Suicide Prevention and Intervention Efforts in the Navy and Marine Corps

Hosted by HPW Department in Collaboration with Navy Suicide Prevention Branch (OPNAV N171) and Marine and Family Programs

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Presenters

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Webinar Courtesy

- Good Afternoon and thank you for joining us!
- We ask that all participants please mute your phone lines either by pressing *6 or the mute button on your phone.
- Please do not put your phone on hold at any point during the call.
Objectives

- Describe current evidence-based suicide prevention and intervention efforts across the Navy and Marine Corps.

- Communicate the importance of recognizing and understanding the factors that put Sailors and Marines at risk for suicide.

- Identify helping resources available to Sailors, Marines, and their families across the Department of the Navy (DoN) and Department of Defense (DoD).
Every Sailor, Every Day

1 Small ACT
It's about being there for every Sailor, every day.

Evidence-Based Suicide Prevention and Intervention Tools for the Fleet

September 1, 2015
OPNAV N171 Current Efforts and Priorities

Changing Culture, Reducing Barriers

- New scenario-based SP GMT released to Fleet
- New “Every Sailor Every Day” video produced by BUMED and distributed to all commands
- Deployed Resilience Counselors and Embedded Mental Health Providers
- Communications alignment with Action Alliance Framework for Successful Messaging
- OSC course mandate (NAVADMIN 262/13)
- NECC and C10F community specific training

Multi-Organization Collaboration

- Suicide Cross Functional Team (O6) reestablished
- Strengthened partnerships with Navy and Marine Corps Public Health Center, Navy Reserve Force, Real Warriors Campaign
- Defense Suicide Prevention Office coordination

Evidence Based Tools and Policy

- Rollout of Columbia Suicide Severity Rating Scale and VA Safety Plan training for gatekeepers
- Chief of Chaplains’ FY15 Chaplain Professional Development Training, “Pastoral Care in Suicide Prevention, Intervention, Postvention”
- NAVADMIN 263/14 implementing Under Secretary of Defense memo guidance for reducing access to lethal means through voluntary storage of privately owned firearms

Assessment and Analysis

- Released findings from 2012 Navy suicides annual case review (“Deep Dive”) and just completed review of 2013 suicides conducted by multidisciplinary team of experts
- Completing studies with USUHS, NMCPHC, Naval Postgraduate School, Centers for Naval Analyses

Analysis of Fleet feedback to shape efforts
OPNAV N171 partnered with Navy Chaplain Corps to enhance the pastoral care skills of chaplains and religious program specialists in suicide prevention, intervention and postvention.

- **Columbia Suicide Severity Rating Scale (C-SSRS):** Suicide risk assessment tool proven to detect both suicidal ideation and suicide attempt risk when used by clinicians and non-clinicians alike, with the ability to capture “missed” referrals of individuals at high risk. Average administration time is 1-2 minutes.

- **VA Safety Plan:** Evidence-based intervention tool that can be administered by non-clinicians to help at-risk individual identify positive coping strategies, contacts that may distract from crisis, professional resources and means reduction.
• Most recent data available for Deep Dive conducted in September 2014, reviewing 58 AC and 8 RC Navy suicides that occurred in 2012.

• Findings yielded recommendations for increased vigilance when:
  – Intimate relationships ending or in danger of ending (break-up, separation, divorce, death of loved one);
  – Sailors experience occupational, academic and/or disciplinary/legal issues that can potentially damage reputation or career; and
  – Sailors in transition period (e.g. PCS, advancement, retirement, transition to civilian sector, etc.).

• Barriers to seeking help due to perceived occupational risk still exist among Sailors and families.

• Failure to “connect the dots” and communicate warning signs detected by commands, providers, family members, or peers was found (most evident during transition periods).
2012 Chain of Events and Observations

**History**
- Trauma/Abuse (Physical, Sexual, Emotional): 38%
- Mental Health Treatment in past year: 33%
- Substance Abuse: 29%
- Prior Suicide Related Behavior: 27%
- Prior Suicide Attempt: 17%

**Stressors**
- Relationship Problems: 53%
- Recent Career Transition: 44%
- Disciplinary/Legal Issues: 38%
- Significant Career Problems: 36%
- Physical Health: 35%
- Significant Loss: 29%
- Financial: 29%
- School/Training Issues: 11%

**Disrupted Social Network**
- Demotion, PCS: 38%
- Retirement: 21%
- On/Off Active Duty: 21%
- Separating from Navy: 17%

**Contributory Risk Factors**
- Recent Event Causing Feelings of Helplessness: 42%
- Shame, Guilt, Loss of Status: 50%
- Feelings of Rejection/Abandonment: 36%
- Pattern of increased alcohol/drug use: 27%

**Judgment Factors**
- Sleep Problems/Restlessness: 45%
- Anger: 38%
- Under the influence of Alcohol: 33%

**Access to Lethal Means**
- Access to Firearms: 53%
- Firearm Ownership: 26%
Reducing Access to Lethal Means

- **NAVADMIN 263/14** states that commanders and health professionals may ask Sailors who are reasonably believed to be at risk for suicide or causing harm to others to voluntarily allow their privately-owned firearms to be stored for temporary safekeeping by the command.

- Working with Navy Medicine and DoD to incorporate information on means restriction in Navy-wide suicide prevention training (e.g., removal of firearms from the residence). This will place greater emphasis on the importance of limiting access to lethal means of suicide for those deemed to be at risk.

**Lethal Means Reduction**

- Firearms used in half of all Navy suicide deaths in 2012 and 2013, and continue to be the primary method used in both military and civilian suicides.
- Reducing access to lethal means has been proven to save lives.
- Voluntary measures proven to interrupt the impulse and allow time to seek help, providing the opportunity for care and recovery.
• **1 Small ACT:** new message within *Every Sailor, Every Day* campaign, focusing on simple actions that can make a difference and ultimately save a life.

• Navy Suicide Prevention Month is launch-pad for tailored deckplate engagement throughout the fiscal year. Key initiatives for 2015 include:
  - **“1 Small ACT” Photo Gallery:** Members of the Navy community or general public can submit photo holding up “1 Small ACT” sign personalized with an example of a small act that they can perform to make a difference in shipmates’ lives. Image gallery will be housed on Facebook from Sept. 1, 2015 – Aug. 30, 2016.
  - **“1 Small ACT” Toolkit:** Downloadable resources for suicide prevention coordinators to assist with planning local efforts. Includes posters, social media posts, key messages, graphics, “1 Small ACT”-a-Day Calendar, partner organization resources and more.

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Online  
Navy Suicide Prevention: www.npc.navy.mil/bupers-npc/support/21st_Century_Sailor/suicide_prevention/Pages/default.aspx  
Navy Operational Stress Control: navstress.wordpress.com  
Facebook: www.facebook.com/navstress  
Twitter: www.twitter.com/navstress  
Issuu: www.issuu.com/opnavn171
USMC Suicide Prevention Model & The Marine Intercept Program

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01 September 2015

“Keeping Faith”
USMC Prevention Approach

Integrated Community Based Public Health Model

Institute of Medicine Model

Ecological Systems Model

Joiner’s Interpersonal Theory of Suicide

USMC Suicide Prevention Approach

“Keeping Faith”
Community Care for Suicide Risk

Suicide Care in Systems Framework
National Action Alliance for Suicide Prevention, 2011

- Cooperation and communication across these multiple levels of care is critical
- Care for risk must be comprehensive and continuous until the risk is eliminated
- The person at risk is everyone’s responsibility
- Each setting has a critical role in verifying that the subsequent supportive services have the information and resources they can provide
- While some organizations may be able to deliver a full continuum of care, collaborative service arrangements will be required for others

Commanders
- Accountable for Marine welfare and mission
- What can I know?
- Reintegrate Marines

Community Counseling Program
- Community focused and situated
- Non-medical counseling
- Does not determine duty status, Med Board, Ad Sep, etc

Navy Medical
- Medical-focused care
- Patient volume
- HIPPA – What can I tell?

"Keeping Faith"
In 2013, Headquarters Marine Corps (HQMC) Behavioral Health Branch (MFC) and Wounded Warrior Regiment (WWR) partnered to develop an evidence-based response that could address risk for Marines who expressed suicide ideation or attempt (SI/SA). WWR attempted to reach these Marines, with a 10% success rate.

Reviewed the research for effective means of addressing risk:

- Fast contact after SI/SA
- Caring contact reflecting availability, empathy, and concern
- Continuous contact at intervals
- Focus on highest risk time period
- Use of evidence-based suicide risk assessment (C-SSRS)
- Create and update a Safety Plan, an evidence-based tool
- This type of outreach has been shown to increase treatment compliance
- SI is strongly correlated with death by suicide
MIP Process

Purpose
- Rapid Assistance
- Ongoing risk assessment
- Focus on period of highest risk
- Increase use of existing services

Command

Reports
- SIR
- PCR

Contacts
Installation
CCP

Contacts
- Command
- Marine
  - C-SSRS
  - VASP

Receive
- On-going contact, 90 days
- Scheduled follow-ups

Voluntary Services:

Command Offered:
- POC to assist in tracking the Marine's care and resources
- Assistance with re-integration
- Status and updates from MIP Outreach Coordinator

Marines Offered:
- Counseling Services
- Care Coordination with existing services
- System Navigation
- Continuous caring contacts, risk assessment and updated safety plan
- Reintegration assistance

Benefits
- Can prevent suicides
- Leverages Commanders' influence
- Eases system navigation
- Provides POC for commander feedback
- Enhances reintegration efforts

“Keeping Faith”

v.1 04 August 2015
Some Initial Reactions

Commanders:
- We have too many “programs” already
- My Marine is covered: Emergency Dept. evaluation, inpatient treatment, appointment with hospital mental health clinic, medications, inpatient substance abuse treatment, Force Preservation Council
- This is an over response to SI: just a bad day, everyone thinks about it, Marine was intoxicated, malingering, flippant comment, medical said Marine is “low risk”
- Protect Marine: “They don’t want to hear from a stranger who knows about this”

Medical Providers:
- Suicide involves serious risk so this belongs only with medical
- Why is CCP getting involved? Marines will be experience confusion with dual “providers”
- We already have the Marine’s care covered

Counselors:
- When I cold-call them, Marines won’t like that I know this very private information
- I don’t think I am ethically covered talking to CO’s about my interactions with the Marine
- What do I say to CO’s? What if they turn me away?

“Keeping Faith”
Military personnel released from a psychiatric hospitalization were:
- 5x more likely to die from suicide
- Risk of dying from suicide within 30 days 8.2x higher than one year after hospital

Nationally:
- About half of psych inpatients receive outpatient mental health care within first week after discharge
- About two-thirds receive mental health care during the first month

A recent survey (n = 325):
- 25% of emergency department physicians felt confident in their ability to create personalized safety plans for suicidal patients
- Only 50% knew how to find these patients appropriate specialized care

Medical intervention is important in many cases, but not enough….
(From peer-reviewed studies. Citations available in back-up slides)

“Keeping Faith”
**Initial Look at MIP Impact**

Average number of days between ideation/attempt and first post-incident behavioral health appointment

- **Pre-MIP**: 11.5 days
- **MIP**: 4.6 days

- MIP cases access care faster
- MIP cases missed fewer appointments
- MIP cases access specialty care more often

*Data provided by NMCPHC

**“Keeping Faith”**

v.1 17 July 2015
• Marine expressed ideations of suicide. Marine transferred to a new command due to pending deployment
  o Receiving command not notified and assigned Marine as Rifle Range Coach
  ✓ MIP intervened, informed command and Marine was reassigned duties

• Marine barricaded himself in apartment threatening to kill himself. Immediate threat safely abated. During hospitalization Command discovered additional homicidal threat concerns
  o Command experienced difficulty navigating the system of care.
  ✓ MIP intervened and guided Command to ensure the Marine received proper care

• Marine with SI and plan to shoot himself while in his dress blues
  o Hospitalized and released to MIP & Community Counseling (Adjustment Disorder)
  ✓ Developed insight that transition into military and fear of failure was overwhelming
  ✓ Promoted, continued to be a leader, and turnaround won command approval of MIP
• MIP leverages SIR/PCR reports to deliver support, and thus brought emphasis to requirements to report SI/SA
• Increased identification of suicide risk, and the reports that followed, have coincided with a marked decrease in death by suicide

"Keeping Faith"
“Suicidal ideation, such as the wish to die during sleep, to be killed in an accident, or to develop terminal cancer, may seem relatively innocuous, but it can be just as ominous as thoughts of hanging oneself. Although passive suicidal ideation may allow time for interventions, passive ideation can suddenly turn active.”


Our goal is not framed strictly as stopping a Marine’s death by suicide, rather it is ending distress. Ending distress stops death by suicide.

MIP provides continuous assessment (C-SSRS) to check if ideation worsens; and skills (Safety Plan) to help Marines manage distress.

“Keeping Faith”
Key Points

• **A voluntary** service offered to the Marine by licensed CCP counselors
• Offers the command feedback regarding Marine’s status
• Is unique, does not duplicate or replace existing services (still needed if the Marine is an inpatient or has outpatient therapy set up)
• Is *outreach* NOT treatment (although treatment needs will be arranged, if absent)
• Does not interfere with existing services but may increase compliance with existing treatment
• Maintains a collaborative approach with healthcare providers and command leadership
• Provides continued risk assessment at intervals throughout the highest risk period
• Empowers Marines to enhance their coping skills
• Informed by research findings and recommendations

“Keeping Faith”
• Messages from CCP trying to reach your Marine need quick response
• No existing services replace what MIP offers.
• Provide contact information
• Automatic separation is not an appropriate response to SI or SA as every case must be viewed independently
• Research has found that those considering suicide usually identify multiple reasons. Not solely to get out of something
• SI, while intoxicated, is always equally serious, often times more risk is present
• If Marine is currently receiving inpatient care, provide contact information now and inform CCP immediately upon discharge. This is one of the riskiest times
• A sense of belongingness is a protective factor. If duties are changed, provide new duties of value and show ongoing genuine concern

“What Leaders Must Know”

v.2 06 August 2015
• Anonymous calls may tap a comfort level for those uncomfortable with traditional intervention (a “way in”)
• MIP is voluntary and centered on “caring contacts,” thus does not place additional expectations on the Marine
• Non-medical counselors can not make duty status determinations
  – No second gain to be made if suspected by command
  – Lessens Marine’s concerns based on perceived risk to career
• MIP is not conducted by the Marine’s therapist
  – Keeps focus on caring contact
  – Marine not entirely lost to follow up if therapy relationship sours
  – MIP outreach can coordinate resources such as arrange new therapist or other needed care
Way Forward: MIP

- Improve rate of successful contact with Commands and Marines
- MIP Plus: model of enhanced services for higher risk cases
- Integrate community partnerships (Chaplains, Family, WWR)
- Staff development for MIP providers
- Promote training and use of CDC standardized definitions and nomenclature

“Keeping Faith”
Way Forward: Key Gatekeepers

Selective Population | Associated Roles
--- | ---
Legal charges / NJP | JAG, Legal Aid, Command, PMO
Alcohol / Substance Abuse | SACC, SACO, SARC
Financial Problems | Command, Financial Counselor
Marital / Blended Family | CCP, FAP, Dependents
Chronic Pain | Primary Care
Existing Behavioral Health Diagnosis | CCP, FAP, MTF Mental Health, PCM
Sexual Assault | SARC, UVA, Nurse
Distress, Hopelessness | Chaplain, Command, ED staff
Job Stress | EO Advisor, Command, EAP staff
PCS, AdSep, Retirement, Med Board | Command, TAP, PCM, PEB staff

Universal training not appropriate when working with a selective population!

• Targeted Training
• Depth of Training
• Specific to Role
• Screening Procedures
• Cross Communication

"Keeping Faith"
Definitions

**Suicide**
Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

**Suicide attempt**
A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt *may or may not result in injury*.

**Suicidal ideation**
Thinking about, considering, or planning for suicide.

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**“Unacceptable” Terms**

- Completed Suicide
- Successful Suicide
- Committed Suicide
- Failed Attempt
- Suicide Gesture
- Manipulative Act
- Suicide Threat

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- 2011 Centers for Disease Control (CDC)
- Adopted by the Department of Defense
- MCO 1720.2 Marine Corps Suicide Prevention Program

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*v.1 04 August 2015*
BACK UP SLIDES
DSTRESS Line

• Anonymous, 24/7 Call Center
• Marine-to-Marine Counseling
• Phone, Chat, or Skype
• World-Wide Capabilities

1-877-476-7734
WWW.DSTRESSLINE.COM
Relevant Policy

MARADMIN 073/14, MARINE CORPS MARINE INTERCEPT PROGRAM (MIP)
MARADMIN 568/13, GUIDANCE FOR TRANSITION TO MARINE CORPS COMMUNITY COUNSELING PROGRAM (CCP)
MCO 3504.2A, OPERATIONS EVENT/INCIDENT REPORT (OPREP-3) REPORTING
  • From Deputy Commandant, Plans, Policies, & Operations
  • Requires SIR for SI, SA, and deaths by suicide
MCO 3040.4, MARINE CORPS CASUALTY ASSISTANCE PROGRAM
  • From HQMC Military Personnel Services (Casualty)
  • Requires PCR for SA and deaths
MCO 1720.2, MARINE CORPS SUICIDE PREVENTION PROGRAM (MCSPP)
  • From HQMC Behavioral Health
  • Requires DoDSER for SA and deaths and references PCR requirement in MCO 3040.4
MARADMIN 236/14, THIRTIETH EXECUTIVE FORCE PRESERVATION BOARD RESULTS
  • Commands are to “ensure all units are familiar with the Marine Intercept Program”

“Keeping Faith”
MFC launched the Marine Intercept Program (MIP) in Nov ‘13.

- In CY14 1,277 cases of SI/SA were identified and reported in MIP
  - 63.2% of Marines were reached and offered services
  - 79.8% accepted
- In CY15 72.9% of Marine were offered, 76.7% accepted
- Since implementation, over 2,000 MIP events have been reported
What is MIP?

Partnership
Commanding Officer (CO), Installation Community Counseling Program (CCP), Navy Medicine, and Headquarters Marine Corps

Evidence Informed Process
• Marine/Sailor is identified with SI/SA, primarily via Serious Incident Report and/or Personnel Casualty Report (SIR/PCR).
• CCP offers services to Marine with assistance of the CO or designee
• CCP encourages Marine to use this outreach to promote a return to hope during the highest risk period (90 days)
• MIP services include:
  – Ongoing suicide risk assessment using the Columbia-Suicide Severity Rating Scale (C-SSRS)
  – Safety Plan (continuously updated)

“Keeping Faith”
• “Roughly one-third of all suicides in the first year following hospital discharge have been found to occur within the first 28 days.”
  …“Discharged patients viewed at being high risk of suicide require immediate community follow-up.”

• “Structured transition programs and aggressive follow-up after hospital discharge are recommended.”

• Better collaboration between mental health service providers and providers of other services, including outreach to individuals with intimate partner problems, may help reduce suicide deaths.”

• “Case management approaches are known to increase service contact and improve patient satisfaction.”
MIP Outcomes

- For CY14 and YTD CY15, one Marine died by suicide just after hospitalization and before being offered MIP. Two Marines died by suicide after receiving one week of MIP outreach and then declining further services.
- Since MIP inception in Nov 2013, one Marine died after accepting services.
- Remaining Marines died by suicide since Nov 2013 were not identified to be in need of services.

Actual MIP Case shared by a CCP Counselor:
“I worked with a SM with a SI where he was going to shoot himself in his dress blues. He was hospitalized and released to [continue counseling] with me in individual therapy. Throughout therapy, this Marine realized the transition into military life and the fear of failure was very overwhelming to him. Through his process, SM became more confident and [reported he] could not believe he had even contemplated suicide. The SM was promoted and continues to be a leader in his unit. The command could not believe how this Marine came around and changed their viewpoint regarding services.”

- MIP is not the answer to prevent suicide, but is a key capability to help Marines at-risk
- Enhances safety and provides skills to manage suicidal thoughts
- Evaluation and therapy with a mental health professional is important but MIP is a separate asset and required to be offered Marines that have had SI/SA

“Keeping Faith”
Ideation is a significant step on the path to suicide and must be addressed. The path from ideation to attempt can be stopped.

86.2% of all 1,201 CY14 cases and 76.7% of all 617 CY15 cases accepted MIP services when Marine reached. Reaching Marines requires full command engagement!

<table>
<thead>
<tr>
<th></th>
<th>Total Cases</th>
<th>Cases with CCP Notification Complete</th>
<th>Cases with Completed Command Contact</th>
<th>Cases with Marine Contact Information Provided</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>CCP did not make contact with Command</td>
<td>CCP completed contact with Command</td>
<td>Command refused to provide contact information</td>
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<td>Command refused to provide contact information</td>
<td>Command provided contact information</td>
<td>CCP pending contact with Marine</td>
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<td></td>
<td></td>
<td>Command refused to provide contact information</td>
<td>Command provided contact information</td>
<td>Marine Declined MIP Services</td>
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<td></td>
<td></td>
<td>Command refused to provide contact information</td>
<td>Command provided contact information</td>
<td>Marine Accepted MIP Services</td>
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<td>CY14</td>
<td>1,201</td>
<td>105 (8.7%)</td>
<td>1,096 (91.3%)</td>
<td>272* (22.6%)</td>
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<td>Through 31 Dec 14 as of 5 Feb 15</td>
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<td>824 (75.2%)</td>
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<td>107 (13.0%)</td>
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<td>104 (12.6%)</td>
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<td>613 (74.4%)</td>
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<tr>
<td>CY15</td>
<td>617</td>
<td>36 (5.8%)</td>
<td>581 (94.2%)</td>
<td>78* (13.4%)</td>
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<tr>
<td>Through 10 Jul as of 17 Jul</td>
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<td>503 (86.6%)</td>
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<td>64 (12.7%)</td>
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<td></td>
<td>105 (20.9%)</td>
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<td>334 (66.4%)</td>
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</tbody>
</table>

* CY14 data includes 49 cases in which command refused to provide contact information that CCP staff were able to contact through other means; of these, 14 declined and 35 accepted MIP services. CY15 data includes 13 cases in which command refused to provide contact information that CCP staff were able to contact through other means; of these, 2 declined and 11 accepted MIP services.

These data are live and subject to change.

“Keeping Faith”
136 suicide attempts by 72 military members

Presented with 33 potential reasons from four behavior categories: Emotion Relief, Feeling Generation, Avoidance/Escape, Interpersonal Influence

• 95% motivated by multiple categories, with an average of 10 reasons
• 100% of suicide attempts were motivated “to stop bad feelings” (emotion relief)
• Only 10% “to get out of doing something,” ALWAYS identified emotional relief as another reason

University of Utah
National Center for Veteran’s Studies


Rationale for Case Management and Caring Contacts

Caring Letters for Suicide Prevention: Implementation of a Multi-Site Randomized Clinical Trial in the U.S. Military and Veteran Affairs Healthcare Systems. Luxton et al., 2013. Journal of Contemporary Clinical Trials

Caring Text Intervention: Military Continuity Project
Kate Comtois, Michael McDonell, and Richard Ries. Military Suicide Research Consortium Preliminary Findings, 2013

Management for the Prevention of Suicide Reattempts
Wei-Jen Chen, Cheng-Chung Chen, Chi-Kung Ho, Ming-Been Lee, Guei-Ging Lin, Frank Huang-Chih Chou Community Mental Health Journal December 2012, Volume 48, Issue 6, pp 786-791 Community-Based Case

Home-Based Mental Health Evaluation (HOME): A Multi-Site Interventional Trial Bridget Matarazzo, PsyD

Methodology for Providing Follow Up Contacts


Management for the Prevention of Suicide Reattempts


Importance of Quick Follow Up


Link Between Suicide Ideation, Attempt and Death


Questions?

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“Keeping Faith”
NMCPHC HPW Department Helping Resources

- Suicide Prevention Web page
  - Suicide Prevention Coordinators
  - Leaders
  - Clinicians
  - Behavioral Health Providers
  - Other Helping Professionals (e.g. chaplains)
HPW Department Helping Resources

- **HP September Toolbox**
  - Planning Ahead Documents such as Message for Commanding Officer and Activity Ideas
  - Posters
  - Infographics
  - Fact Sheets
  - Guides and Brochures
HPW Department Helping Resources

- Navy Leaders Guide For Managing Sailors in Distress
- Relax RelaxToolkit
- Psychological and Emotional Well-Being Web page
NMCPHC’s Social Media

- Facebook: https://www.facebook.com/NavyAndMarineCorpsPublicHealthCenter
- Twitter: https://mobile.twitter.com/nmcphc
- Pinterest: https://www.pinterest.com/nmcphc/
DoN Helping Resources

- Chaplains
  - SECNAV Instruction 1730.9: Confidential Communications to Chaplains
  - Contribute to everyday health and wellness of Sailors, Marines, and Families
  - Chaplain Support Fact Sheet
DoN Helping Resources

- Fleet and Family Support Centers
- Marine Corps Community Services
- Medical Home Port Clinics/ Primary Care Clinics / Branch Health Clinics

To locate a resource in your community, visit MilitaryInstallations.dod.mil to search for resources near you.
DoD Helping Resources

- **Military OneSource**
  - Confidential services for service members, reserves, and family members
  - Non-medical counseling
  - New peer-to-peer specialty consultation launched 15 June
  - 1-800-342-9647
DoD Helping Resources

- **Military Crisis Line**
  - Provides confidential support
  - 24/7 call center, online chat, and text messaging service
  - Crisis support for service members or those who know a service member in crisis
  - In Europe, call 00800 1273 8255 or DSN 118 *
  - In Korea, call 0808 555 118 or DSN 118
  - In Afghanistan, call 00 1 800 273 8255 or DSN 111

*In Europe toll free service may not be available to all callers or in all countries*
DoD Helping Resources

- **Marine DSTRESS Line**
  - 24/7, anonymous phone and chat counseling service
  - Marines, attached Sailors, families
  - 1-877-476-7734
DoD Helping Resources

- Real Warriors Campaign [http://realwarriors.net/](http://realwarriors.net/)
Please Answer Poll Question
Discussion and Questions
Additional Questions

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Continuing Education

- NMCPHC is a designated provider of continuing education contact hours (CECH) in health education by the National Commission for Health Education Credentialing, Inc. This program is designated for Certified Health Education Specialists (CHES) to receive 1 Category 1 CECH but only when viewed during the live webinar. If you are a CHES and you viewed the live webinar, email your name and CHES number to: delquesha.f.boyette.ctr@mail.mil.