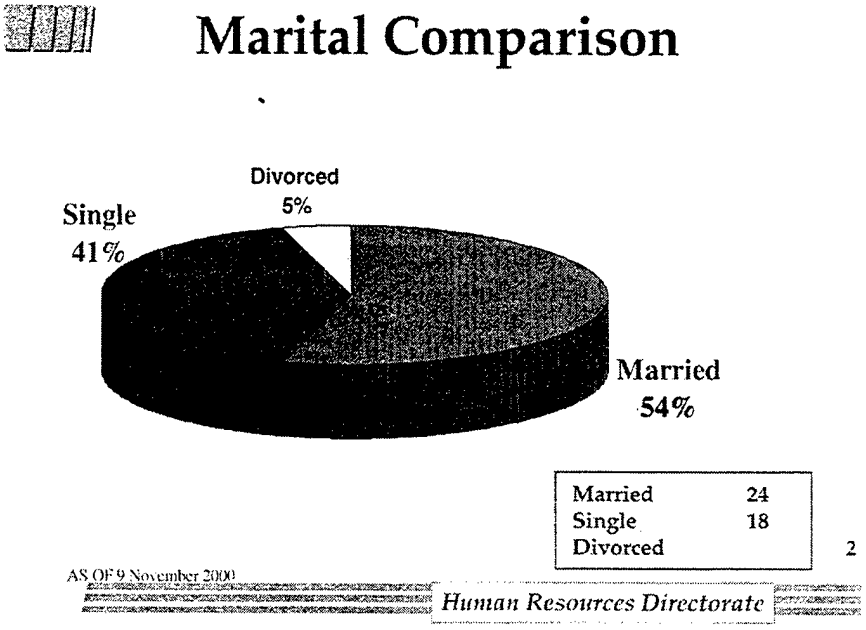
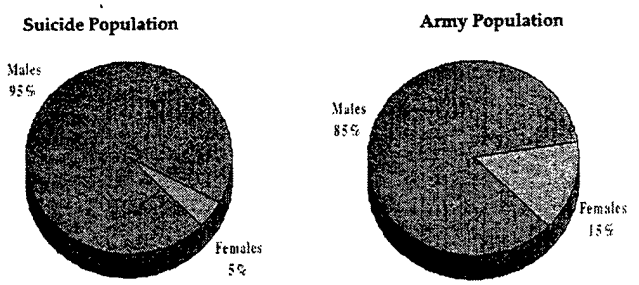


FIGURE 6 MARITAL COMPARISON, NOVEMBER 2000.

Gender



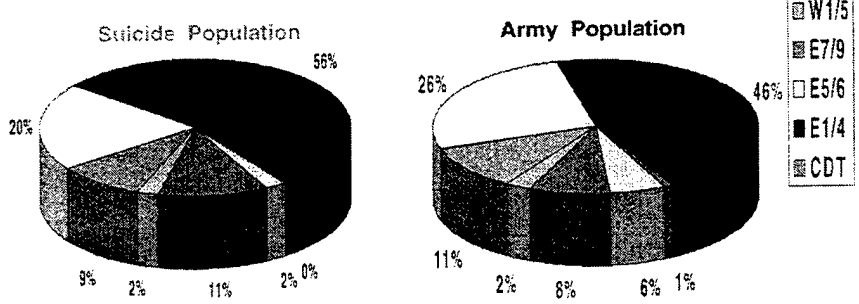
CY	Male	Female
OO	42	2
99	68	3
98	67	1
97	56	0

AS OF 9 November 2000

Human Resources Directorate

FIGURE 7 GENDER, NOVEMBER 2000

CY 00 Comparison By Rank



	FG	01/03	W1/5	E7/9	E5/6	E1/4	USMA
Suicide Population	1	5	1	4	9	24	0
Army Population	26,561	38,133	11,605	50,992	124,793	217,737	4,089

AS OF 9 November 2000

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FIGURE 8 COMPARISON BY RANK, NOVEMBER 2000.

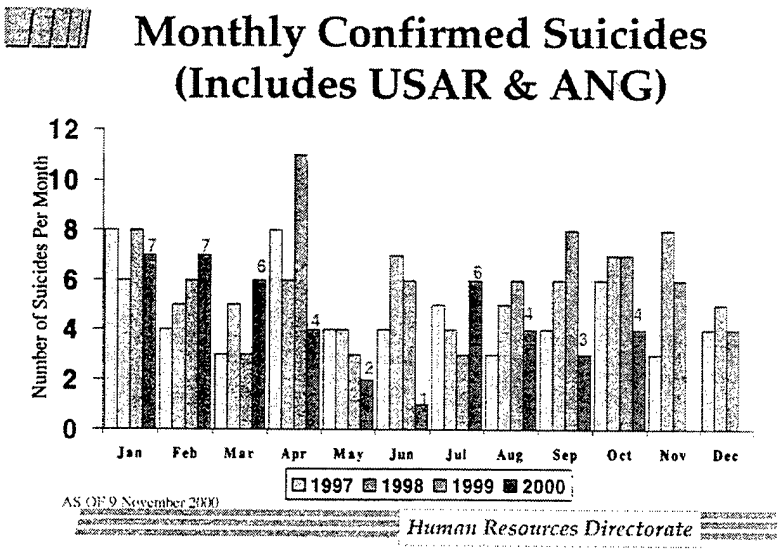

FIGURE 9 MONTHLY CONFIRMED SUICIDES (USAR AND ANG), NOVEMBER 2000.

Guard/Reservist/RA Suicides Trends

	1995	1996	1997	1998	1999	2000
Guard	3 (4%)	5, 1 (7%)	3 (5%)	4 (6%)	5, 2 (7%)	3, 1 (7%)
Reservists	2 (2%)	1 (1%)	3 (5%)	2 (3%)	5 (7%)	0, 1 (0%)
Regular Army	75 (94%)	61 (91%)	52 (90%)	58 (91%)	63, 3 (86%)	41, 17 (93%)
Total (confirmed plus undetermined)	80	67 68	58	64	73 78	44 63
Total Army Rate (per 100k)	15.73	13.64 13.85	11.80	13.23	15.23 16.27	9.20 13.13
RA Rate Only (per 100k)	14.75	12.42	10.58	11.99	13.14 13.56	8.54 11.67

2000 figures are current totals only, not projections

Red figures represent undetermined deaths

AS OF 9 November 2000

FIGURE 10 GUARD/RESERVE/RA TRENDS, NOVEMBER 2000.

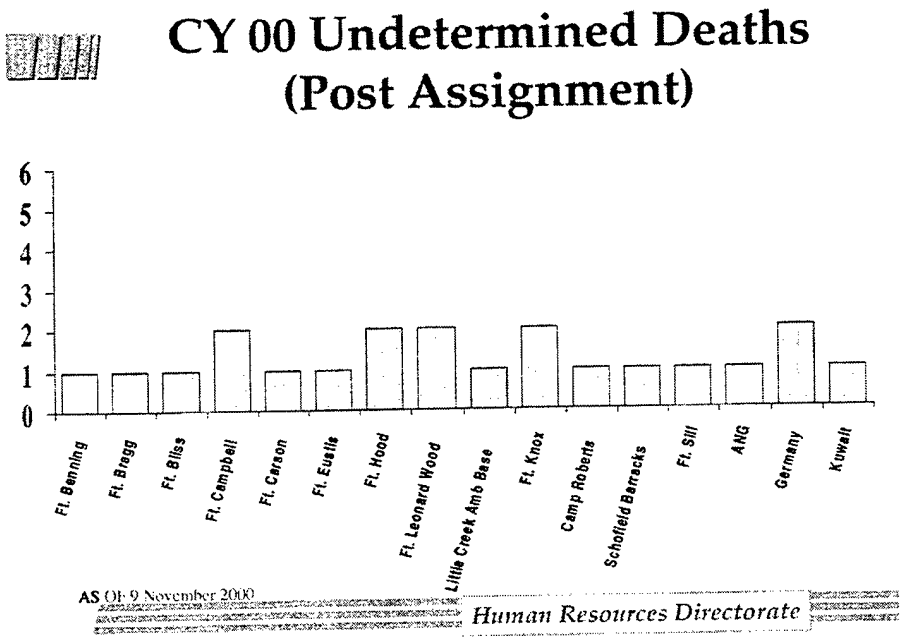

FIGURE 11 UNDETERMINED DEATHS BY POST ASSIGNMENT, NOVEMBER 2000.

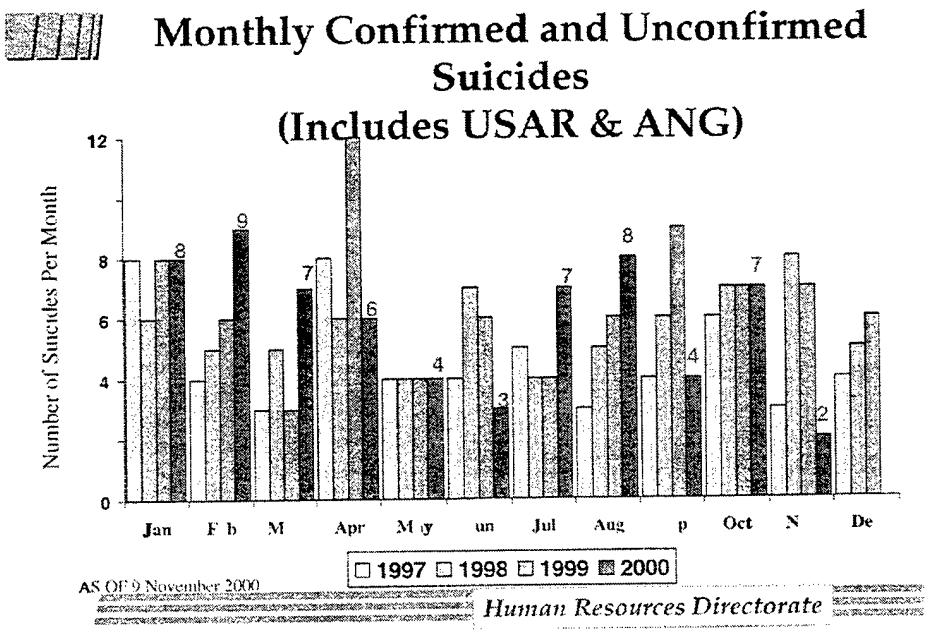

FIGURE 12 MONTHLY CONFIRMED/UNCONFIRMED SUICIDES, NOVEMBER 2000.

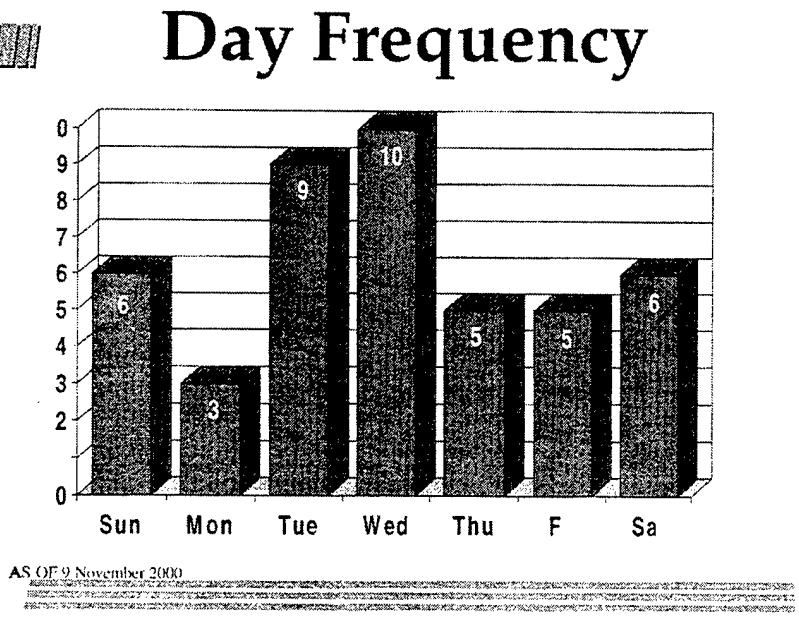

FIGURE 13 DAY FREQUENCY, NOVEMBER 2000.

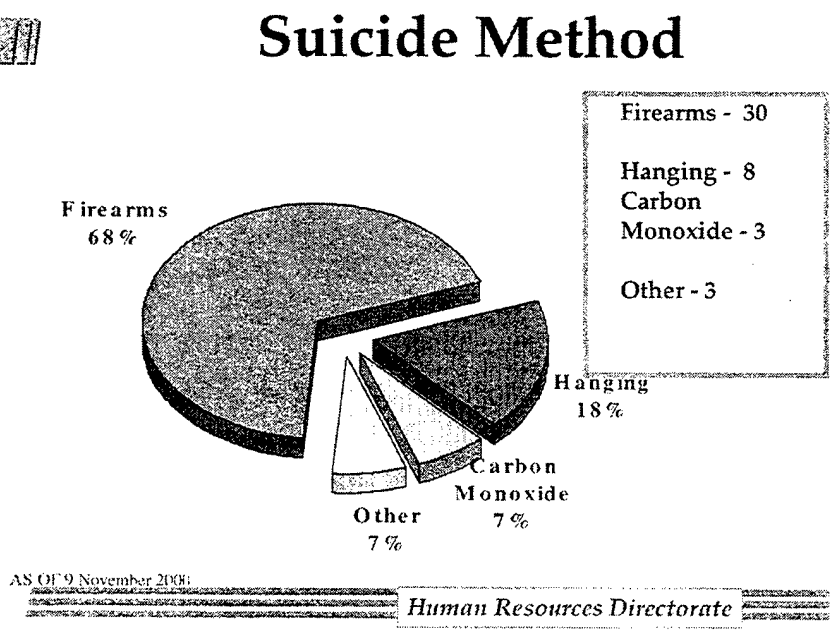

FIGURE 14 SUICIDE METHOD, NOVEMBER 2000.

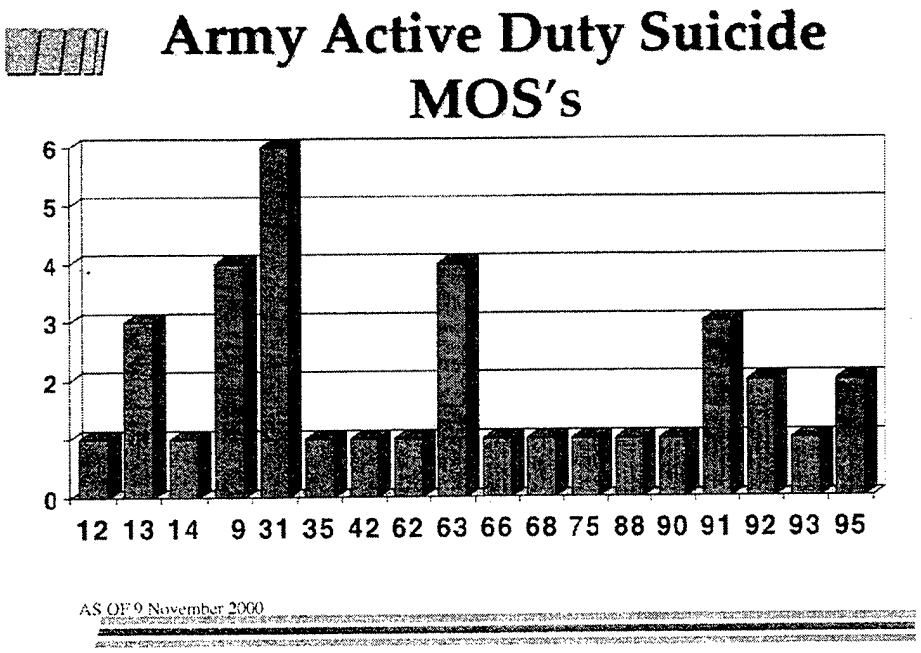

FIGURE 15 ARMY ACTIVE DUTY SUICIDE BY MOS, NOVEMBER 2000.

HOPELESSNESS AND DESPAIR

One of the key elements leading to suicide is depression. Traumatic life events can trigger depression. Chronic illness can trigger depression. Genetic factors can predispose individuals to respond to illness and traumatic events with depression. A traumatic event can be many things; death of a parent, spouse or child, rape, sexual or physical abuse, divorce, financial problems, loss of job or demotion in rank. Catastrophic events like taking someone's life, being a casualty of war or witnessing a traumatic death can also trigger depression, or lead to post-traumatic stress syndrome if the person is not de-briefed and followed by a health care professional or chaplain.

What leads people to the depths of despair and hopelessness? Depression is a dark hole and thoughts of suicide an even darker hole. Hopelessness and despair often comes from a feeling of inability to control the situation, of having no other options. People who are in the depths of despair and hopelessness feel it takes more energy to live than it does to die. Death can be one of the options chosen to eliminate the pain and ultimately take control again. For example, we find in 1Samuel, chapter 31, after King Saul being over-run in battle felt genuinely alone and hopeless. Wounded, he requested that his armor bearer draw his sword and pierce him through with it. He didn't want the enemy to come and make

sport of him. "But, his armor bearer would not, for he was greatly afraid. So Saul took his sword and fell on it. Thus, Saul died with his three sons, his armor bearer, and all his men on that day together." [6] When using this illustration, it is imperative to understand that this was Saul's choice, not God's plan. We find throughout the Bible, God communicates that His hope is available and that we as chaplains and unit ministry members need to be an encouraging vehicle sharing God's love and hope with all of our soldiers and family members.

WHY IS INTERVENTION NECESSARY?

Intervention has been defined as one of the last methods that may work when everything else fails. From a psychological perspective, a crisis can result when an individual finds himself or herself unable to cope with a challenging or aversive situation. Psychological homeostasis is destroyed at that point and a dysfunctional spiral of distress and decomposition is initiated in response to this failure of usual defenses and coping mechanics. Crisis has been defined as a condition wherein an individual meets an obstacle or challenge that proves insurmountable through the use of usual coping or problem-solving mechanisms. This condition results in a subsequent state of emotional discord and decomposition. Common cognitive symptoms may include cognitive distortions or a decrease in decision-making capabilities. Affective symptoms could include panic, anxiety and/or depression.[7]

Most simply, crisis intervention is the provision of **emotional first aid**. The crisis intervention is an exercise in psychological **damage control**.[8] Whether a mild crisis or an acute trauma situation, the concept of emotional first aid remains applicable. One way the crisis can be offset is through the uses of a telephone hotline. The National Crisis Hotline Center states that in the last twenty years the state of California has evidenced a 25% decrease in overall suicides and suicide attempts through what they believe is from the use of a hotline.[9]

Most people attempt to change a person or situation through education, reason, and discussion. If this fails however, frustration may lead to isolation and withdrawal. One of the critical ways that intervention is used in the life of a person who is going through thoughts of self destructive behavior is one-on-one contact and follow-up through un-intimidating suggestions to help alleviate the crisis. In order to have a successful intervention the chaplain or mental health worker must take the time to discuss the details of the problem

with the soldier and family members if available. If the family is available the form of intervention can be discussed. The discussion includes who should be included in the intervention, the development of education and treatment plans, develop the intervention plan and schedule, and then execute the plans. The shared goal of the ***intervention*** allows them (the soldier and family) to **transform** the **helplessness** that has isolated the soldier from getting critical and needed help into feeling purposeful caring from another person. This communicated caring can be the beginning of the transition from helplessness and hopelessness to where the soldier can understand that hope can be rekindled in their life if they are willing to follow the counsel of the chaplain or mental health worker through the intervention plan.

Of equal concern, the little that is known about interventions is too often simplistic, distorted, incorrect, overstated, understated or misconceived. For example, the public generally believes an intervention to be an aggressive, intrusive, attack of some kind, rather than being, as it should be, the kindest and most loving thing a friend, family member, or counselor can do for someone who is in crisis.[10] What should be the objective of the intervention? The relief of suffering is the underlying agenda of any intervention. Changing the self-destructive behavior at the root of suffering or crisis is always the focus regardless of the form an intervention may take. Another critical aspect of intervention is the ability of the chaplain and/or mental health worker to communicate a sincere trust and acceptance of the person and of the problem without being judgmental or skepticism. This, without question, will involve some degree of specialized training in the areas of identification and planning to introduce intervention into the life of the soldier.

This proposed intervention model will:

- Help intervene/prevent suicides from occurring
- Intervene/prevent problems from worsening and becoming insurmountable
- Intervene/prevent the circumstances which lead to problems
- Intervene and teach soldiers and families how to manage their own lives, while providing alternatives and support resources when needed
- Teach better coping skills and early identification signs of potential crisis
- Reduce the sense of isolation
- Provide mutual comfort and support

- Reduce stigmatization
- Identify common issues and goals
- Encourage mutual help
- Normalize the experience
- Restore individual and unit pride

Intervention truly starts with the first inquiry for intervention help and will normally last well beyond intervention day. However, hope and ambivalence and fear are common for many people embarking on an intervention. Accordingly, intervention can sometimes be very stressful. Therefore we need to remember the fundamentals. First of all, no one can predict with certainty how the soldier might react. Acceptance, anger, relief, hope, and confusion can sometimes be present as intervention begins. Even though these may be manifested in some way intervention, if explained simplistically with a caring communication almost always will generate hope and trust in the caregiver.[11]

While many threats confront strategic leaders, none is more lethal than the internal threat of despair that leads to suicide. Future leaders need an in depth understanding of the complexities of suicide. Thus strategic leaders must, above all, be people of hope in the face of despair.[12]

One source of hope lies in the assurance of God's faithfulness and the thought that God never changes provides a reassuring truth. To commit ourselves to the care of His never changing ***stability*** is a demonstration of His faithfulness and assures us that hope is available.

SURVEY AND SURVEY RESPONSES

A survey given to approximately 300 Active and Reserve Component soldiers substantiates the need for and benefits of the Army's Intervention Program. Suicide impacts this generation of soldiers more than ever before.

Survey Questions

1. Do you know anyone who ever seriously thought about committing suicide?

   67 yes (27%) 179 no (73%)

2. Why do you think soldiers commit suicide?

In looking at the responses 90% of the soldier's felt that too much stress was the key factor in finding a reason why soldiers commit suicide. Furthermore soldiers felt people commit suicide because of the following feelings; they feel overwhelmed, they may have chronic depression, loss of hope, lost control of my life, they have too many personal and professional conflicts, feelings of being trapped, lack of options, don't like being away from their family, loss of individuality, family and financial problems, and too much distress.

3. Do you believe an intervention program is needed in the military? Why?

80% needed Why?

An overwhelming number felt an intervention program is needed. An intervention program is needed to prepare and teach soldiers how to deal with problems, to teach them there are other options, to make them aware things aren't as bad as them seem, today's soldiers are too weak and need to be taught how to cope, an intervention program shows we care for each other, it promotes teamwork within the unit, it is not learned elsewhere, it helps morale, and if you have a program available to help soldiers they will utilize it.

4. Why do you think soldiers commit suicide while in the military?

90% of the soldiers responded with feelings of hopelessness and depression as the main reason soldiers commit suicide in the military. Some of the other reasons given are because they can't handle the stress whether personal or job related, that there are too many environmental changes, they have low self worth and low self esteem, they can't deal with adversity, they are unable to cope and have no coping mechanisms to help them learn how to cope, they have a lack of self discipline, they are too weak minded, they have no sense of direction, they lack of purpose to life, they are a failure in civilian life, they feel isolated, they feel no-one truly cares, they have too many financial problems, too many family problems, too many pressures of deployment and possible deployment, they are unable to resolve their problems, the problems seem to be magnified in the military, they feel like they are cut off from people, they feel they have no outlet to use nor any place to go to get relief, and they have no place or person that they can trust to ventilate or talk to.

5. What does the military do (or not do) that might cause someone to think about or commit suicide while in the military?

Soldiers felt there is not enough training in suicide prevention, they feel unappreciated by the military, that there are too many deployments, they feel that there is poor leadership, they feel the mission is put first and your needs are put last, the military makes things harder than they really are or need to be, deployments place too much stress on my family, the military is too concerned about being politically correct than in finding out what the truth really is, they are trying to discipline soldiers who are undisciplined, there is insufficient counseling for soldiers available, they feel that soldier's complaints are not taken seriously enough, that the leaders don't care, there is no response to soldiers needs, they would like to see more suicide prevention services, and the soldiers need to be paid more.

6. What can the military do better to help those who might be thinking or planning suicide?

The military can help by taking soldiers complaints more seriously, first line supervisors need to know their soldiers better, they can teach leaders how to better recognize warning signs, they can do a six month screening process on each soldier looking for problems to stop them before they get worse, we need more training on early warning signs, they can build a greater sense of purpose, they can have group counseling available, create outlets of relief, eliminate the stigma to those seeking counseling, they can have better pay and housing, they can have professional help available, they can provide more services and resources for counseling, assure confidentiality, they can have more awareness programs briefed, they can provide better care for families, give more respect for being a soldier, remind the leaders that chaplain's are available, early detection of those with problems, send them to the proper people i.e. mental health worker or chaplain or make sure it is reported to the first line supervisor, they can change the soldiers surroundings and take them away from the problem and the surroundings while they get help.

7. Do you think the military really does care about suicide prevention among the troops? Why?

181 yes (61%) Why?

Soldiers believe the military does care about a suicide prevention program because it saves personnel, suicide causes bad morale, suicide in a unit makes the commander look

bad, it devastates unit cohesiveness and the unit commander, it costs too much to retrain the soldier, if can effect retention, it's bad for recruiting, if you take care of the soldier; he will take care of you, loss of a soldier hurts everyone and makes us look bad to the public.

42 no (7%) Why?

Soldier's felt the military doesn't care because they try more to be politically correct than showing that they care, it happens too often therefore they don't care, the issues regarding suicide are kept too quiet, some people just don't care, and there is not enough training in suicide.

8. Have you experienced anyone committing suicide while in the military?

23 yes (8%) 245 no (91%)

9. What can the Chaplain Corps do, to better serve you and others in this area?

90% of the soldiers want the chaplains to be more available and more visible. In addition they want the chaplain's to provide more counseling, more services, more briefing to inform how the chaplain is available, to make more appearances at the company level (once per week if possible), more frequent visits to the unit with time available for one on one counseling, assign more chaplains, have more chaplains assigned to match the op tempo, chaplain's need to be more in touch with the soldiers needs, soldiers want to feel a greater connection with the chaplain, talk to soldiers more, more easily accessible in private, make the suicide prevention programs more accessible, go out to the units and give classes, open up more counseling opportunities, communicate soldiers problems and concerns to the highest level, teach seasoned soldiers to mentor green ones with what to expect, make a stronger presence in the day to day activities of the unit, spend more time with the troops just hanging out, try to identify disturbed soldiers, and be more available.

10. Do you believe a chaplain can help you? Would you trust a chaplain in helping you or another soldier needing counsel?

180 yes (89%) 22 no (11%)

The response was the same to both parts of the question.

11. Do you believe suicide can hinder deployments? Why?

230 yes (88%) 32 no (12%)

An overwhelming 90% identified that deployments can be hindered because suicide hurts morale. They also felt it causes fear, it causes preoccupation with the suicide rather than completing the mission, and causes others not to perform their duty to the fullest because they are thinking about the suicide.

12. Do you believe faith in God can change ones direction from suicide? Why?

223 yes (87%) 32 no (13%)

90% of the responses felt that hope in God is what changes ones direction. They said faith changes things, faith is the positive influence over depression, they believe in God's promises, faith gives me hope and knowledge of spiritual help, gives me understanding, faith teaches that God is always there, faith gives strength, a reason to live, something to hold on to, it helps me solve my problems, God can resolve my problems, God listens when I talk, God is somebody you can believe in, God conquers all, He gives me hope and a better direction for my future, God truly loves me, God cares about everyone, my faith gives me hope, God truly does take care of me, God doesn't like suicide, suicide is not God's answer to the problem, God can carry the burden, and He gives me purpose to live.

13. Do you believe God cares about the person who may be thinking about suicide?

240 yes (92%) 22 no (8%)

Survey Approval Authority: U.S. Army Research Institute For the Behavioral and Social Sciences
Survey Control Number TAPC-ARI-AO-01-03
RCS: MILPC-3

CONCLUSION

In the last ten years suicide has increased as a method of relieving life's hopelessness. Suicide is being embraced as a possible course of action if problems or circumstances become either unbearable or no solution can be found. However, soldiers

answering this survey say they desire more resources available to help understand the problem. They obviously are very trusting of the chaplain corps or the mental health worker where they are asking for more opportunities to learn about crisis intervention and confidential counseling. Soldiers today want the camaraderie that the military can and does provide because of lack of family at home or who have never experienced the closeness of a true friend. Therefore loss becomes more catastrophic and devastating to a soldier who cannot cope or who hasn't learned the skills necessary to cope with the problem. Soldiers need, want and deserve encouragement. The question is, how is that going to be accomplished? I believe this is where the chaplain's corps can take the lead working with and supporting the commanders on this issue. We have already heard from the soldier that they want to see and hear from the chaplain. Chaplain's and the Unit Ministry Team (UMT) have a great opportunity to mentor and disciple soldiers who obviously want and believe in God's direction and comfort through the chaplain's ministry. They have clearly identified that God can provide strength for them during hard times. Their hope is renewed and their purpose is well defined through spiritual guidance and self-discipline to keep them focused on their purpose and mission at hand.

RECOMMENDATIONS

I recommend that an active duty and reserve post be used as a test site to develop a 24/7 crisis hotline. It may be beneficial for the Army to look at teaming up with the local mental health hotline system as joint partners. The results should be examined at the end of one year. The hotline system needs to be frequently briefed to the soldiers and highly visible in places often visited by the soldier. The installation chaplain and unit ministry team along with the mental health professional can develop a highly visible prevention/intervention program. Specialized training for the unit ministry team (UMT) must be provided in triaging calls and basic crisis intervention response. Working with family life centers to incorporate those classes already offered in finance, family, and domestic violence. This plan will give the soldier one place to start, one phone call to make and the availability to get the help he/she needs.

WORD COUNT: 4502

ENDNOTES

[1] COL. Robert W. Thomas, PhD., "History of the Army Suicide Prevention Program" electronic mail message to John South from LTC Glen L. Bloomstrom, bloomgl@occh-at.army.mil, Accessed 20 December 2000.

[2] LTC Gregory L. Black, "Army Structure Helps Prevent Suicide" (AMEDDS Mercury Monthly Periodical, 2000), 8.

[3] Ibid.

[4] Department of the Army, Suicide Prevention, Army Regulation 350-6 (Training and Doctrine Command Fort Monroe, Virginia, U.S. Department of the Army, 30 November 1998), 3-39.

[5] Rex Becker and Sharon Llewellyn, "Countering Family Violence Among Soldiers," Soldiers (August 2000): 5.

[6] Samuel, " I Samuel," Holy Bible, (Nashville: Broadman and Holman Publishers, 1985), 260.

[7] Jeffrey T. Mitchell and George S. Everly, Jr., "Critical Incident Stress Debriefing", (Chevron Publishing Corporation, 1997) 67.

[8] Ibid., 68.

[9] National Hotline Center, Baltimore, MD.

[10] Bruce Singh; Rachel Jenkins, "Suicide Prevention Strategies-An International Perspective", International Review of Psychiatry (February 2000): 7.

[11] Vernon E. Johnson, "What is Intervention?", International Review of Psychiatry (February 2000): 19.

[12] Douglas S. McLeroy, "The Strategic Leader and Despair,"Stinet ADA 326645 (April 1997): 1.

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United Nations. "Prevention of Suicide-Guidelines for the Formulation and Implementation of National Strategies" Department of Policy Coordination and Substantial Development, (June 1996)