Suicide Prevention for Attorneys and Legal Staff

Navy, Suicide Prevention Branch, OPNAV N171
Oct. 2017

Agenda

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Navy Suicide Prevention Program

- The Navy Suicide Prevention Program provides policies and resources to the Fleet, encouraging an organizational climate that supports and develops leaders, fosters resilience and promotes Total Sailor Fitness.
  - The program's goal is to reduce **suicides** by developing resilient Sailors, encouraging help seeking behaviors and providing support to those in need.

Every leader has a responsibility to develop a command climate that allows Sailors to seek help, receive help and be welcomed back to the unit

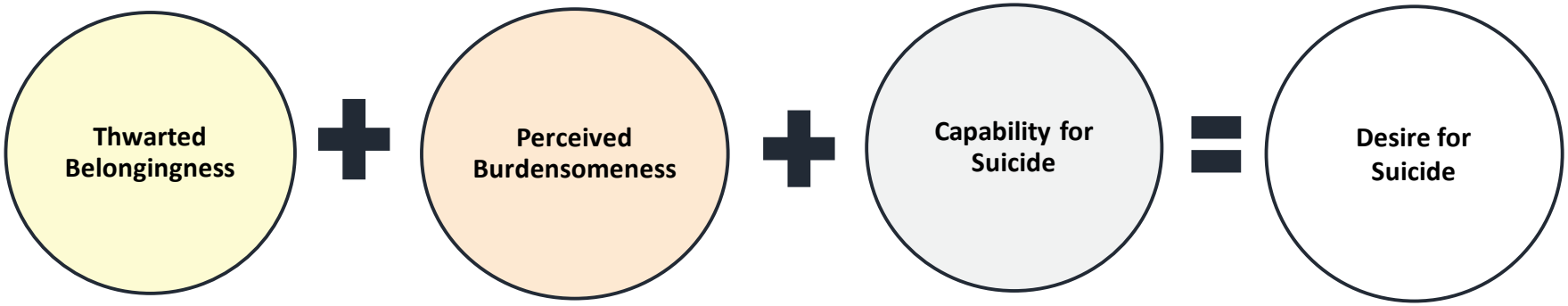
Navy Suicides: Just The Facts

- Among top three causes of death in the Navy annually
- Average 2,000 suicide-related behaviors annually
- Navy rate better than civilian rate
- Most deaths occur at home or off duty
- Barracks deaths often by hanging
- Annually, greater than 50% involve a personal firearm
- Most victims are under the age of 25, male, and Caucasian
- Attorneys and legal staff will interact most with Sailors facing some type of loss
- These Sailors may also be in Transient Personnel Units (TPU) and may be facing disciplinary action

METHOD	2012	2013	2014	2015	2016
Firearm	60% [35]	54% [22]	56% [30]	60% [26]	60% [31]
Hanging	21% [12]	29% [12]	28% [15]	30% [13]	15% [8]
Jumping	7% [4]	5% [2]	11% [6]	5% [2]	12% [6]
Other	12% [7]	12% [5]	6% [3]	5% [2]	13% [7]

TOTAL/RATE	2012	2013	2014	2015	2016
Total Navy	66	46	69	57	62
Navy AC rate/100k	18.1	12.7	16.6	13.1	15.9* Prelim.
Navy RC total	8	5	15	14	10
Civilian rate/100k (adjusted: males 17-60)	25.7	25.2	25.6	26.4	N/A

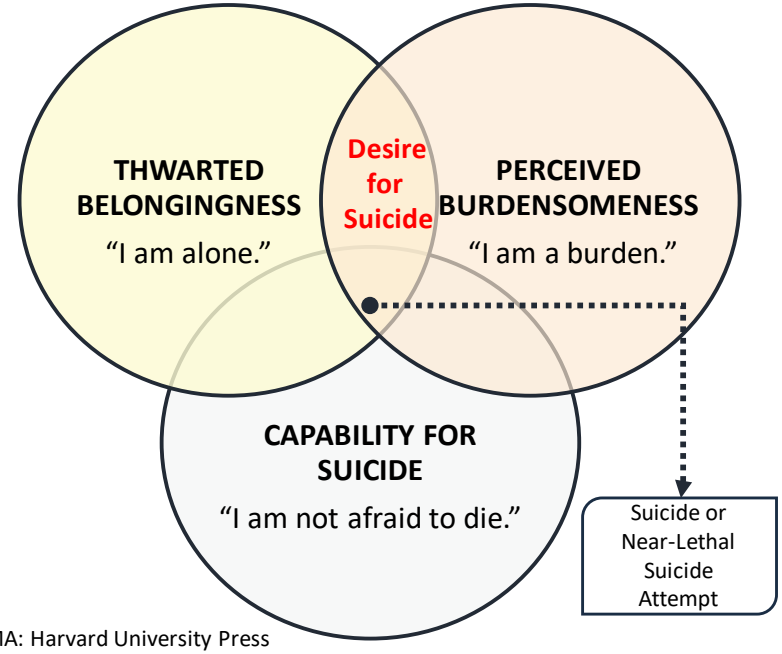
Why Do Some Choose To End Their Lives?



Deep Dive findings consistently reveal:

- Suicide risk is higher when Sailors are experiencing multiple stressors, including transitions, relationship issues, fall from glory
- Missed opportunities to "connect the dots" ahead of destructive behaviors, tipping point
- Failure to communicate the warning signs or risk factors detected by commands, providers, family members or peers (most evident during transition periods)
- ***Access to lethal means***

Joiner's Suicide Theory:



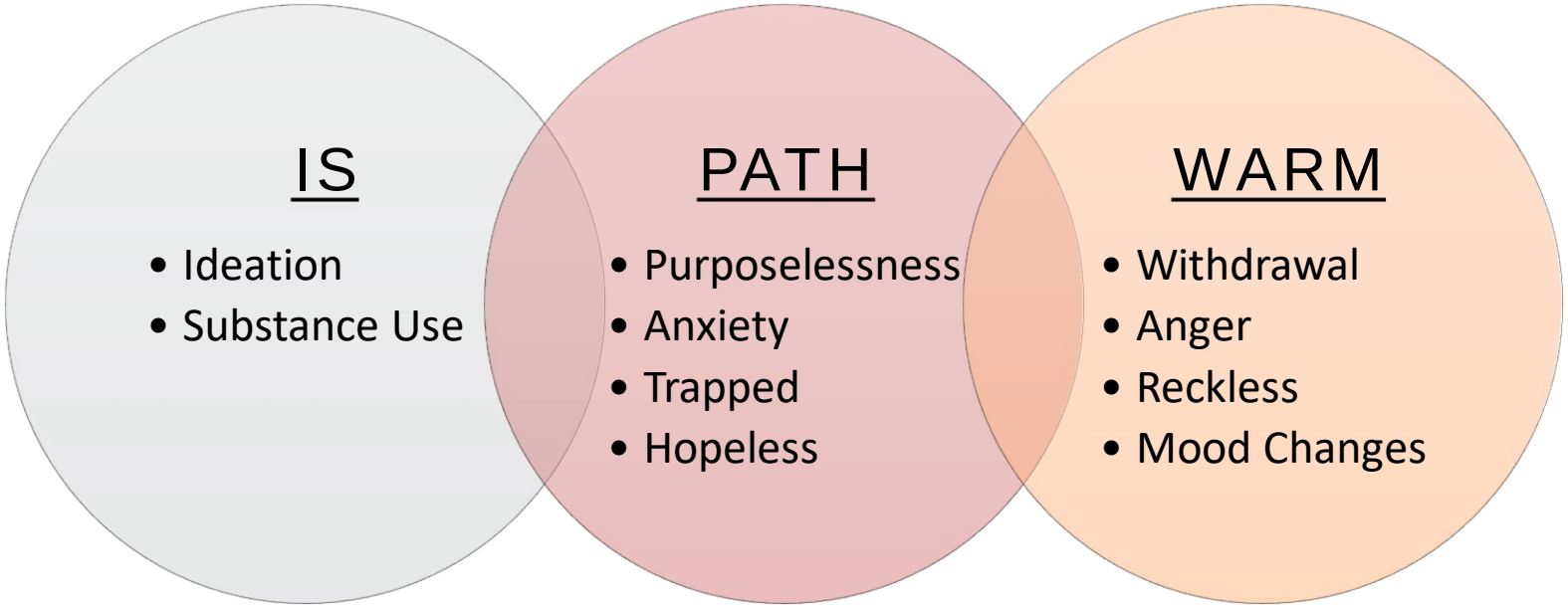
Joiner, T. (2005) Why People Die by Suicide Cambridge, MA: Harvard University Press

Understanding Suicide Risk Factors

Navy Mirrors Society	Stressors Unique to the Navy
• Individual factors • Relationships • Culture • Economic • History of abuse • Substance abuse • Mental health history • Legal problems • Access to care • Barriers to seeking help • Chronic pain • Sexual harassment, ostracism	• Unpredictability in job • Job environment, long hours • Navy and rating culture • Lack of privacy • Frequent transition/PCS • Stress on families, time away • Reporting requirements • Fear of career loss, failure • Security clearances • Chronic sleep deprivation • Familiarity with weapons • Excessive use of energy drinks

Rage and suicide are HIGHLY correlated.

Understanding Warning Signs



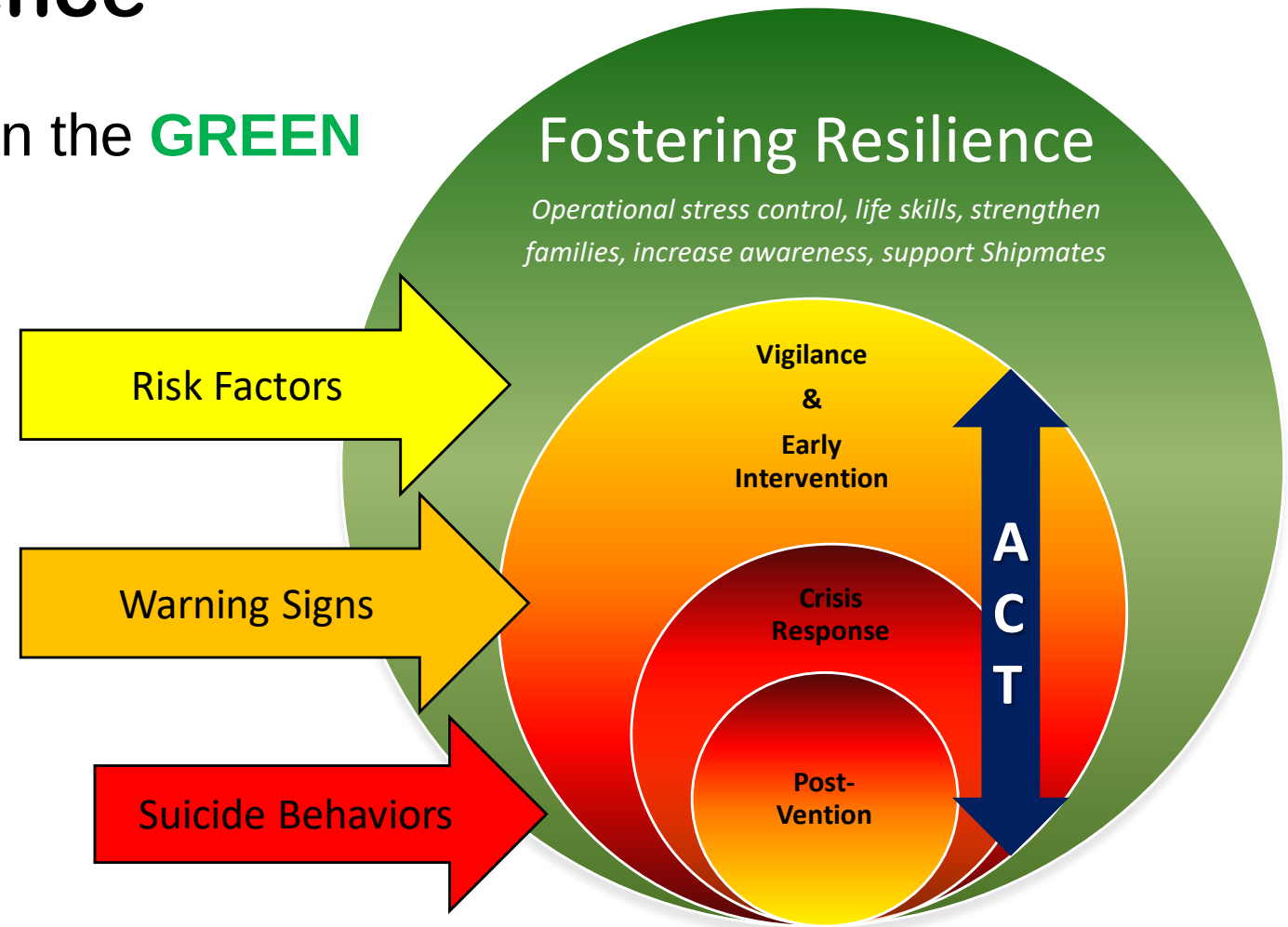
Connecting the dots...

Protective Factors

Individual Protective Factors	Command-level Protective Factors
Good problem-solving skills	Unit cohesion
Cognitive flexibility	Belonging and purpose
Coping skills	Peer support
Good self-care	Strong relationships
Willing to seek help	Properly trained for job
Positive hobbies	Communication
Spirituality	Work-life balance
Resilience	Positive environment

Prevent Suicide by Focusing on Resilience

Focusing on the **GREEN**



Connecting the Dots – Who is at Risk?

History

History of Abuse (Physical, Sexual, Emotional):	22%
Prior Suicide Related Behavior:	62%
Mental Health Treatment in Past Year:	41%
Prior Suicide Attempt:	19%
Alcohol Abuse:	35%

Disrupted Social Network

Transition (Pending demotion/PCS/Upcoming Separation from the Navy, Retirement):	77%

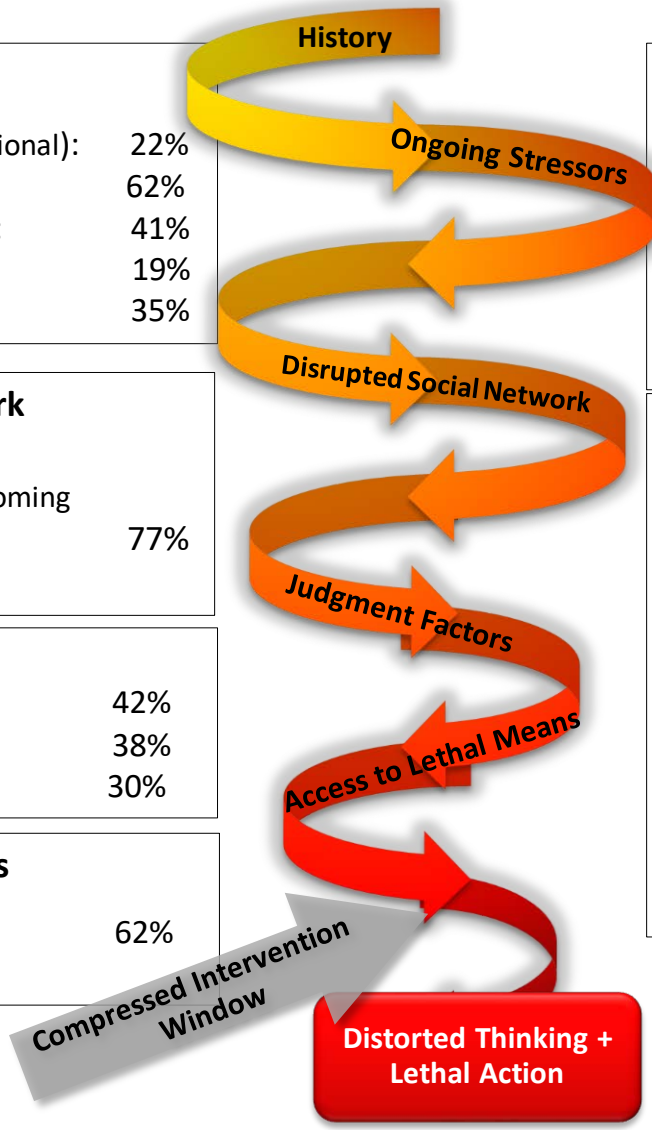
Judgment Factors

Sleep Problems:	42%
Recent event causing anger:	38%
Under the Influence of Alcohol:	30%

Access to Lethal Means

Access to Firearms:	62%

***NAVADMIN 263/14**



Ongoing Stressors

Experienced Loss:	78%
Intimate Relationship Problems:	75%
Work Problems:	58%
Disciplinary/Legal Issues:	35%
Financial Issues:	7%
Life Event	78%

Warning Signs

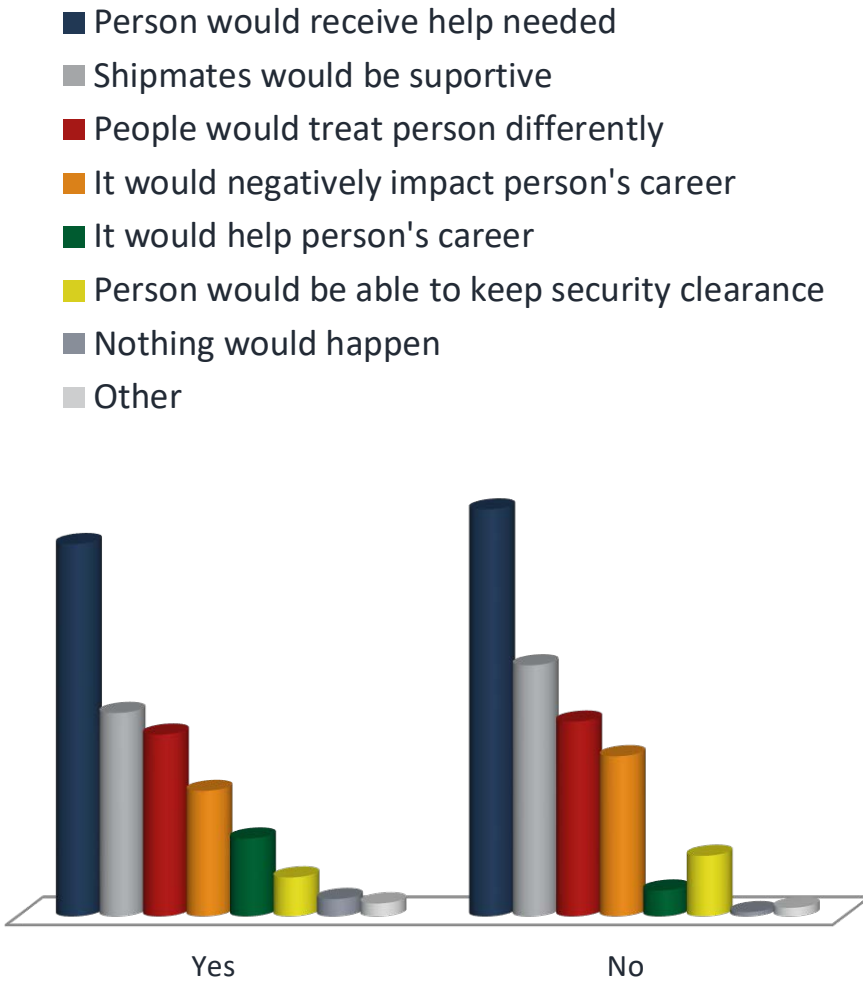
Recent Event Causing Shame, Guilt, Loss of Status:	49%
Recent Event Causing Feelings of Rejection/Abandonment:	42%
Feelings of Hopelessness:	38%
Recent Event Causing Feelings of Helplessness:	35%

***Missed Opportunities to connect the dots**

Source: 2014 Navy Suicide Prevention Annual Multi- Disciplinary Case Review

Why Sailors Don't or Won't Seek Help

- Most Sailors believe they'd receive help if they asked and their peers would be supportive. However…
  - Many believe they'd be treated differently
  - Many fear they would lose the trust of their leaders
  - Many believe it would negatively impact their career
  - Some believe they'd lose their security clearance
  - Most fear loss of privacy
  - Most fear gossip, being perceived as weak
  - Discouraging command climate, "get over it."



The Truth About Seeking Help

SPREAD the TRUTH

Psychological Health Treatment and SF86 Question 21

Standard Form 86 (SF86) "Questionnaire for National Security Positions" is used to evaluate individuals under consideration for Confidential, Secret, and Top Secret security clearances. One of the many reasons service members choose not to seek help for psychological health concerns is fear that doing so will jeopardize their clearance eligibility and careers. Here are the facts about answering Question 21:

It's okay to speak up when you're down

Less than 1% of security clearance denials and revocations involve psychological health concerns.

Seeking help to promote personal wellness and recovery may favorably impact a person's security clearance eligibility.

Not all psychological health treatment is required to be reported when answering question 21.

Any psychological health care you report when answering Question 21 is protected by privacy rights.

Discussing suicide openly and responsibly encourages help-seeking

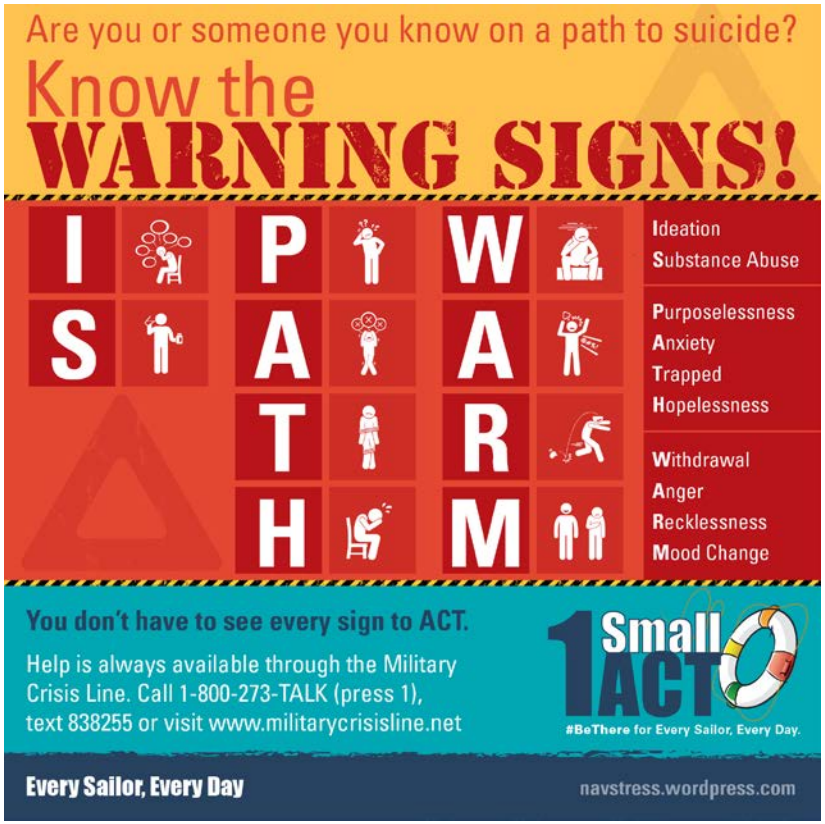
- Less than 1% of security clearances lost are due to mental health reasons
- Most return to duty and remain in the Navy
- Mental health providers can only routinely communicate with your doctor and your Commanding Officer
- Language counts
- Leaders set the tone

Implications for Legal

- Sexual offenses against children
  - Extreme social rejection
  - Increased likelihood of loss of relationships
  - Facing prison time
- Violent crimes
  - Willingness to harm others correlated with ability to harm self
  - Access to weapons increases risk
- Drug and alcohol crimes
  - Drugs and alcohol decrease inhibitions and anxiety that would normally protect against suicide
- Administrative separations and other discharges
  - Period of transition, loss of career and finances, loss of support, TPU

Recognizing Risk in Legal Clients

- Listen to your client:
  - "I'd rather be dead, my family is better off without me."
  - "I have no one to turn to, everyone has turned on me."
  - "I don't know what I'm going to do, I have no where to go."
  - "If I lose my family I've lost everything."
- Things to look for:
  - No discussion of life after the verdict, no reasons for living
  - Declining self-care (weight loss, disheveled appearance, no hobbies)
  - Not participating in defense anymore, seems to have given up
  - Social media posts with increasing images of alcohol, weapons and feelings of loneliness and rejection



Theoretically Speaking

- Thwarted Belongingness:
  - Rejection by or separation from unit
  - Rejection by or separation from friends and family
  - Loss of relationships (significant other, children, mentor)
  - Loss of identity (Navy status, culture, society, organizations)
  - Emotionally disconnected
  - Feeling ostracized
  - Fear of gossip and judgment

Theoretically Speaking

- Perceived Burdensomeness:
  - Others standing the watch, extra work load for peers
  - Disappointing leaders, peers and family
  - Added stress for family
  - Financial strain for family
  - Frequent or embarrassing mistakes at work
  - Difficulty getting qualifications or learning the job

Theoretically Speaking

- Acquired Capacity:
  - Nearly all hands trained to use a weapon, some use daily
  - Many military own private weapons
  - Exposure to combat or death
  - Prior traumatic experiences with near death or abuse
  - High risk takers, impulsivity
  - Preparations for death, rehearsals
  - Prior suicide attempts

Helping A Suicidal Person

- **ASK**: "Are you thinking about suicide?"
  - "Do you wish you were dead? Do you wish you wouldn't wake up? Have you thought about a way to kill yourself?"
  - Leading questions are okay, "With this amount of stress, it's common for people to feel they'd be better off dead. Have you had those thoughts?"
  - Ask the client if he/she is getting support, how the unit is treating them, are they eating and sleeping or increasing alcohol

- **CARE**: Listen without judgment
  - Don't give your opinions of suicide, don't tell them that others have it worse
- **TREAT**: Get the person to a professional
  - Take them to the ER, medical, the command or call 911
  - Remove any weapons (guns, pills, knives, ropes), stay with the person until safe
  - It's okay to ask about safety at every appointment
  - Even with the best decisions and actions, tragedies do occur

Under NO circumstances should you use a contract for safety!

Leadership Tips

- Updated Command Directed Evaluation Instruction
- NAVADMIN 263/14, Reducing Access to Lethal Means
- Medical communication with line leaders
- Protect privacy of Sailors who need help
- Know the local resources and support help seeking
- Prohibit repercussions, belittling, ostracism
- Be careful of how you talk about suicide
- The Sailor is your Sailor until discharges/PCS

Columbia-Suicide Severity Rating Scale (C-SSRS)

Suicide Ideation Definitions and Prompts		
Ask questions that are **bolded** and **underlined**.	YES	NO
Ask Questions 1 and 2		
1) Wish to be Dead: **Have you wished you were dead or wished you could go to sleep and not wake up?**		
2) Suicidal Thoughts: **Have you actually had any thoughts of killing yourself?**	If 2 yes, ask 3-6	If 2 is NO go to 6
If YES to question 2, ask questions 3, 4, 5 and 6. If NO to 2, go directly to question 6.		
3) Suicidal thoughts with method (without specific plan or intent to act): **Have you been thinking about how you might kill yourself?**		
4) Suicidal Intent (without specific plan): **Have you had these thoughts and had some intention of acting on them?**		
5) Suicide Intent with Specific Plan: **Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?**		
6) Suicide Behavior Question: **Have you ever done anything, started to do anything, or prepared to do anything to end your life?**		

*Min of 3 Questions

*Max of 6 Questions

Administration (1 of 3)

- Time frame for Questions 1-5: Past month
- Ask questions that are in bold and underlined
- All receiving C-SSRS are asked Questions 1 and 2
- Based on responses, decision tree is used to determine which additional questions are asked

1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up? ***Have you wished you were dead or wished you could go to sleep and not wake up?***
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan*." ***Have you had any actual thoughts of killing yourself?***

Consider frequent and recent thoughts.

Administration (2 of 3)

- If response to Question 2 is “YES,” ask Questions 3-6
- If response to Question 2 is “NO,” go directly to Question 6

3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. *“I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.”* ***Have you been thinking about how you might do this?***
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to “*I have the thoughts but I definitely will not do anything about them*.” ***Have you had these thoughts and had some intention of acting on them?***
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***

Ask about lethal means.

Administration (3 of 3)

- Time frames for Question 6: Lifetime and Past three months

6) Suicide Behavior Question **a.** ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.
If YES, ask: b. ***Was this within the past 3 months?***

The best predictor of future behavior is past behaviors.

General Guidelines

HIGHEST "YES" RESPONSE	RISK VARIABLE	SEVERITY LEVEL	POTENTIAL ACTION
Q1 Yes	Wish to die	Low Risk	**Routine Behavioral Health Referral** Assist to connect with behavioral health provider. Monitor, but next available appointment is acceptable.
Q2 Yes	Active thoughts	Mild	**Urgent Behavioral Health Referral** Advocate for priority appointment (priority behavioral health referral). Inform professional of circumstances and request service member be seen within a few days.
Q3 Yes	Method(s)	Moderate	**Urgent or Immediate Outpatient Behavioral Health Referral** Priority-, i.e. within few days or Immediate (today) outpatient Behavioral Health referral. Emergency Room (ER) not otherwise required.
Q4 Yes	Intent	Severe	**Immediate evaluation at MTF Outpatient or Emergency Room** Arrange 100% observation, send with written documentation
Q5 Yes	Plan and intent	Extreme	**Immediate evaluation at MTF Outpatient or Emergency Room** Arrange 100% observation, send with written documentation

Q6 provides information on history of suicide related behavior and should heavily inform risk level determination.
***Use ALL details to inform your response. "Level" is only one piece of information!**

Veteran's Affairs Safety Plan
"The Sailor's Plan"

SAFETY PLAN: VA VERSION

Step 1: Warning signs:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problem without contacting another person:

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5:Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services _____
   Urgent Care Services Address_____
   Urgent Care Services Phone _____
4. VA Suicide Prevention Resource Coordinator Name_____
   VA Suicide Prevention Resource Coordinator Phone_____
5. VA Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), push 1 to reach a VA mental health clinician

Step 6: Making the environment safe:

1. _____
2. _____

Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008).

Under NO circumstances should you use a contract for safety!

Resources for Legal & Clients

- Local Resources:
  - Chain of command for support, mentorship and guidance
  - Chaplains:100% confidentiality, CREDO, premarital & marital counseling, spiritual guidance and support
  - Fleet and Family Support Centers (FFSCs): counseling, classes, education, support programs
  - Primary Care Manager and Primary Care Mental Health Provider – Integrated Behavioral Health, assessments and treatment
- National 24/7 Resources:
  - Military OneSource: 1-800-342-9647
  - National Suicide Prevention Lifeline: 1-800-273-8255
  - Veterans' Military Crisis Line: 1-800-273-8255, Press 1
  - BeThere Peer Support Call & Outreach Center: 1-844-357-PEER
  - DoD Safe Helpline: 877-995-5247

- Don't be afraid to ask about access to lethal means (firearms, medications, etc.). Free gun locks are available at local FFSCs and NOSCs. For more information, refer to NAVADMIN 263/14 or visit www.suicide.navy.mil.
- Be mindful of your own mental health when working with suicidal clients

Other Resources

- **General Suicide Prevention Resources**
  - Navy Suicide Prevention: www.suicide.navy.mil
    - Contact information
    - Facts and warning signs
    - Informational products and resources
  - Suicide Prevention Resource Center: www.sprc.org
- **Navy Operational Stress Control Resources**
    - Wordpress blog: www.navynavstress.com
    - Twitter: www.twitter.com/navstress
    - Facebook: www.facebook.com/navstress
- **Columbia Suicide Severity Rating Scale (C-SSRS) Training**
  - http://cssrs.columbia.edu/training/training-options/