Instilling Hope. Saving Lives.

If you or someone you know is in need of immediate assistance, use the Military Crisis Line.

➨ **CALL**

1. CONUS: Military Crisis Line 24/7 at 1-800-273-TALK (8255) and Press 1
2. OCONUS:
   - ***Europe:*** *Call 00800-1273-TALK (8255) or DSN 118 (The toll-free service in Europe may not be available through all carriers or in all countries.)*
   - ***Korea:*** *Call 0808-555-118 or DSN 118*
   - ***Afghanistan:*** *Call 00-1-800-273-TALK (8255) or DSN 111*

➨ **TEXT 838255** to be connected to a crisis responder.

➨ **CHAT ONLINE** at www.militarycrisisline.net.

➨ Contact your local Navy Fleet and Family Support Center (FFSC) for assistance during times of transition or stress. To locate the closest FFSC, visit www.militaryinstallations.dod.mil.

LOCAL RESOURCES TEAM:

SAIL Case Manager: ______________________________

FFSC #: ______________________________

Chaplain: ______________________________

Medical Treatment Facility: ______________________________

Behavioral Health: ______________________________

Other: 1. ______________________________

2. ______________________________

SAIL is a cooperative effort between OPNAV N171, the 21st Century Sailor Office's Suicide Prevention Branch, CNIC, FFSP, BUMED, and the Chaplain Corps.

B10/16-06

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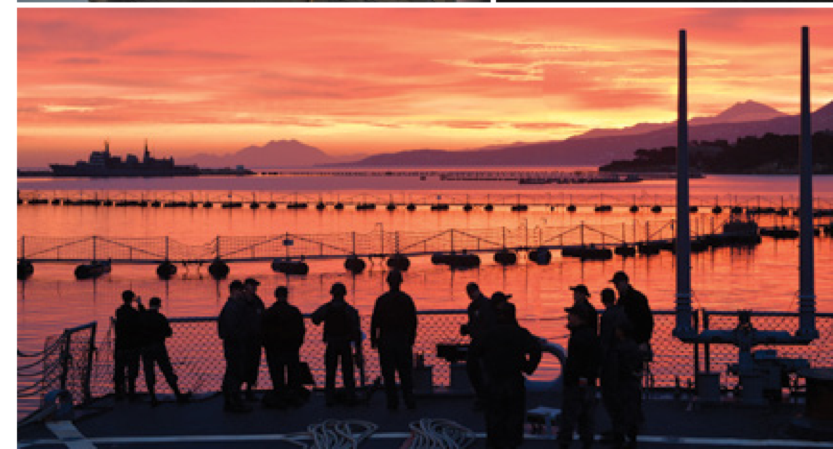

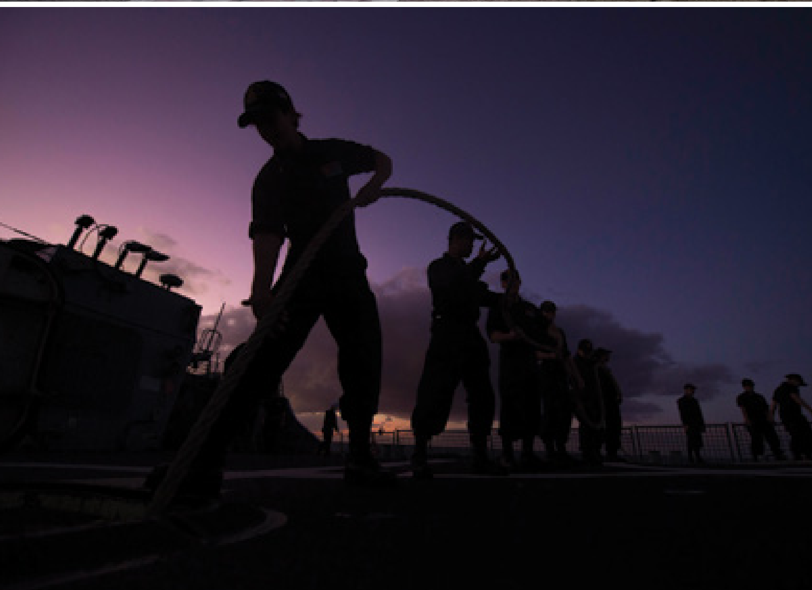

Q: Does SAIL duplicate existing suicide prevention programs?

A: No, SAIL does not replace existing services and it is not a form of treatment. SAIL complements the Navy's current Suicide Prevention Program, which is a cooperative Navywide effort that involves leadership engagement and awareness at all commands and ranks. OPNAV, BUMED, CNIC, and the Chaplain Corps already work together to provide a wide range of suicide prevention and awareness resources, including: mental health treatment, spiritual counseling, personal wellness counseling, crisis intervention, and financial education.

SAIL provides clinical case management services that supplement these resources through ongoing suicide risk assessment and treatment planning and regular collaboration with all support providers, including command leadership and health care providers. Case management services are provided through caring contacts at a minimum of 3, 7, 14, 30, 60, and 90 days after a suicide-related behavior.

Q: Is there stakeholder negligence liability if a Sailor enrolled in SAIL dies by suicide?

A: Negligence would be difficult to substantiate for stakeholders involved in delivery of SAIL program services according to established protocol because the program is voluntary to the Sailor, is not considered treatment, and exceeds the standards of care in assisting someone potentially at risk for suicide.

Q: Given the nature of the issue, are there Privacy Act violations that should be considered?

A: Privacy Act and HIPAA concerns have been considered carefully. SAIL is a voluntary program provided to the Sailor; all PII/health information will be protected in compliance with applicable directives on a need-to-know basis only and stored on secure servers if/when necessary.

Frequently Asked Questions About SAIL

Q: How does a Sailor become involved in the program?

A: A command notifies their SPC when a SRB occurs. The SPC then contacts the Navy Suicide Prevention Branch (OPNAV N171), which forwards the Sailor's information to Commander, Navy Installations Command (CNIC). CNIC contacts the appropriate FFSC SAIL case manager (CM), who first reaches out to the command SAIL representative regarding the incident, and then reaches out to offer SAIL services to the Sailor.

Q: Who is the command's SAIL representative?

A: The command's SAIL representative is the commanding officer. The commanding officer may designate the XO or CMC as the SAIL representative. The SAIL representative should not be the SPC or a peer of the Sailor engaging in SAIL services.

Q: Does every SRB have a SITREP? Are there other ways a Sailor could be referred for SAIL services?

A: Most SRBs will result in a SITREP and the SPC will initiate the referral process noted above; however, there are isolated instances where the SRB does not result in a SITREP. In order for SAIL services to be put in place to benefit a Sailor, the command must be engaged in the process. There may be times where a SAIL CM will contact the commanding officer or their designee to engage in a SAIL referral that has come from outside the SITREP process.

Key Points for Leaders

- SAIL is an outreach effort that provides rapid assistance, ongoing clinical case management, and care coordination and reintegration assistance for Sailors identified during the 90 days after a suicide-related behavior (SRB), the period of highest risk.
- SAIL is not a form of treatment.
- SAIL strengthens the impact of existing mental health treatment and other support by providing coordinating clinical case management services.
- SAIL increases compliance with existing mental health services.
- Risk assessment is continuously updated through a series of caring contacts for a minimum of 90 days.
- The series of SAIL collaborative contacts occur at minimum intervals during the 90-day period of monitoring and provide command leadership:
  - ~ *A case manager POC to track the Sailor's care and referrals*
  - ~ *Assistance with reintegration into normal functioning*
  - ~ *Status updates on the Sailor's progress*
- A Sailor's participation in SAIL is voluntary.
- Sailors are empowered by the opportunity to strengthen their coping skills.
- SAIL procedures are heavily informed by research findings and recommendations.

Testimonial

A young enlisted service member recently expressed a plan to kill himself in his dress blues. He was hospitalized, and then released for outpatient mental health treatment with a series of caring contacts and evidence-based case management services — very similar to SAIL — also engaged. Through these services and command support, this service member realized over time that the transition into military life and the fear of failure had been overwhelming to him, and the pain had been so great that ending his life seemed to be the only answer. He discovered that he did not want to die, but he did want to end the pain. With the support of his case manager, his mental health clinician and command during this healing process, he was empowered to learn healthy coping strategies and build resilience in the face of adversity. He became more confident, and later reported that he could not believe he had contemplated suicide. Ultimately, this service member was promoted and continues to be a leader in his unit. Having seen how helpful these services can be, his command continues to advocate for case management and caring contact support.

Suicide at a Glance

Suicide (su•i•cide) - *Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.*

Approximately **40%** of Sailors who die by suicide had a previous suicide-related behavior.

Previous suicide-related behavior significantly increases the risk of future suicide.

In 2013 in the U.S.

10th leading cause of death in all populations

2nd leading cause of death for those aged 15-34

4th leading cause of death for those aged 35-44

FACT: *__Military__ suicides continue to occur in both __active duty__ and __Reserve components__.*

DID YOU KNOW?

Firearms are the most commonly used method of suicide among males.

Suicide-Related Behavior: *Includes both suicidal ideation and suicide attempt.*

Suicidal Ideation: *Thinking about, considering or planning for suicide.*

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.*

Sources

Defense Suicide Prevention Office:
http://www.dspo.mil/Portals/113/Documents/DoD_Quarterly_Suicide_Report_CY2015_Q4.pdf
Centers for Disease Control and Prevention Violence Prevention:
http://www.cdc.gov/violenceprevention/pdf/Suicide-DataSheet-a.pdfand
http://www.cdc.gov/violenceprevention/pdf/Self-Directed-Violence-a.pdf
Navy Annual Case Analysis "Deep Dive"

Risk Factors

These factors have been found to be associated with suicide and increase the risk of suicidal behaviors. Risk factors DO NOT cause or predict suicide.

- History of depression and other mood disorders
- Past suicide attempts: family history of suicide
- Alcohol and other substance use disorders

- Lack of social support and sense of isolation
- Major physical illness
- Loss of relationship or significant personal loss

- Severe, prolonged or perceived unmanageable stress, and/or anxiety
- Feeling like a burden to others, helplessness
- Easy access to lethal means

- History of trauma or abuse
- Impulsive and/or aggressive tendencies
- Hopelessness
- Job, financial, school, or legal problems

- Life transitions such as retirement, permanent change of station (PCS), or change in job or work duties

Sources
Centers for Disease Control and Prevention Violence Prevention:
http://www.cdc.gov/ViolencePrevention/suicide/riskprotectivefactors.html
Suicide Prevention Resource Center Risk and Protective Factors for Suicide:
http://www.sprc.org/sites/default/files/migrate/library/RiskProtectiveFactorsPrimer.pdf

How Does SAIL Work?

The SAIL Referral Process

Sailor → *Experiences suicide-related behavior*

Command → *Suicide Prevention Coordinator (SPC) reports SAIL information to OPNAV (N171)*

OPNAV → *Receives and tracks SAIL referral information; sends referral to CNIC*

CNIC → *Within 1 business day, sends referral to FFSC clinical supervisor*

FFSC SAIL CM → *Contacts command to verify information and incident within 1 business day, contacts Sailor to initiate caring contact upon receipt of referral*

Sailor → *Accepts voluntary SAIL services, receives caring contacts at a minimum of 3, 7, 14, 30, 60, and 90 days*

Command → *Receives updates from SAIL case manager and Sailor*

The Truth About Sailors and Suicide

***Truth:* Discussing suicide openly promotes help-seeking behavior.**

One of the many reasons Sailors do not speak up about their feelings of hopelessness is because they fear negative perceptions. By starting a discussion, you are not giving a suicidal person morbid ideas or increasing risk. Discussing suicide does not encourage suicide-related behavior. In fact, the opposite is true – bringing up the subject of suicide and discussing it openly is one of the most helpful things you can do. Most people with suicide-related behaviors are open to helpful intervention.

***Truth:* Sailors who talk about suicide aren't just joking around.**

Research shows that those considering suicide usually identify multiple reasons; ideations and attempts should all be taken seriously and not downplayed. In addition, most people who attempt or die by suicide have given some warning. No matter how jokingly it's said, statements like "You'll be sorry when I'm dead" or "I can't see any way out" may indicate serious suicidal feelings that shouldn't be ignored.

***Truth:* A non-fatal suicide attempt should be taken seriously, not downplayed as an attention-seeking act or the result of alcohol.**

Suicidal behaviors must be taken seriously, especially if the individual is using drugs or alcohol, which often indicates an even higher risk. A non-fatal attempt by a Sailor is an opportunity to help him or her live. Addressing these behaviors can prevent a future attempt or death by suicide.

***Truth:* A Sailor considers suicide as an alternative to make the pain stop, not because he or she actually wants to die.**

Very few people who consider suicide are determined to end their life. Most suicidal people do not want death; they want the pain to stop. Traumatic life events or jolting changes may surpass a Sailor's ability to cope and cause them to suffer feelings of helplessness. While the majority of those who consider suicide at some time in their life find a way to continue living, offering them help and alternatives can relieve feelings of isolation and hopelessness.

***Truth:* Suicidal thoughts do not mean that someone is mentally ill or "crazy."**

Most suicidal people are not psychotic or insane. They might be upset, grief-stricken, depressed, or despairing. Extreme distress and emotional pain are not necessarily signs of mental illness. Other disorders related to depression, such as substance abuse, may worsen symptoms related to depression and lead to thoughts of suicide.

***Truth:* In most situations, seeking help or treatment is an indicator of the good reliability and judgment that is required for security clearances.**

Less than 1 percent of revoked or denied clearances are for psychological problems. Failure to seek help and allowing problems to get worse, impacting performance, conduct and finances, are more likely to lead to clearance loss. With changes in April 2008, marital, family or grief counseling (not related to violence by the applicant and unless the treatment was court-ordered), and any counseling for post-combat deployment concerns, are not required to be reported on the security clearance form SF 86. While other counseling or psychological treatment is reported by the applicant on the SF 86 form and leads to an extra step in the clearance process, this very rarely results in denial or revocation of clearance.