Department of Defense Suicide Prevention

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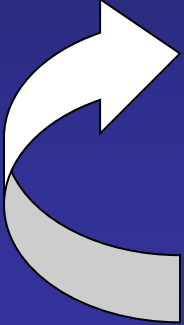Office of the Assistant Secretary of Defense (Health Affairs)
(Jun 05 –Aug 09)

Overview

- Primary DoD Suicide Risk Factors

- DoD Suicide Protective Factors

- Approaches to Suicide Prevention

  - Risk factor-focused prevention

  - Resource-focused prevention

  - Plausible theory-driven prevention

- DoD suicide prevention--unfinished business

Primary Risk Factors for Suicide in the Department of Defense

- Relationship problems
- Financial, administrative, legal problems
- Operational stressors
- Association with alcohol use

Protective Factors

- Attitudinal/Behavioral Characteristics
- Social support
- Belonging and caring
- Leadership responsibilities
- Effective coping & problem-solving skills
- Healthy lifestyle

- Policies and culture promoting:
  - Help-seeking behavior
  - Protecting those who seek help
- Access to assistance
- Spiritual support
- Unit cohesion, support, & camaraderie

Military Psychology: Clinical and Operational Applications, Ed. C. Kennedy & E. Zillmer, Guilford Press, 2006, p. 136

Risk Factor-Focused Suicide Prevention

Risk Factor-based Suicide Prevention

- 1° Prevention—Prevent/Reduce risk factors:
  - Support healthy social relationships
    - Classes/training to enhance relationships
    - Deployment, training, TDY, PCS policies
    - Leadership clarity regarding adultery and "Jodies"
      - Interpretation of UCMJ Article 134: re: Behavior prejudicing "…good order & discipline in the armed forces…"
  - Clear leadership policies re: legal/UCMJ violations
  - Ready availability of financial counseling services
  - Clear and consistent policies re: alcohol misuse, use of another's prescribed medications, dangerous supplements, and illicit drug use

Risk Factor-based Suicide Prevention

- 2º Prevention—Mitigate effect of risk factor
  - Provide support group and training for those who have lost an important relationship
    - In-theater Dear John/Jane "clinics"
    - Emphases on coping, self-regulation, personal growth
      - "Success is the best revenge"
  - Post legal or UCMJ or financial disaster:
    - <u>Confidential</u> support from unit & BH pros, as indicated
    - <u>NO</u> JAG charge-and-release at 1630 Friday policy
    - <u>Hand-off</u> policy post charge w/ crime/UCMJ violation
  - Responsible Drinking training, EtOH/Drug rehab

Risk Factor-based Suicide Prevention

- 3° Prevention
  - Treat injuries associated with a suicide attempt
    - Follow-on BH care
    - Military disposition (retain or not)
      - (Even pilots have been retained and resumed flying duties after suicide attempts and sufficient observation interval)
      - Transition assistance (f/up care) if discharged
  - Provide postvention services for family, friends, and unit members of those who complete suicide (2° prevention for family)

Resource-focused Suicide Prevention

<u>Resource</u>-focused Suicide Prevention

- Conservation of Resources Model
  Stevan Hobfoll (1989)
  - Is an integrated model of stress
  - Individuals seek to acquire and maintain resources including:
    - objects (e.g., homes, clothes, food)
    - personal characteristics (e.g., self-esteem)
    - conditions (e.g., being married or living with someone who provides social support, more financial security)
    - and energies (e.g., time, money, and knowledge)

Resource-focused Suicide Prevention

- <u>Stress</u> is a "reaction to the environment in which there is:
  - The threat of a net loss of resources
  - A new loss of resources, or
  - A lack of resource gain following the investment of resources"
- Key Principle
  - Loss of resources has a greater impact than gain in resources

Resource-focused Suicide Prevention

- 1° Prevention – (no suicidality)
  - Enhance & develop well being resources to prevent onset of suicidality
- 2° Prevention – (suicidality)
  - After resources are lost, suicidality is reduced If other well-being resources still remain
- 3° Prevention – (suicide attempt / suicide)
  - Enhance & develop dimensions of well being for attempt survivor or for the bereaved

Resource-focused Suicide Prevention

- ## Mind-Personality well being
  - Deal healthfully w/ anger, resentment, fear
  - Increase feelings of genuine self-worth
  - Generate reality-based hope
  - Resolve guilt & unforgiveness, reconcile with self and others
  - Continuous learning and intellectual stimulation

Well Being, Howard Clinebell, (Harper San Francisco, 1991), p 63f

Resource-focused Suicide Prevention

- Bodily well being
  - Appreciating our whole selves, including taking care of our bodies

Resource-focused Suicide Prevention

- Well being in <u>relationships</u>
  - A protective factor
  - A longevity factor
  - Social support a critical factor to prevent and recover from PTSD

Resource-focused Suicide Prevention

- Well being in work
  - Would be willing to work a job for the satisfaction it gives, even if not paid
  - While work is satisfying, it is not all-consuming
  - Develops mutually supportive relationships
  - Experiences "a sense of vision and purpose with a commitment to a larger meaning"
  - Experiences "a sense of oneness with a higher order giving a sense of calling"

    *Well Being, Howard Clinebell, (Harper San Francisco, 1991), *pp 135f & 156

Resource-focused Suicide Prevention

- Well being in laughter and play
  - Effective use of humor and able to laugh at self
  - Recreates regularly
  - Stimulating hobbies
  - Stimulating activities (as music)

*Well Being, Howard Clinebell, (Harper San Francisco, 1991), *p 167ff

Resource-focused Suicide Prevention

– Well being in one's world

- Update one's patriotism to include our planet
- Time, monetary, and literal and symbolic investments in planetary health

*Well Being, Howard Clinebell, (Harper San Francisco, 1991), *p 196f, **p 205
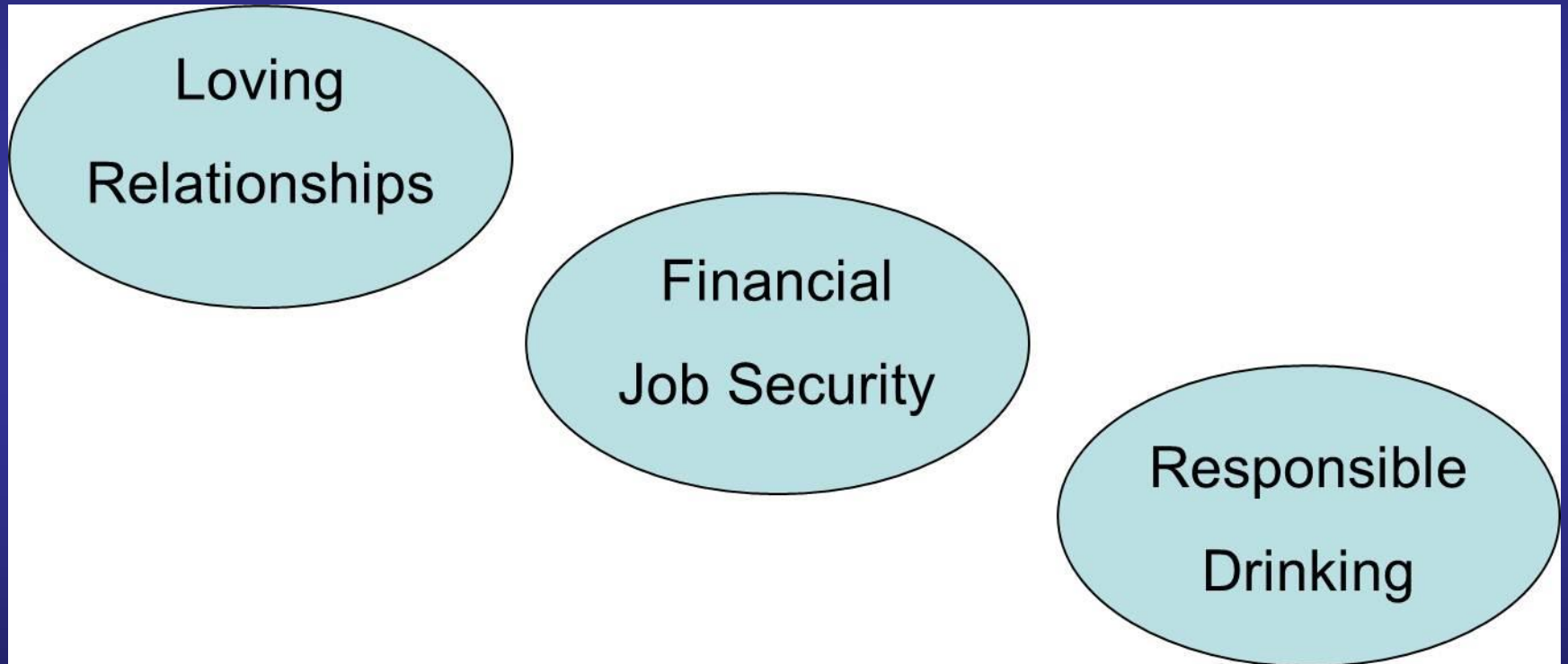
Resource-focused Suicide Prevention

- ## Self-transcendent well being
  - Wholeness-nurturing spirituality, integrated center of being, non-neurotic existential anxiety, engaging life versus half-dead w/non-satisfying work, guilt, depression, unawareness

  - Lao-tzu
    - *One of outward courage dares to die, one of inward courage dares to live…***
    - *The surest test if one is sane is if one accepts life whole, as it is****

The Way of Life According to Lao-tzu, trans by Bynner (NY: Capricorn Books, 1944) p71, * p37, 40, as quoted by
*Well Being, Howard Clinebell, (Harper San Francisco, 1991), p 19ff

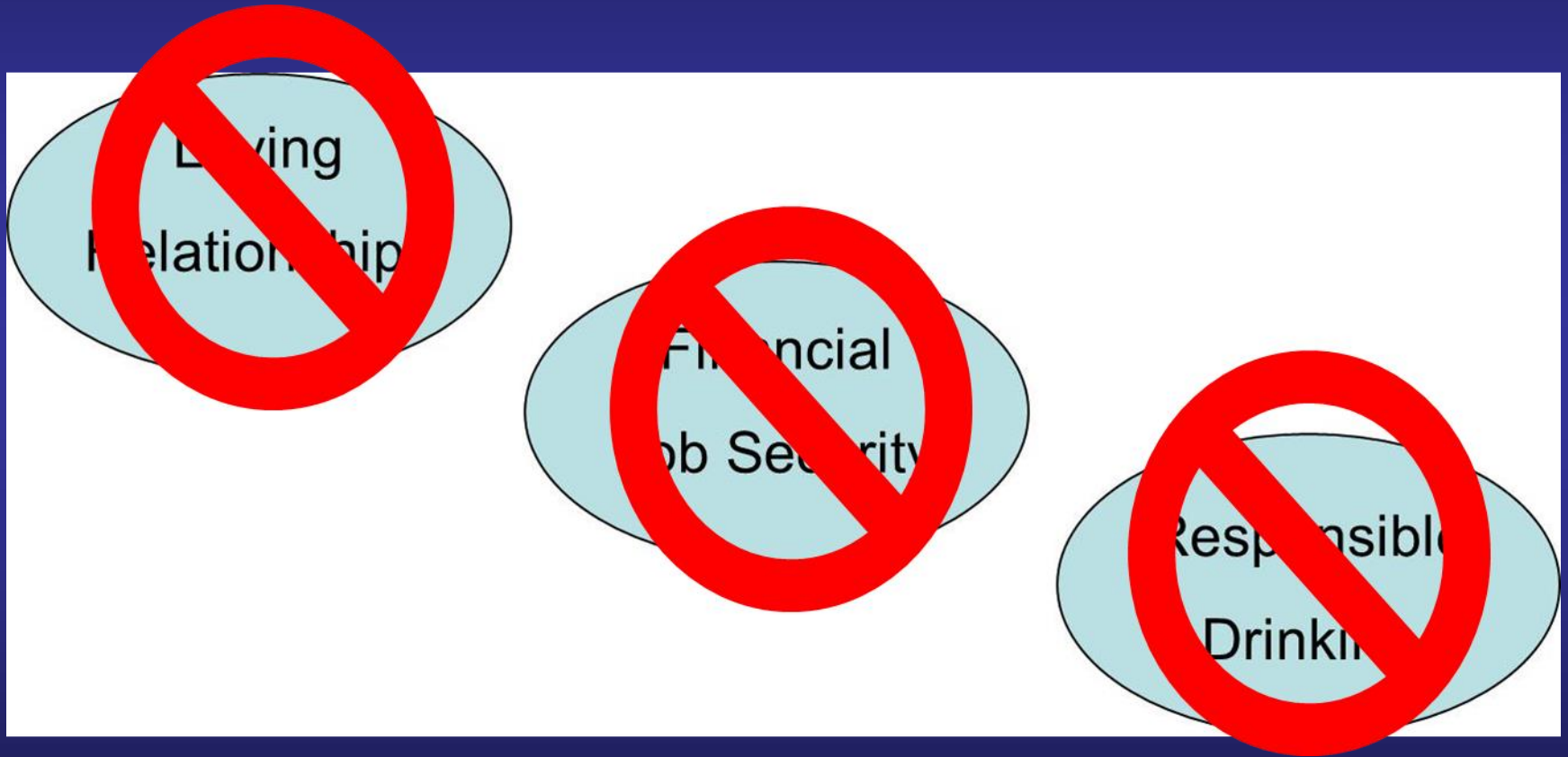# What happens when a person has few resources?

…and then loses them?

Take away these resources and what is left?

Take away these resources and what is left?

No coping resources….

Secondary Suicide Prevention May be Inadequate

Instituting prevention interventions when person suicidal, at the end of a cycle of undeveloped and lost resources

------Suicidal------

PRIMARY Prevention
Continuously Promotes Multi-Dimensional High Level Sustained Well Being

------Suicidal------

Suicide Prevention Must Involve:

Pro-Active Community-Based
Comprehensive Resource-Enhancing
Programs & Support for
Service members and their families

Then,

- When some resources are threatened or lost, there will be other personal and community resources upon which to rely while recovering lost resources, healing, or coping with behavioral health challenges

Well Being At Work

Well Being At Play

Loving Relationship

Financial, Legal, and UCMJ Well-Being

Self-Transcendent Well Being

Responsible Drinking

Mind-Personality Well-Being

Planetary Well Being

Well Being
At Work

~~Loving
Relationships~~

Well Being
At Play

Self-
Transcendent
Well Being

~~Financial, Legal,
and UCMJ
Well-Being~~

~~Responsible
Drinking~~

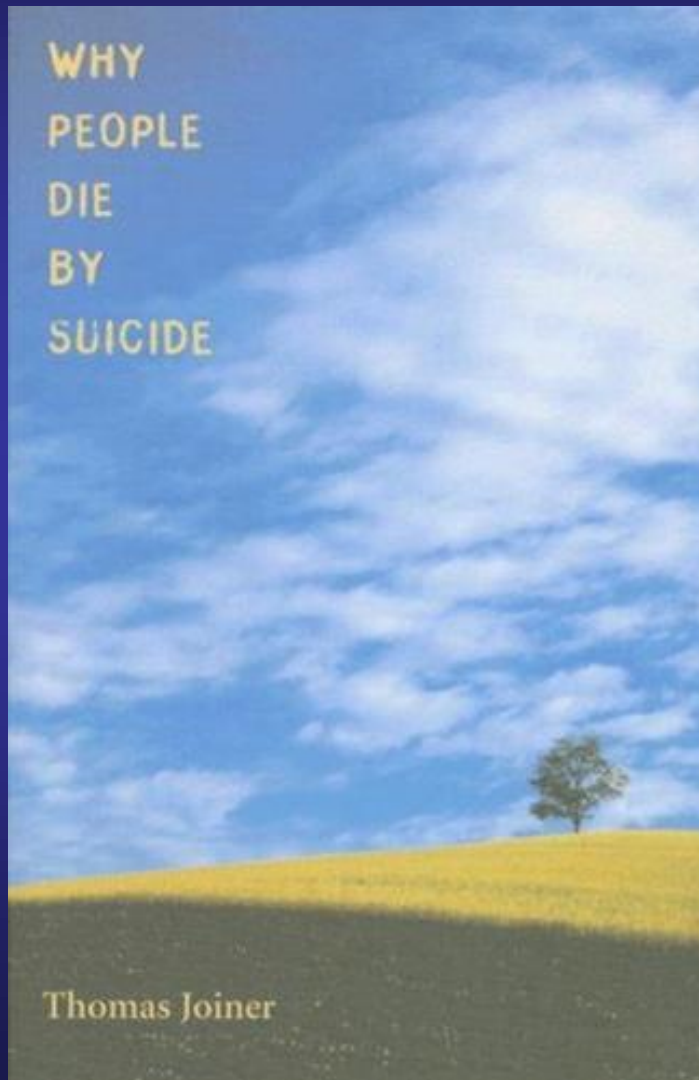Mind-
Personality
Well-Being

Planetary
Well Being

Plausible Theory-Driven Suicide Prevention

Why People Die by Suicide

Thomas Joiner, PhD   2006

Plausible Theory-Driven Suicide Prevention

- 3 elements very common in completed suicides
  - *Thwarted effectiveness, a sense that one is a burden*
  - *Thwarted connectedness, a sense that one does not belong*
  - *Acquired ability to enact lethal self-injury*
- In many military settings, day-to-day dynamics may exacerbate these 3 elements associated with suicide

Plausible Theory-Driven Suicide Prevention

- *Thwarted effectiveness, a sense that one is a burden*
  - Common in units in which leaders regularly divide their members into "Dirt Bags" (or worse) and "Full-up Rounds", leading to dividing significant tasks (going on patrol) and demeaning tasks (cleaning latrines) accordingly

- Suicide prevention emphasizes:
  - Inculcating leadership skills that rely upon strength-based assessments, and then leveraging identified strengths while improving less well-developed ones (positive psychology--coaching)

Plausible Theory-Driven Suicide Prevention

– *Thwarted connectedness, a sense that one does not belong*

- In-group/out-group divides a unit and exacerbates isolation/alienation experiences of those in the out-group

- Suicide prevention emphasizes:

  - Developing unit cohesion by eliminating splitting and isolating social practices, with an emphasis upon collaborations even between a unit's most disparate members—ALL BELONG

Plausible Theory-Driven Suicide Prevention

– *Acquired ability to enact lethal self-injury*

  • *When people get used to dangerous behavior—when they lose the excitement that only exists when there is danger—the groundwork for catastrophe is laid down…* (<u>Why People Die by Suicide,</u> *p. 48)*

  • American military Stoic tradition mitigates against concern about self-deprivations and "flesh wounds" as reflected in aphorisms: "Pain is weakness leaving the body", and "I love the smell of napalm in the morning…."

– Suicide prevention emphasizes overcoming:

  • Potential adverse outcomes of continuous deprivations and "flesh wounds" by requiring ongoing periodic restoration and replenishment of human resources

DoD Suicide Prevention
Unfinished Business

DoD Suicide Prevention
Unfinished Business

- Population-Based Suicide Prevention Elements
  (USAF late-90's--Nationally recognized "Best Practice")
  - 33% reduction of suicides (K Knox et al,BMJ 2003: 327: 1326, & pending 2009 study)
  - Non-adoption of many elements across DoD (see italicized elements)
    - Should adoption of certain elements be recommended to all Services?
- Program integrity and compliance monitoring
  - Should all Services regularly monitor compliance with their programs?
- Mental disorders and DoD suicides
  - New accessions w/ mental disorders and suicide rates
  - Are mental disorders primary or secondary to other DoD risk factors?
  - Does DoD adequately assess for mental disorders?
- Considerations for structuring DoD suicide prevention efforts in the future

Elements of Suicide Prevention
(USAF 1996 forward)

- Service-Level Leader Ownership
- Addressing Suicide through Professional Military Education
- *Guidelines for Commanders*
  - As "Leaders Guide for Personnel in Distress"
- Community Preventive Services
- Community Education and Training (to unit level)

Italics indicate elements that may not be uniform across Services or Service-wide in some Services

Elements of Suicide Prevention
(USAF 1996 forward)

- *Investigative Interview Policy*
  - (Hand-off Policy)
- Psychological 1st Aid after Traumatic Events
  - Expert consultation to installation leaders
- *Integrated Delivery System Prev. Services*
- *Limited Patient Privilege*
- *Behavioral Health Survey*
- Epidemiological Database and Surveillance System

AF Suicides Increased in 2004

- Initial concern that program was not working
- However, a survey indicated 80% of installations were not working the program
- Led to implementation of installation compliance-monitoring
- Suicides normalized after compliance achieved in 2005
- Suicides increasing 2009 f. after replacing 30-minute live unit training with web-based training

Air Force Suicide Prevention Program (AFSPP) Checklist

Purpose: This checklist assesses the base level implementation of the 11 initiatives of the Air Force Suicide Prevention Program, which are described fully in AFPAM 44-160.

#1 Leadership Involvement:	Yes	No
1.1 Were policy letters from senior AF leaders disseminated across base?		
1.2 Did the base commander release a suicide prevention memo upon assuming command?		
1.3 Did Wing, Group, and Squadron commanders address suicide prevention at least once per year during commander's call?		
1.4 Did commanders publicly encourage early help-seeking behavior?		

#2 Addressing Suicide Prevention Through Professional Military Education:	Yes	No
2.1 Did all professional military education courses conducted on base include suicide prevention training as required by AFI 44-154?		
2.2 Was a minimum of 30 minutes devoted to this training?		
2.3 Did the training curriculum cover all the required topics?		

#3 Guidelines for Commanders: Use of Mental Health Services:	Yes	No
3.1 Was training conducted by the Life Skills Support Center for commanders and first sergeants on the use of mental health services?		
3.2 Did every commander and first sergeant receive this training at least once per assignment?		

#4 Community Preventive Services:	Yes	No
4.1 Did base Life Skills Support Center personnel code time spent on suicide prevention activities as FAZY in the MEPRS system?		

#5 Community Education and Training:	Yes	No
5.1 Did all military and civilian personnel accomplish suicide prevention training?		
5.2 Did the training curriculum cover all the required topics?		
5.3 Was a minimum of 30 minutes devoted to this training?		
5.4 Did units track suicide prevention training and report statistics quarterly to the base suicide prevention program manager?		

#6 Investigative Interview Policy:	Yes	No
6.1 Were base commanders, first sergeants, supervisors, and OSI, SFS, IG, MEO, EEO, JA, HC, MDG, and Life Skills personnel trained at least once per assignment on the investigative interview policy?		

#7 Trauma Stress Response:	Yes	No
7.1 Did the base have a fully trained Trauma Stress Response Team?		

#8 Integrated Delivery System (IDS) and Community Action Information Board (CAIB):	Yes	No
8.1 Did the CAIB and IDS monitor suicide statistics and ensure implementation of AF Suicide Prevention Program initiatives?		
8.2 Did the installation IDS provide instructors to support this program?		
8.3 Did the Life Skills representative to the IDS serve as the OPR for implementation of the standardized educational content and coordination of this instruction?		

#9 Limited Privilege Suicide Prevention Program (LPSP):	Yes	No
9.1 Were base commanders, first sergeants, supervisors, and OSI, SFS, IG, MEO, EEO, JA, HC, MDG, and Life Skills personnel trained at least once per assignment on the LPSP Program?		

#10 IDS Consultation Assessment Tool (IDS-CAT):	Yes	No
10.1 Did the base IDS and CAIB consider sending members for training as IDS-CAT consultants, capable of administering the tool and consulting with commanders about the results?		
10.2 If trained IDS-CAT consultants were available, were base commanders educated on the availability and purpose of the IDS-CAT?		

#11 Suicide Event Surveillance System (SESS):	Yes	No
11.1 Were all ADAF suicides on base entered into SESS by OSI?		
11.2 Did Life Skills personnel enter all ADAF suicide attempts into SESS?		

Installation Name & Key Personnel Signatures:

Installation Name:

IDS Chair:

CAIB Executive Director:

CAIB Chair:

# Mental Diagnoses and DoD Suicides

- New accessions w/mental disorders & suicide rates
  - In 2005, there was a sharp spike in new accessions with mental diagnoses in their first 6 months of service in the Army due to policy allowing early application of retention standards to retain new recruits with disorders discovered after 24 hours in basic training
  - By 2007, Army suicides increased by 50%
  - **Were suicides due to those with mental diagnoses during their 1st 6 months of service?**
  - In a DoD-wide analysis, the answer is "NO". The suicide rate of accessions with mental diagnoses during their 1st 6 months of service was ½ of that of those without an early MH diagnosis; and statistically, was not significantly different from those without a mental diagnosis their 1st 6 months of service (suicide data through 2008 analyzed for entering cohort from Oct 2003 through 2006)

Mental Diagnoses and DoD Suicides

- Are mental disorders primary or secondary to other DoD risk factors?
    - Broken relationships and legal/UCMJ/financial difficulties frequently result in mental disorders (as adjustment and depressive disorders)
        - Standardized DoDSER may help to define relationship
- Suicides and Depression
    - New analyses demonstrate old axiom stating 15% of those diagnosed with depression die by suicide is a myth—far fewer die by suicide (Bostwick et al, Am J Psychiatry, Dec 2000)

Mental Diagnoses and DoD Suicides

- Does DoD adequately assess mental health?
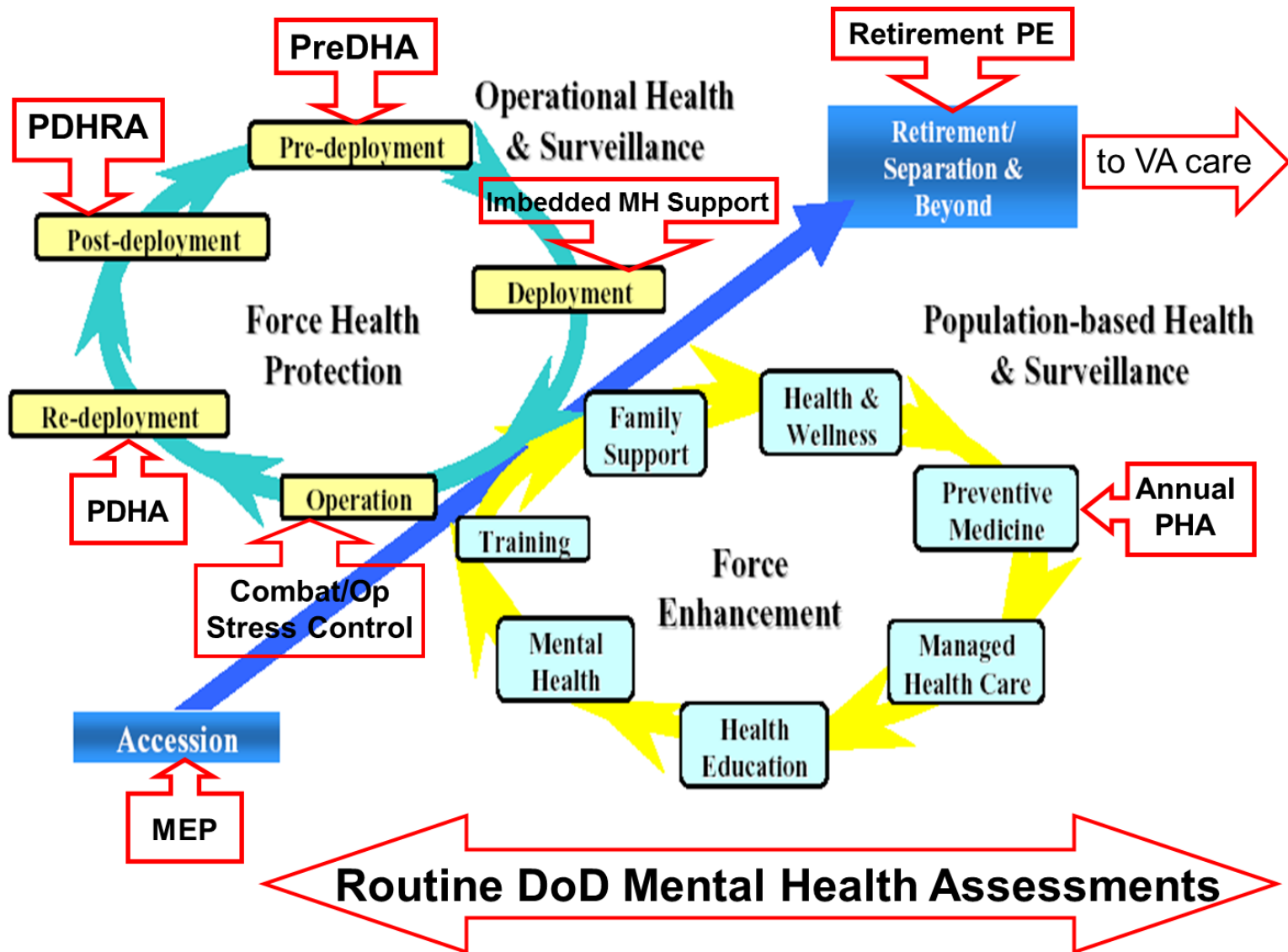
Suicide Prevention and Risk Reduction Committee (now Council)--SPARRC

- DoD Level Suicide Prevention
  - Monthly meetings hosted by Clinical and Program Policy/Health Affairs until mid-2008, when transitioned under DCoE
    - Service Suicide Prevention Program Managers and AFME reps
    - DoD Mental Health, Family Support, Chaplain, USUHS, VA reps
  - Share resources and new programs, coordinate initiatives
  - Host Annual DoD/VA Suicide Prevention Conference
- Suicide Data Standardization Work Groups (05-08)
  - Rate, nomenclature, database standardizations (DoDSER)

Suicide Prevention and Risk Reduction Committee (now Council)--SPARRC

- Future considerations
  - Analysis of Army implementation of Positive Psychology training and annual Global Assessment Tool relative to suicides
  - Data analyses of whether any suicide prevention training modalities (live vs web vs BH pro vs lay presented, etc.) affect suicide rates
  - Analyses reflecting variation in rates due to which and number of program elements are implemented

Suicide Prevention and Risk Reduction Committee (now Council)--SPARRC

- Future considerations
  - Longer term analyses of relationship of suicide program compliance with suicide rates
  - With standardized Service DoDSER data accumulation, begin analyses of self-injurious behaviors/suicide attempts structured by agreed-upon nomenclature
  - As CJCS's Total Fitness program is implemented, correlate measures of fitness components to suicide rates, especially those components of psychological fitness

Suicide Prevention and Risk Reduction Committee (now Council)--SPARRC

- Future considerations
  - SPARRC alignment
    - Service collaborations were enhanced by leadership provided at a DoD level
    - Recommend preserving such alignment should DCoE be reorganized under another agency

Discussion