

Note: November 2022.

This Directive may no longer be current. Please check with the program office responsible for this Directive to determine if there are any updates or if the Directive is no longer in use.



COMDTINST 1734.1A
7 Dec 2009

COMMANDANT INSTRUCTION 1734.1A

Subj: SUICIDE PREVENTION PROGRAM

- Ref:
- (a) Unit Leadership Development Program, [COMDTINST M5351.5](#) (series)
 - (b) Medical Manual, [COMDTINST M6000.1](#) (series)
 - (c) [5 CFR Part 339](#), “Medical Qualification Determinations”
 - (d) Coast Guard Family Advocacy Program, [COMDTINST 1750.7](#) (series)
 - (e) Critical Incident Stress Management (CISM), [COMDTINST 1754.3](#) (series)
 - (f) Coast Guard Investigative Service Roles and Responsibilities, [COMDTINST 5520.5](#) (series)
 - (g) Administrative Investigations Manual, [COMDTINST M5830.1](#) (series)
 - (h) U.S. Coast Guard Competency Management System Manual, [COMDTINST M5300.2](#) (series)

1. **PURPOSE.** To provide policy and procedures, and assign responsibilities for the Coast Guard’s Suicide Prevention Program.
2. **ACTION.** Area, district, and sector commanders, Commander Deployable Operations Group, commanding officers of headquarters units, deputy/assistant commandants for directorates, Judge Advocate General and special staff offices at Headquarters shall ensure that the provisions of this Instruction are followed. Internet release authorized.
3. **DIRECTIVES AFFECTED.** Suicide Prevention, COMDTINST 1734.1, is cancelled.
4. **APPLICATION.** This Instruction applies to all Coast Guard active duty and reserve personnel and appropriated civilian and non-appropriated fund employees and their families. It also applies to other Uniformed Services members and their families while either serving with the Coast Guard or using Coast Guard facilities.
5. **DEFINITIONS.** Terms used in this Instruction and additional terms used to describe suicide-related behaviors are defined in enclosure (1).

DISTRIBUTION SDL No. 154

	a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x	y	z
A	1	1	1	1	1	1	1	1	1	1		1	1	1	1	1	1		1		1	1				
B	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
C			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
D	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
E	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1		
F																	1	1	1							
G		1	1	1	1																					
H	1	1	1	1	1	1																				

NON-STANDARD DISTRIBUTION:

6. DISCUSSION.

- a. Suicide is not just a medical problem, but a problem of the entire community. A responsible suicide prevention program must empower all persons, no matter what their rank or position, to intervene early in helping persons who appear distressed.
- b. 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 increase a person's suicide risk and also interfere with individual efficiency and unit effectiveness. Ironically, as problems become worse, persons are less likely or willing to accept help. Early referral by a concerned, caring family member, coworker, or supervisor can make all the difference in enabling someone to seek help.
- c. Many Coast Guard personnel have been reluctant to seek help due to the perceived stigma associated with treatment. They have feared they will lose their security clearances and their careers. Additionally, many have assumed that supervisors, Commanding Officers (CO), and Officers-in-Charge (OINC) routinely view mental health records, which reinforces a reluctance to seek help. Coast Guard supervisors and COs/OINCs play an important role in correcting the misperceptions associated with treatment.
- d. The goals of the Coast Guard's Suicide Prevention Program are to:
 - (1) Minimize suicidal behavior among all Coast Guard employees and their family members by empowering all Coast Guard personnel to recognize persons in distress and to take supportive action to help them,
 - (2) Encourage help-seeking behavior by reducing the stigma historically associated with receiving mental health care, and
 - (3) Protect those who responsibly seek mental health treatment from unfair actions resulting from seeking help.
- e. Measures of success for the Coast Guard Suicide Prevention Program include:
 - (1) reduced suicidal behaviors,
 - (2) increased awareness of warning signs and circumstances associated with suicidal behavior,
 - (3) increased number of personnel of all ranks who know what to do to assist distressed individuals, and
 - (4) an increase in the number of personnel who understand that mental health care can be obtained without risk to one's career.
- f. Medical personnel, Chaplains, and Work-Life staff support local leaders by providing information regarding intervention services, and consultation and assistance in crisis management.

7. PROGRAM COMPONENTS. The Coast Guard Suicide Prevention Program consists of seven components including Command Climate, Crisis Response, Limit on Command Access to Mental Healthcare Information, Notification and Hand-off in Criminal Investigations, Postvention, Reporting, and Training.

- a. Command Climate. Command climate refers to command and supervisory attitude and behavior that collectively help to set the cultural norms within the unit and workgroup that promote and protect responsible help-seeking behavior. These actions also increase social support and sense of belonging – protective factors that can decrease suicidal behavior.

(1) Attitude. Command's support for personnel should reflect the following positions:

- (a) Mission readiness and mishap prevention are keenly related to personal issues that affect on-the-job performance. Therefore, the safety of the entire crew requires that personnel experiencing problems seek and obtain the help they need.
- (b) Taking good care of your mind is as important as taking good care of any other part of your body.
- (c) There is no shame in asking for help. In fact, it is a sign of strength to face one's problems and to want to deal with them in a constructive way.
- (d) Your chain of command will respect your right to confidentiality but not when it comes to concerns about your committing suicide. We must get you the help you need before a tragedy occurs.
- (e) This command has confidence that with the right support you will get over any current difficulty you are experiencing. To the extent possible, the command will help you obtain the help you need.

(2) Behavior. Command and supervisory personnel shall promote activities to improve psychological health consistent with operational stress control principles. For example:

- (a) Foster unit morale and cohesion;
- (b) Provide tough, realistic training that builds confidence;
- (c) Provide clear direction and sense of mission;
- (d) Deglamorize alcohol use;
- (e) Know your personnel;
- (f) Ensure adequate time for rest;
- (g) Encourage good communication;
- (h) Help members maintain a work-life balance;
- (i) Do positive after-action reviews;
- (j) Reward accomplishments;
- (k) Always act ethically; and,
- (l) Lead by example.

(3) Unit Leadership Development Program. All units are required to participate in the Unit Leadership Development Program (ULD) per reference (a). The required annual ULD Assessment process is a means for commands to get feedback from unit members on how the command cadre is doing in establishing a positive climate. For purposes of this Instruction special attention should be given to the results from three assessment questions:

- (a) Item 11: My Command cares about me.
 - (b) Item 22: The members at my command are encouraged to maintain mental and physical well-being.
 - (c) Item 34: The people I work for create an environment that supports diversity, fairness, dignity and compassion.
- b. Crisis Response. Crisis Response means that action is taken to ensure distressed persons are identified early and that they receive the help they need. Crisis Response attempts to prevent a life crisis or mental disorder from leading to thoughts of suicide, and includes identifying and managing all incidents of suicide-related behaviors and communications as soon as they are reported. Early involvement is a crucial factor in suicide risk reduction. Responses include, to the extent possible, alteration of the conditions that produced the current crisis, treatment of underlying mental health problems that contribute to suicidal thoughts, and follow-up care to assure problem resolution. COs/OINCs play an integral part during this phase, as it is their responsibility to ensure a particular problem or crisis has been resolved before assuming the threat has passed.
- (1) Each command shall have a protocol for handling incidents of suicide-related behavior and suicide-related communication. See enclosure (2) for a Sample Command Suicidal Incident Response Protocol.
 - (2) Each command shall provide support for those who seek help with personal problems as well as those who possibly are suicidal but are reluctant to seek help voluntarily. Access must be provided to prevention, counseling, and treatment programs and services supporting the early resolution of mental health, family, and personal problems that may underlie suicidal behavior.
 - (3) If the comments, written communication, or behaviors of a civilian employee, military member, or family member lead the command to believe there is an imminent risk that the person may cause harm to self or others, command leadership must take safety measures. These measures include restricting access of at-risk personnel to means of inflicting harm, and assisting at-risk personnel in obtaining mental health evaluations and treatment. Mental health evaluations can be obtained as follows:
 - (a) Military members. Supervisors, OINCs, and COs can request the member's voluntary cooperation to agree to an evaluation by a mental health professional. When necessary the member's CO/OINC can order a member to be evaluated. See Chapter 5-C of reference (b) for procedures. In emergency situations military members can be taken directly to the nearest military or civilian medical treatment facility for evaluation.
 - (b) Civilian Employees. It is preferred that civilian employees use providers of their choice and agree to sign a release of information for the supervisor as needed. In situations in which civilian employees do not submit adequate medical documentation, agree to an evaluation, or to sign a release of information, the command must consult with their local Command Staff Advisor or Human Resources Specialist to ensure compliance with reference (c).
 - (c) Use of Employee Assistance Program (EAP). Use of the EAP for individuals who have demonstrated suicidal communications or behaviors is not recommended. However, in

- emergency situations where medical care is not readily available, Supervisors, OINCs, and COs can refer Coast Guard active duty members and civilian full-time employees to the EAP. The information that the EAP can provide back to the command regarding the person is limited. The EAP cannot provide recommendations regarding fitness for duty, time off, or duty assignment and does not provide written reports of any kind. With the client's written consent to share information with the command, the EAP can provide verbal information regarding the client's condition. If a client is determined to be a danger to self or others, the EAP provider is required to take action to ensure proper authorities (e.g., law enforcement) are notified. The purpose of notification is to ensure that the client and/or others are protected, regardless of whether or not the client has given his/her consent.
- (d) Use of Coast Guard Chaplains. Supervisors, OINCs, and COs can refer Coast Guard active duty members and civilian full-time employees to chaplains for matters they may be reluctant to share with any other official. Chaplains are trained to act as a conduit to get personnel the care they need while preserving confidentiality, often providing an easier transition to mental health evaluations.
- c. Limit on Command Access to Mental Healthcare Information.
- (1) Coast Guard healthcare providers (HCP) shall not notify a member's command regarding a member's receipt of mental healthcare services unless the need to do so involves one of the following conditions or situations:
- (a) The provider believes the member is a danger to him/herself or others. This includes any disclosures concerning child abuse or domestic violence, consistent with reference (d).
 - (b) There is reason to suspect the person's condition would compromise the unit's mission or safe performance of duties.
 - (c) The member has an acute mental health condition that would interfere with performance of duties.
 - (d) The member has entered a formal substance abuse outpatient or inpatient treatment program. Those who seek alcohol-use education who have not had an alcohol-related incident, such as driving under the influence, do not require command notification unless they also choose to be formally evaluated and are diagnosed with a substance abuse or dependence disorder.
 - (e) The mental health services are obtained as a result of a command-directed mental health evaluation.
- (2) When command notification is required, the minimum amount of information is to be provided to satisfy the purpose of the disclosure. In general, this shall normally consist of the diagnosis, a description of the treatment prescribed or planned, recommended duty restrictions, and the prognosis.
- (3) COs, Executive Officers, OINCs, and Executive Petty Officers with direct access to members' medical records (e.g., when serving as the medical records custodian) will honor the spirit and intent of the above restrictions and will limit their access to member information accordingly.

- d. Notification and Hand-off in Criminal Investigations. The initiation of a criminal investigation is one of the known circumstances associated with suicidal behavior. Every investigation has its own unique set of factors and case-specific circumstances that will dictate how suspect notification will be conducted. The Coast Guard Investigative Service (CGIS), in consultation with the appropriate command cadre and servicing Legal Office, shall make the determination on when, how, and by whom a Coast Guard member or other employee will be notified or otherwise made officially aware that they are under investigation.
 - (1) Once notification is made, the CGIS agent making the notification will determine what support the subject of the investigation may need. At minimum, the agent will provide referral information for the EAP.
 - (2) If the CGIS agent determines at anytime during the investigation that the subject is in need of emergency support, or the subject requests emergency support, the agent will “hand off” the person to the source of help needed (e.g., command representative who will act as an escort, a civilian emergency room, a chaplain, a mental health provider, Coast Guard or other military medical facility, etc.).
 - (3) The CGIS agent will keep the command fully informed regarding all actions taken to support the individual who is the subject of the investigation.
- e. Postvention. A postvention is an intervention conducted after a suicide or serious suicidal attempt, largely taking the form of support for the bereaved (family, friends, workmates, and command cadre). Postventions recognize that those bereaved by suicide may be vulnerable to suicidal behavior themselves and may develop complicated grief reactions. In the event of a suicide or serious suicide-related behavior, the command will, to the extent possible, request and coordinate support services for families and affected Coast Guard personnel. Assistance can be obtained from the unit’s Regional Health, Safety, and Work-Life (HSWL) Field Office (HSWL FO) per reference (e).
- f. Reporting. The purpose of reporting is threefold: 1) to protect lives, 2) to enhance treatment efforts by ensuring important information is gathered, and 3) to discover actionable intelligence that may be found in aggregate data. Reporting responsibilities are as follows:
 - (1) Individual. All personnel are required to share knowledge regarding possible suicidal behavior or the threat of suicidal behavior by co-workers, military and civilian, up the chain of command for appropriate action.
 - (2) Coast Guard Medical Office. The Coast Guard Medical Clinic/Sickbay that provides support for the unit shall report suicide attempts and incidents of self-harm by active duty personnel and reservists on active duty that result in physical injury within 10 business days of initial notification to Commandant (CG-1112) using Suicide-Related Behavior Incident Report, Form CG-1734.
 - (3) Commandant (CG-1112). A Suicide-Related Behavior Incident Report, Form CG-1734, will be completed by Commandant (CG-1112) on active duty suicides and incidents of self-harm that result in death once all related investigative reports are received from the CGIS and any other investigative agencies involved. A copy of the completed Form CG-1734 in fatal incidents will be provided to the CGIS per reference (f).
- g. Training.

- (1) Mandated training on suicide prevention is an annual requirement for all active duty Coast Guard members, full time civilian employees, and all drilling Reservists. This requirement can be met by completion of the online Suicide Prevention Mandated Training currently in development and to be made available at <https://learning.uscg.mil/portal.asp>. However, the optimum method for delivery of this training is by an approved subject matter expert such as an Employee Assistance Program Coordinator (EAPC). This training must include:
- (a) The goals of the program as described in paragraph 6.d. of this Instruction.
 - (b) Knowledge of the warning signs and circumstances associated with suicidal behavior as listed in enclosure (3).
 - (c) How to respond to suicidal persons and to whom incidents should be reported as listed in enclosure (4).
 - (d) How to access emergency and other support services, including local services. See http://www.uscg.mil/worklife/suicide_prevention.asp for a listing of related national web sites and hotlines.
- (2) Applied Suicide Intervention Skills (ASIS) Training is a two-day training provided to Coast Guard personnel by certified ASIS trainers. This training is provided periodically by HSWL FO staff. It is designed to teach participants how to intervene and assist distressed persons who may be contemplating suicide. All units are encouraged to send representatives to this training. Other approved courses may also be available for supervisors through the HSWL FO staff.
- (3) Use of Command or other-agency-sponsored trainings that teach resilience and performance enhancement skills are strongly encouraged. These trainings could cover a range of performance enhancement skills that reinforce a positive command climate and reduce problems that might detract from personal and unit readiness. Examples of topics: stress management, attention control, confidence building, goal setting, imagery/visualization, energy management, time management, textbook study, note taking, communication and interpersonal skills, decision-making skills, and lifelong learning skills. HSWL FOs currently do not have the capability to provide all these types of trainings. However, such classes may be available via local community organizations or available through other military installations.

8. KEY DUTIES AND RESPONSIBILITIES.

- a. Commandant (CG-11) shall promulgate policy and guidance regarding the Coast Guard's Suicide Prevention Program.
- b. Commandant (CG-00A) shall ensure all Chaplains are aware of the requirements of this program.
- c. Commandant (CG-111) shall:
 - (1) Promote self-care and the use of mental health care resources available to all Coast Guard employees. Emphasis shall be given to promoting the health, welfare, and readiness of the Coast Guard community; to providing support for those who seek help for personal problems; and to ensuring access to care for those who seek help.

COMDTINST 1734.1A

- (2) Coordinate, support, assist and guide all Coast Guard suicide prevention efforts and ensure that related requirements are carried out.
- d. Commandant (CG-112) shall:
- (1) Ensure that the 18 Coast Guard Medical Requirements for Managing Suicidal Behavior, listed in enclosure (5), are implemented to the extent possible throughout the Coast Guard.
 - (2) Provide guidance and training on enclosure (5) as needed to all Coast Guard medical personnel.
 - (3) Ensure that mental health information shared with commands by Coast Guard HCPs is limited to the exceptions listed in paragraph 7.c.(1) of this Instruction.
 - (4) Ensure that all discovered incidents of suicide attempts and self-harm that result in injury, committed by Coast Guard personnel while on active duty, are reported to Commandant (CG-1112) by Coast Guard medical personnel using Suicide-Related Behavior Incident Report, Form CG-1734, within 10 business days of initial notification.
- e. Coast Guard Force Readiness Command (FORCECOM-512) shall assist Commandant (CG-1112) in the development of Suicide Prevention training products. Assistance includes analysis of requirements and supporting policy; review of task lists; cost benefit analysis; product development, implementation, and evaluation; and, life cycle maintenance.
- f. Commandant (CG-1112) shall:
- (1) Prepare policy and guidance regarding the Coast Guard's Suicide Prevention Program.
 - (2) Provide consultation regarding this Instruction as needed to the Health, Safety, and Work-Life Support Activity (HSWL SUPACT) staff to ensure adequate and appropriate implementation.
 - (3) Establish a Coast Guard reporting system as required by this Instruction and create and evaluate quarterly statistical updates for training and actionable intelligence purposes and for monitoring the effectiveness of the program.
 - (4) Coordinate the development of Suicide Prevention training products with FORCECOM-512, and HSWL SUPACT staff.
 - (5) Represent the Coast Guard on the Department of Defense Suicide Prevention and Risk Reduction Committee.
 - (6) Complete Suicide-Related Behavior Incident Report, Form CG-1734 in all cases of fatal suicide-related behavior within 10 days after receipt of all related investigation reports.
- g. CGIS Headquarters (CG-2-CGIS) shall:
- (1) Ensure that CGIS field elements conduct formal investigations per reference (f) and internal CGIS policies and procedures in all cases where the death of a Coast Guard member may have been the result of fatal suicidal behavior.
 - (2) Ensure that CGIS field elements include in their Report of Investigation a completed CGIS Suicide Incident Report Form and obtain and include any completed Form CG-1734 on file in fatal incidents for appropriate Command, Legal, and Commandant (CG-1112) review and reporting requirements.

- (3) Ensure that CGIS field elements serve as the Coast Guard liaison in those investigations conducted by civilian authorities for the purpose of coordination and obtaining relevant investigative and medical reports for Coast Guard use as necessary.
 - (4) Provide Commandant (CG-1112), as requested, with access to all investigation reports completed in cases of fatal suicidal behavior for the purpose of completing reporting requirements.
 - (5) Encourage all CGIS agents to attend the 2-day Applied Suicide Intervention Skills Training when offered by their nearest HSWL FO.
 - (6) Ensure that all CGIS agents are aware of, and comply with, the Notification and Hand-off in Criminal Investigations requirements described in paragraph 7.d of this Instruction.
- h. Commanding Officer, HSWL SUPACT shall:
- (1) Ensure the HSWL requirements of this Instruction are implemented in the field.
 - (2) Assist Commandant (CG-1112) in identifying policy, program implementation, and funding needs of this program.
 - (3) Assist Commandant (CG-1112) in developing training products in support of the program.
 - (4) Provide quality assurance reviews on the implementation of this Instruction at Coast Guard HSWL FOs and Medical Treatment Facilities.
 - (5) Ensure the Independent Duty Health Services Technician (IDHS) notifies the cognizant Designated Medical Officer Advisor (DMOA) and submits an inpatient hospitalization e-mail message to the applicable "HQS-DG" address listed in the Coast Guard Global Directory for all CG members hospitalized. The IDHS will track each member when that member is receiving care outside of Coast Guard clinics to ensure continuity of care per enclosure (5).
- i. Coast Guard HCPs shall:
- (1) Limit Coast Guard member mental health care information shared with commands per paragraph 7.c. of this Instruction.
 - (2) Assess, track, and manage all patients reporting and/or exhibiting suicidal communications or suicide-related behaviors per requirements contained in enclosure (5). Ensure medical follow-up with each patient regardless of whether or not patient is thought to be complying with treatment recommendations.
 - (3) Complete Suicide-Related Behavior Incident Report, Form CG-1734 in cases of injury resulting from a suicide attempt or an incident of self-harm committed by Coast Guard personnel on active duty. Submit completed Form CG-1734 to Commandant (CG-1112) within 10 business days of initial notification and include a copy in the patient's medical record.
 - (4) Provide a copy of the completed Form CG-1734 to the mental health provider treating the patient.
 - (5) As needed in cases where there is no Coast Guard HCP involved in the patient's direct care, engage and coordinate with the IDHS assigned to patient's unit to ensure, to the extent

possible, that requirements contained in enclosure (5) are met and that the reporting requirement in injury cases is completed. Note: though much of enclosure (5) is beyond the Coast Guard's direct care and control in such cases, with proper releases of information obtained from the patient, outpatient management and continuity of care can be monitored to ensure needed care is obtained and provided.

- (6) Obtain written permission from the patient as required to obtain information from, and share information with, the patient's provider(s) to coordinate care needed and to meet the requirements contained in enclosure (5).

j. Command Chaplains shall:

- (1) Provide and/or coordinate spiritual care and postvention services as requested by commands.
- (2) Provide and/or coordinate chaplain support for the Regional HSWL FO ASIS trainings and/or similar "how-to-intervene" trainings to Coast Guard unit representatives within the AOR.

k. COs and OINCs shall:

- (1) Establish a Suicidal Behavior Response Protocol for their Command. See enclosure (2) for a sample protocol.
- (2) Take leadership actions to ensure all personnel feel they are valued members of the team.
- (3) Promote a command environment that supports help-seeking behavior and early identification of distressed personnel who need unit support. Emphasize to all that:
 - (a) It is perfectly acceptable to seek and receive help in resolving emotional problems,
 - (b) The goal is self-improvement, and
 - (c) Self-referral is the best referral.
- (4) Be alert to warning signs and circumstances that could increase the likelihood of suicidal behavior. Require supervisors to do the same. Personnel known to be experiencing relationship, substance abuse, financial, administrative action, and/or legal/criminal problems - known triggers of suicidal behavior - warrant particular attention. Once persons experiencing problems are identified ensure support and follow-up is provided.
- (5) Advocate on behalf of personnel when there are roadblocks to getting needed services.
- (6) Set the tone for a compassionate response when a member or civilian employee is in need of emergency attention or hospitalization for mental health care. If possible and appropriate visit or call the person while hospitalized to express your support. Follow-up as needed.
- (7) Address relevant findings related to encouraging help-seeking behaviors when completing the required Unit Leadership Development Program Assessment process per reference (a).
- (8) Protect all information pertaining to the mental health condition of personnel. Respect personnel's right to limit the sharing of personal information. Demonstrate respect whenever possible by asking for verbal permission from the person before sharing information regarding the person's mental health condition with others who have a need to know.

- (9) Ensure that notifications given to personnel that they are under CGIS investigation are made by CGIS personnel per Notification and Hand-off in Criminal Investigations requirements described in paragraph 7.d. of this Instruction.
- (10) Limit command and supervisor access to mental healthcare information on personnel to the exceptions listed in paragraph 7.c.(1). of this Instruction.
- (11) Ensure all military and full-time civilian personnel meet the mandated training requirement for suicide prevention training each calendar year.
- (12) Seek available training support from Coast Guard Work-Life and community organizations to promote healthy lifestyles.
- (13) Request postvention CISM services per reference (d) as needed in response to suicidal behavior incidents.
- (14) Provide Commandant (CG-1112) a copy of all completed command-initiated investigation reports completed per reference (g) as a result of suicide-related behaviors by an active duty member.
- (15) Per reference (h), designate personnel to receive the Applied Suicide Intervention Skills Training competency code after completion of requirements.

l. HSWL FO Group Practice Managers (GPM) shall:

- (1) Ensure that Work-Life personnel and services are available as needed to assist commands in handling suicidal behavior incidents.
- (2) Identify training and funding needs for implementing this program in their area of responsibility (AOR). Submit requests to the HSWL SUPACT.

m. Employee Assistance Program Coordinators (EAPC) shall:

- (1) Provide consultations to commands as needed regarding services available for distressed personnel.
- (2) Coordinate and/or provide postvention services as requested by commands.
- (3) Advise commands regarding the establishment and implementation of a Suicidal Incident Response Protocol as required by this Instruction.
- (4) Provide annual Suicide Prevention Mandated Training as required by this Instruction.
- (5) Provide an annual ASIS training and/or similar “how-to-intervene” training to Coast Guard unit representatives within the AOR.
- (6) Establish a file of local community intervention and referral resources for suicide prevention within the AOR.
- (7) Assist commands in identifying resilience and suicide prevention training resources that may be available in the community.

9. **PRIVACY PROVISIONS.** The Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 apply to records that contain protected health information. These acts and regulations place procedural requirements on the use and disclosure of such information. The Coast Guard Healthcare Program may disclose protected health information about an individual whom it

reasonably believes to be suicidal to persons who are in a position to intervene and protect the individual from harm to self or others. The applicable Systems of Records Notice for the reporting requirement contained in this Instruction can be found at <http://edocket.access.gpo.gov/2008/E8-25967.htm>.

10. ENVIRONMENTAL ASPECT AND IMPACT CONSIDERATIONS. Environmental considerations were examined in the development of this directive and have been determined to be not applicable.
11. FORMS/REPORTS AVAILABILITY. The form referenced in this Instruction is available in USCG Electronic Forms on the Standard Workstation or on the Internet: <http://www.uscg.mil/forms/> and Intranet at <http://cgweb.comdt.uscg.mil/CGFORMS>.

MARK J. TEDESCO /s/
Rear Admiral, U.S. Public Health Service
United States Coast Guard
Director of Health, Safety and Work-Life

- Encl: (1) Definitions
(2) Sample Command Suicidal Incident Response Protocol
(3) Warning Signs and Circumstances Associated with Suicidal Behavior
(4) Responding To Warning Signs and Circumstances Associated with Suicidal Behaviors
(5) 18 Coast Guard Medical Requirements for Managing Suicidal Behavior

Definitions

1. Healthcare Provider (HCP). Unless otherwise indicated in this Instruction, Healthcare providers are Public Health Service Officers, Coast Guard Physician Assistants, Civilian or Contract licensed/certified professionals and Coast Guard Health Services Technicians who are responsible for either the care of Coast Guard personnel or for arranging care and follow-up.
2. Injury. For purposes of the reporting requirement contained in this Instruction, injury refers to the presence of any physical consequences resulting from the suicide-related behavior incident that require medical treatment. This requirement does not include the need for mental health care.
3. Medical Officer. Medical Officers include Physicians, Physician Assistants, and Nurse Practitioners who are members of the Coast Guard or Public Health Service detailed to the Coast Guard.
4. Postvention. A postvention is an intervention conducted after a suicide or serious suicide attempt, largely taking the form of support for the bereaved (family, friends, workmates, and command cadre). Postvention is part of Critical Incident Stress Management. See reference (e).
5. Resilience. A set of habits, actions, and attitudes that prepare individuals to adapt to challenging situations, find a “new normal,” and potentially grow as a result. Improving psychological resilience will enhance mission effectiveness and decrease the adverse effects of difficult missions. Resilience-building training is a proactive prevention effort that can reduce the risk of suicide, the ultimate expression of feeling overwhelmed and hopeless.
6. Self-Inflicted Death with Undetermined Intent. Self-inflicted death for which intent is either equivocal or unknown.
7. 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.”
8. Suicide-Related Behaviors. A self-inflicted potentially injurious behavior for which there is definite evidence, either explicit or implicit, that: (a) the person wished to use the appearance of intending to kill himself/herself in order to attain some other end; or (b) the person intended at some known degree to kill himself/herself. Suicide-related behaviors can result in no injuries, injuries, or death. Suicide-related behaviors include:
 - a. Suicide. Self-inflicted death with evidence, either explicit or implicit, of intent to die.
 - b. 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. For reporting purposes Suicide Attempt Level 1 = no injury, and Suicide Attempt Level 2 = injury.
 - c. Self-Harm. A self-inflicted potentially injurious behavior for which there is evidence, either implicit or explicit, that the person did not intend to kill himself/herself (i.e., had no intent to die). Persons engage in self-harm behaviors when they wish to use the appearance of intending to kill themselves 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 or injuries, or death. For reporting purposes Self Harm Level 1 = no injury, Self Harm Level 2 = injury, and Self Harm Level 3 = death.

9. **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. Suicide-related communications include:
 - a. **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.
 - b. **Suicide-Related Ideations.** Any self-reported thoughts of engaging in suicide-related behaviors. In one survey more than half of 26,000 students across 70 colleges and universities reported having at least one episode of suicidal thinking at some point in their lives.* Suicide-related ideations, while not that uncommon, nonetheless should be taken seriously as they could indicate the beginning of a downward-spiral of worsening suicidal behavior. One of the surest ways to increase suicide risk for those who are already at risk is to dismiss their suicidal ideations as efforts at “manipulation”.
 - c. **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.
10. **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.
11. **Quick Reference Chart.**

SUICIDE-RELATED BEHAVIORS AND COMMUNICATIONS			
BEHAVIORS	NO INJURY	INJURY	FATAL
Self-Harm Level 1	X		
Self-Harm Level 2		X	
Self-Harm Level 3			X
Suicide Attempt Level 1	X		
Suicide Attempt Level 2		X	
Suicide			X
COMMUNICATIONS Ideations, Threats, and Plans	X		

* Drum, David J.; Brownson, Chris; Burton Denmark, Adryon; Smith, Shanna E., “New Data on the Nature of Suicidal Crises in College Students: Shifting The Paradigm,” *Professional Psychology: Research and Practice*, Vol 40(3), 2009, 213-222.

Sample Command Suicidal Incident Response Protocol

1. Activating Event: any report involving the possibility of suicide-related behavior or suicide-related communication as defined in enclosure (1).
2. Points of Contact:
 - a. Command Center (206) 220-XXXX
 - b. Coast Guard Investigative Service (206) 220-XXXX
 - c. District Legal (206) 220-XXXX
 - d. Employee Assistance Program Coordinator (EAPC) (206) 217-XXXX
 - e. Employee Assistance Program (EAP) (800) 222-0364
 - f. HSWL Field Office Supervisor (206) 217-XXXX
 - g. Senior Medical Executive (SME) (206) 217-XXXX
 - h. Designated Medical Officer Advisor (DMOA) (206) 217-XXXX
 - i. Independent Duty Health Services Technician (IDHS) (206) 217-XXXX
 - j. Chaplains (206) 217-XXXX
 - k. Critical Incident Stress Management (CISM) (206) 217-XXXX
 - l. Local Crisis Clinic Hotline (800) 244-XXXX
 - m. Local Emergency Room (206) 217-XXXX
 - n. Nearest Poison Control Center (800) 222-1222
 - o. Decedent Affairs Officer (206) 222-XXXX
3. **Incidents Involving Active Duty Personnel and Reservists on Active Duty**
 - a. All cases of suicide-related behavior or communication not involving injury. If needed, assign individual(s), preferably an IDHS if available, depending on member's condition and level of cooperation, to remain with the member at all times until the member is screened, and a safety plan is established by the command. Applied Suicide Intervention Skills (ASIS)-trained individuals are preferred. If ASIS-trained persons are not available consider using a CISM-trained Peer.
 - b. All cases involving attempts with possible injury. Apply emergency first aid if needed and either contact local emergency services for further assistance, or transport member to the nearest emergency care facility.
 - c. Guidance regarding use of escorts.
 - (1) Use of an escort is a command judgment call based on how the member presents and the level of cooperation from the member. An escort can be any person capable of helping the member get to needed emergency services, including a family member.
 - (2) Assigning an escort may be perceived as demeaning by the member who otherwise is capable of getting himself/herself to needed services. Not requiring an escort would be appropriate for the member who reports he has had thoughts of suicide but reacts with

convincing assertions that he has no plan or any intention of actually harming himself. In such cases it may be appropriate to make the offer of an escort as a support but not require an escort.

- (3) As a general rule, use of an escort is always appropriate in cases involving attempts and self-harm when medical personnel will not be transporting. In these situations a command representative who can also act as an escort should accompany the individual to the treatment facility whenever possible.
 - (4) ASIS-trained individuals are preferred to serve as escorts, if available. If ASIS-trained persons are not available consider using a CISM-trained Peer if available.
- d. Notify support elements: SME, HSWL FO GPM, EAPC, DMOA, etc., as needed.
 - e. Seek professional mental health evaluation in all cases. Obtain professional screening at nearest military treatment facility, civilian medical facility, or contract physician. If care is not available via these sources contact the Employee Assistance Program and arrange for an emergency appointment if member agrees to go as a voluntary client. [See paragraph 7.b.(3)(c) of this Instruction for a description of the limitations in using the EAP for evaluations].
 - f. Safety Plan. As early as possible, consult with the mental health evaluator regarding a recommended safety plan. Normally, where the risk is high, the person will be admitted to a hospital for care. However, there may be circumstances in which professional evaluation is not available and the member is considered at risk for suicide based on the member's behavior and statements and credible collateral information provided by others. In such circumstances the Command should establish a safety plan that includes:
 - (1) Removal of personal hazards (e.g., issued or personal weapons including knives, belt, shoes, bootstraps, shoestrings, draw strings, shirt stays, razor, medications, pencils, pens, etc.).
 - (2) Removal of environmental hazards from room (e.g., sheets, elastic bands, mirrors, window dressings - such as blinds - strings, alcohol, other weapons, cleaning supplies, metal eating utensils, telephones, tools, or any other rope, other sharp-edged or breakable object, etc.).
 - (3) Line of sight supervision especially if removal of personal and environmental hazards is not feasible.
 - (4) Coordinated follow-up plan for personnel following mental health evaluation or other support services in place with pass down (e.g., coordinated communication with next watch).
 - g. Command ensures screening and treatment recommendations are communicated to member, to CG medical and to command as well as any additional safety-related contact (family member, roommate) if authorized by member.
 - h. Command provides CG Medical Clinic/Sickbay that provides unit support with information as needed to establish a care plan for the member and to complete Suicide-Related Behavior Incident Report, Form CG-1734.
 - i. Command and Supervisor address associated problems to the extent possible and refer member for additional assistance (e.g., financial aid/counseling, Family Advocacy, Specials Needs, etc.). Command intercedes and advocates on behalf of member as needed.

- j. Command monitors member's treatment. Ensure member follows through on medical recommendations for further assessment, counseling, or treatment. Communicate with providers as appropriate. Provide updates to others working with member who have a need to know (e.g., medical, EAPC, direct supervisor).
 - k. To the extent possible, respect member's privacy. Do express concern and ask general questions but do not pry. Continue to monitor member's mood, performance, compliance with medical recommendations and response to additional stressors.
 - l. Command IMMEDIATELY makes a voice report to the Coast Guard's National Command Center at 202-372-2100, in all cases involving the death, or possibility of the eventual death, of a regular or reserve member, or a member who separated or retired within the last 120 days. Command follows up with a message within four hours, per Personnel and Pay Procedures Manual, PPCINST M1000.2 (series), enclosure (7).
 - m. If member had access to classified material, the Command reports cases of suicide and suicide attempts, both Level 1 (without injury) and 2 (with injury), to the Coast Guard Security Center via the cognizant Security Manager per Personnel Security and Suitability Program, COMDTINST M5520.12 (series), Chapter 2.
 - n. Request CISM and Chaplain support as needed.
 - o. Command consults with CGIS and conducts an administrative investigation if required in serious attempts and suicides per Administrative Investigations Manual, COMDTINST M5830.1 (series).
 - p. If member is being medically boarded per Physical Disability Evaluation System, [COMDTINST M1850.2 \(series\)](#), Command ensures that he/she is counseled on the medical board process and is kept abreast of its progress. Advocate on behalf of the member as appropriate.
 - q. If member faces discharge, Command ensures access to counseling on the separation process, disability benefits, and his/her right to counsel.
4. **Incidents Involving Family Members and Civilian Employees**
- a. All cases not involving injury. In the case of a family member contact the Coast Guard member if he/she is not already present. If no sponsor or adult family member is available, assign chaperone(s), preferably using CISM- or ASIS-trained individuals, if available.
 - (1) Determining level of escort assistance. The degree of escort assistance to provide is a judgment call. Factors to be considered include the person's appearance, statements regarding suicidal behavior, collateral information provided by workmates or others confirming suicidal behaviors and/or communications, any known history of past suicidal behavior, whether or not the person appears to be under the influence of substances, the presence of bizarre or reckless behavior, the person's level of cooperation, and the person's age, maturity level, and ability to communicate.
 - (2) The chaperone may need to remain with the family member or employee at all times until they are screened by a mental healthcare or medical provider, and a safety plan is established and/or until relieved by a responsible family member.
 - (3) In some cases emergency law enforcement assistance may be needed if the family member or civilian employee is uncooperative and appears to be intent on suicidal behavior.

Enclosure (2) to COMDTINST 1734.1A

- b. All incidents involving attempts with possible injury. Contact local emergency services. If emergency services are not available, have two individuals drive the family member or civilian employee to nearest medical facility if responsible family member is not available.
- c. Notify support elements as needed: Chaplain, EAPC, HSWL FO GPM, and other Work-Life Staff.
- d. Ensure family member or employee is aware of access to additional resources such as Chaplain services, EAP, Tricare benefits if applicable, and local support providers.
- e. Encourage active duty sponsor to monitor situation and reach out for support as needed. If the family member's mental health problems appear to be chronic and on-going, encourage him/her to seek assistance through the Special Needs Program per Coast Guard Special Needs Program, COMDTINST 1754.7 (series).
- f. Consult local Command Staff Advisor or Human Resources Specialist as needed regarding any proposed action to be taken in cases involving civilians. In the event an evaluation is needed, a Command Staff Advisor or Human Resources Specialist can advise the command regarding the requirements in reference (c) of this Instruction.
- g. Request CISM and pastoral/Chaplain support as needed.
- h. If civilian employee had access to classified material, command reports cases of suicide and suicide attempts, Level 1 (without injury) and 2 (with injury) to the Coast Guard Security Center via the cognizant Security Manager per Personnel Security and Suitability Program, [COMDTINST M5520.12C](#), Chapter 2.
- i. Notify District Command Center if incident involved 1) self-harm with injury, 2) self-harm with fatality, or 3) an attempt with injury, or 4) suicide. Command Center will notify Legal, Coast Guard Investigative Service, and other authority as required.

Warning Signs and Circumstances Associated with Suicidal Behavior

1. Here’s an easy-to-remember mnemonic for recognizing warning signs.

IS PATH WARM? *

I	IDEATION	Thoughts of suicide expressed, threatened, or written
S	SUBSTANCE USE	Increased or excessive alcohol or drug use.
P	PURPOSELESSNESS	Seeing no reason for living or having no sense of meaning or purpose of life.
A	ANXIETY	Feeling anxious, agitated, frequent nightmares, or unable to sleep (or sleeping all the time).
T	TRAPPED	Feeling trapped, like there is no way out.
H	HOPELESSNESS	Feeling hopeless about self, others, the future.
W	WITHDRAWAL	Withdrawing from family, friends, usual activities, society.
A	ANGER	Feeling rage or uncontrolled anger, seeking revenge for perceived wrongs.
R	RECKLESSNESS	Acting without regard for consequences, excessively risky behavior.
M	MOOD CHANGES	Experiencing dramatic changes in mood. Unstable mood.

2. A sudden, intense lift in spirits may also be a warning sign, as it may indicate the person already feels a sense of relief knowing the problems will “soon be ended.”
3. The following circumstances are often associated with suicidal behaviors and therefore should heighten concern. While any of the following are cause for concern, those involving relationship, financial, legal/disciplinary, and job performance problems are often considered “triggers” of suicidal behavior.
 - a. Relationship problems, especially in a relationship that appears to have ended or is about to end.
 - b. Legal difficulties, especially if facing criminal charges that impact one’s job and career.
 - c. Obvious drop in duty performance.
 - d. Financial problems, especially those that are perceived to be without a reasonable solution.

* American Association of Suicidology. These warning signs were compiled by a task force of experts and ‘translated’ for the general public.

Enclosure (3) to COMDTINST 1734.1A

- e. Difficulties with others at work. In particular difficulties that result in the person seeing themselves as a burden.
- f. Finalizing personal affairs.
- g. Giving away possessions.
- h. Access to and knowledge of lethal means.
- i. Physical health complaints.
- j. Unkempt personal appearance.
- k. History of mental health problems such as depression or anxiety.
- l. History of prior suicidal threats and behaviors. Those who have had a prior serious attempt are at a much higher risk for taking their lives.
- m. History of suicidal behavior by person's family members.
- n. Ostracism by workmates or others, either real or perceived.
- o. Preoccupation with death (e.g., in music, poetry, artwork).
- p. Noticeable changes in eating habits.
- q. Contacts with family members and/or others reporting person is exhibiting evidence of significant emotional problems. Family members typically contact supervisors only as a last resort. Consider such reports from family members highly credible.

Responding To Warning Signs and Circumstances Associated with Suicidal Behaviors

1. Rarely is suicide spontaneous. It is almost always thought out far in advance and numerous warning signs are almost always given. Becoming aware of these clues and the severity of the person's problems can help us prevent a tragedy. If a person you know is going through a particularly stressful situation, watch for other signs of crisis as listed in enclosure (3). Many persons convey their intentions directly with statements such as "I feel like killing myself" or "I don't know how much longer I can take this." Others in crisis may hint at a detailed suicide plan with statements such as, "I have been saving up my pills in case things get really bad," or "Lately I have been driving my car like I really don't care what happens" or "Life does not seem worth living anymore." It is important to listen to these "cries for help" because they are usually desperate attempts to communicate to others the need to be understood and helped.
2. Tragically, suicide investigations frequently find: 1) disbelief regarding the victim's previous statements regarding suicide and 2) a desire to protect the person by keeping discussions regarding suicide a secret. Quotes like, "He said he was going to kill himself but I didn't believe him," and, "I didn't want to get him in trouble by reporting what he said" are commonplace. The belated lesson learned in these tragic cases is that when it comes to persons talking about or alluding to suicide, believe them, and never agree to keep such knowledge a secret. If you do make a promise, break it. Better to patch up the friendship later rather than have a tragedy occur.
3. Perhaps the largest contributor to the problem of suicide in our society is the idea that talking about suicide is "taboo." There is a general tendency to think that the potential suicide victim does not want to talk about this issue and that trying to do so will annoy him or her. The fact is that they are actually relieved when friends or relatives ask if there are thoughts of suicide. Talking about suicide with someone you suspect of contemplating this act almost always reduces the chances that suicide will occur. If you observe warning signs and circumstances or just have a "gut feeling" something is not right, take a deep breath, think about how you can sensitively approach the person, and begin a potentially life-saving conversation.
4. **You do not need to be a trained professional to discuss suicide with a friend, relative, or anyone you suspect is in trouble, including personnel who outrank you.**
5. Remember this simple mnemonic as an aid for what to do when you suspect someone is thinking of suicide:

ACE: Ask - Care - Escort

- a. A: Ask. This is not an easy thing to ask but it is essential. It helps to role play the question or at least review in your mind how you will ask it. Ask the question directly: "Are you thinking about killing yourself?"
 - (1) It may be helpful to lead into this question with a statement of your observations:
 - (a) "You made a comment about ending your life that concerns me. Are you thinking about killing yourself?"
 - (b) "I know you have been going through a lot recently. Often people going through what you are going through think about suicide. Are you thinking about killing yourself?"

- (c) “You seem really depressed lately and you are not the same cheerful person I knew a few weeks ago. I’m concerned about what you might be thinking. Are you thinking about killing yourself?”
- (2) If the person attempts to make a joke of the question or gives other indications of attempting to deflect the question, hang in there and ask the question again, letting the person know you are serious. Be aware you may be “tested” in this way and that the person may want some indication of your sincerity before opening up. It is as if they want assurances you can handle the truth; that you won’t “feed in” by responding in kind by their effort to change the subject. This is a critical juncture in the conversation.
- (3) If the person responds in the affirmative, or otherwise tacitly indicates he/she has had thoughts of suicide, get additional information on how bad the situation is:
 - (a) How? - Does he/she have a plan? Is the plan specific? Does he/she possess the means (pills, gun, etc.)? Are the means lethal? If there is a plan, does the person express or imply an intention to actually go through with it?
 - (b) Situation? - Is he/she alone (if communication is by phone or e-mail)? Have they been drinking?
 - (c) History? - Prior attempts? Hospitalizations? Any family history of suicidal behaviors?
- b. C: Care. Be willing to listen and allow the person to express feelings in private. Talk openly about suicide.
 - (1) Active listening is likely to produce relief. Calmly control the situation; do not use force. Take a deep breath. In most instances, there is no rush. Sit and listen - really listen to what the person is saying. Give understanding and active emotional support for his or her feelings.
 - (2) Encourage the person to seek help.
 - (3) If it seems appropriate and genuine express optimism that the person will be helped and will feel better.
 - (4) If the person appears to be suicidal do not promise confidentiality if they ask for it. It’s sometimes helpful to respond to such requests with something like, “I have to make sure you get the help you need and that requires that others know what you just told me. I’m sorry if that upsets you but I’d have a tough time forgiving myself if I did nothing and you tried to kill yourself.”
 - (5) If possible and the situation warrants it, remove or take possession of any means that could be used for self-injury.
- c. E: Escort.
 - (1) Never leave the person alone unless you are convinced they are not suicidal and the person has convincingly denied that they are suicidal.
 - (2) Escort to the nearest emergency room, HCP, or mental healthcare professional.
 - (3) Adopt an attitude that you are going to help him/her; that this will save his or her life.

- (4) Be particularly concerned if the person appears to be, or will likely be if left alone, under the influence of alcohol or drugs. When a person who is unhappy or depressed uses alcohol it is similar to pouring gasoline on a fire that is already burning.
 - (5) Get assistance from others as needed, including the Command or military or civilian police.
6. Sources of help. As you attempt to help others in distress know the resources available that can help and encourage their use as appropriate. Below is a list of possibilities. Contact your Regional Work-Life Office for specific contact information.
 - a. Coast Guard Employee Assistance Program Coordinator at HSWL FO Work-Life: 1-800-872-4957 (follow prompts)
 - b. The National Suicide Prevention Lifeline - a national hotline 24/7 suicide prevention service available to all who are seeking help: 1-800-273-TALK (8255)
 - c. Employee Assistance Program 24/7 Phone Center – for phone counseling, setting up face-to-face counseling, and obtaining other services: 1-800-222-0364
 - d. See http://www.uscg.mil/worklife/suicide_prevention.asp for a listing of helpful national web sites and other 24/7 hotlines.
 - e. Local Coast Guard Medical Clinic
 - f. Healthcare Provider
 - g. Unit Independent Duty Health Services Technician
 - h. Hospital emergency room
 - i. Coast Guard Chaplain
 7. Remember: Facing the possibility of embarrassment through overreaction is much easier than facing a person's death because you failed to act.

18 Coast Guard Medical Requirements for Managing Suicidal Behavior *

1. Coast Guard Medical personnel play a key role in providing and/or coordinating the care of Coast Guard members considered at risk for suicidal behavior. Even in situations in which Coast Guard HCPs are not directly involved in the care of the individual, *ensuring, to the extent possible*, that the following standards of care are met remains a primary function of Coast Guard Medical personnel.
2. Assessment of Suicide Risk.
 - a. Requirement 1. Formally assess suicide at every initial evaluation, and as clinically indicated at follow-up contacts. When the member's presenting problem is not related to suicidal behavior but depression or significant stressors are suspected, a screening question regarding suicidal behavior should be asked. See page 36 of the footnoted reference for additional guidance.
 - b. Requirement 2. Use appropriate measures to assess suicidality.
3. A Decision-Making Framework.
 - a. Requirement 3. Determine suicide risk level based on assessment information and match to appropriate suicide-specific interventions.
4. Outpatient Management Strategies.
 - a. Requirement 4. Specifically target suicidal symptoms and risk factors in the formal outpatient treatment plan.
 - b. Requirement 5. Take steps to safeguard the environment; limit accessibility to means of self-harm.
 - c. Requirement 6. Establish processes for ongoing monitoring of suicide risk.
 - d. Requirement 7. Administratively manage and track case per Chapter 5 of Medical Manual, COMDTINST M6000.1 (series) as needed.
5. Documentation Strategies.
 - a. Requirement 8. When documenting a suicide risk assessment, include both current and historical risk factors, observations from the session, rationale for actions taken or considered but not taken, and follow-up plans, including a response plan when there is evidence of increased suicidality.
6. Coordinating with Inpatient Care.
 - a. Requirement 9. Establish a process for coordination when patients are hospitalized.
 - b. Requirement 10. Reassess a patient's needs (including suicidality) following inpatient or partial hospitalization before assuming or reassuming responsibility for outpatient care.

* A clinical guide to assist in further defining each of these 18 requirements is available at <http://afspp.afms.mil/>. Click on "Products" then "Air Force Guide for Managing Suicidal Behavior." This document is also available from COMDT (CG-1112).

7. Clinic Support and Peer Consultation.

- a. Requirement 11. Use a high-interest log or the electronic health care record as a clinic tracking procedure for suicidality and share information between involved providers as needed to coordinate/monitor care.
- b. Requirement 12. Consult professional peers regularly regarding suicidal patients and document the consultation.

8. Ensuring Continuity of Care.

- a. Requirement 13. Use a standardized follow-up and referral procedure for all previously suicidal patients dropping out of treatment prematurely. Treatment compliance must be closely monitored and addressed.
- b. Requirement 14. Ensure clinical coverage when the primary provider is unavailable.
- c. Requirement 15. Establish a procedure for ensuring continuity of care during provider and patient transitions.

9. Links with the Community.

- a. Requirement 16. Establish a written plan for after-hours evaluations. Ensure other relevant agencies and individuals (i.e., Security, OICs, XPOs, Command Master Chiefs, etc.) are aware of the plan.
- b. Requirement 17. Mental health providers are the primary resource within the community regarding mental health issues; as such, they serve as consultants to unit leadership regarding the management of at-risk personnel. In the Coast Guard mental health providers will most often be either Tricare or DoD mental health providers. The Coast Guard member's primary care provider may be the person best positioned to advise Commands based on the member's treatment needs and prognosis as shared by the treating mental health provider. It is up to the Coast Guard primary care provider to ensure that the Command receives the appropriate information needed.
- c. Requirement 18. Use community support resources as needed in managing suicidal behavior. Support includes family members, friends, and the member's unit. Work-Life staff, Morale, Welfare, and Recreation, and other services available from outside civilian agencies and other military installations can be used to help address the member's particular stressors.