MILITARY-CIVILIAN TEAMWORK IN SUICIDE PREVENTION

Armed Forces' Strategies, Procedures, and Responsibilities to Implement their Policy that

Suicide Prevention is Everybody's Business!

Meyer Moldeven

Moldeven Publishing

Del Mar, CA 92014

MILITARY-CIVILIAN TEAMWORK IN SUICIDE PREVENTION

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Compiled and published
by
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THE INFORMATION IN THIS BOOK DOES NOT CONSTITUTE INSTRUCTIONS, PROCEDURES OR OTHER GUIDANCE FOR PROFESSIONAL OR SELF-TREATMENT OF MENTAL HEALTH DIFFICULTIES. THE INFORMATION IS 'DATED' TO THE EARLY 1990s OR BEFORE AND, VERY LIKELY, HAS BEEN SUPERSEDED SINCE THEN. **IF YOU ARE EXPERIENCING SELF-DESTRUCTIVE OR SUICIDAL THOUGHTS CONSULT ASAP YOUR DOCTOR OR THE MENTAL HEALTH RESOURCES OF YOUR ORGANIZATION OR COMMUNITY. GET HELP.**

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Dedicated
to all the people in the
United States Military Services,
uniformed and civilian,
and to the professional and volunteer staffs of
crisis and suicide prevention centers
and other activities
on and off the bases,
who work hard and selflessly
to keep the desperate from
harming or destroying
themselves.

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Caution: The content of this compilation is for background and reference only. Consider all of the material herein as having been supplemented or superseded by this time with new policies, procedures, plans, guides, etc.

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PREFACE TO 1994 EDITION

In 1985, and again in 1988, I compiled studies, plans, directives, motivational guides and other documents of the Armed Forces on their suicide intervention and prevention programs and published them in book form. The 1985 version was *Military-Civilian Teamwork in Suicide Prevention* and the 1988, *Suicide Prevention Programs in the Department of Defense.* This 1994 volume returns to the 1985 title in the hope that it will emphasize the positive potentials of close collaboration between the military, other governmental and public entities, and the private sector in promoting and furthering the objectives of suicide intervention and prevention. The enormous changes in Armed Forces missions and resources over the past several years also suggest that another update is in order.

FOREWORD

The universal human phenomenon of suicide affects us all. A Congressional Report on suicide in the United States stated "... (suicide) has reached unprecedented proportions. Yet, efforts to reduce the suicide rate or to develop effective prevention programs have been largely neglected." The portent of suicide trends among the nation's youth and elderly offers little encouragement.

The United States Armed Forces recognize that suicide, attempts at suicide, and deliberate self-destructive behavior in the Active and Reserve Forces, in the extended military community, and among their civilian employees are of "significant concern." The separate Departments that constitute the Department of Defense have designed and implemented strategies to deal with the phenomenon. Suicide intervention and prevention is, and will continue to be, an intense and ongoing struggle.

The largest single federal department formally recognizing suicide as a critical challenge to the good and welfare of their personnel, took a great leap forward by institutionalizing *suicide prevention.* With the foresight and efforts of advocates and caring managers, comparable initiatives, both formal and informal, can be expected from other government entities. When top-management directed -- and supported -- suicide intervention and prevention policies do take root throughout the federal system, as they inevitably will, they will merge or interact with adjacent Regional, State and community programs. The United States Armed Forces' *everybody's business* approach to crisis intervention and suicide prevention for their military and civilian people is therefore enormous in its potential for the public good.

Public and private sector employers benefit from their awareness of policies, resources, and standard operating procedures for suicide intervention and prevention practiced by institutions and other employers in their area. Where such cross feed and mutuality does not prevail, employer-community initiatives can explore them and use the results for the common good. Such efforts contribute to the well-being of employees and their families, encourage crisis intervention programs at schools, improve industrial plant and community safety, and generally enhance esteem and mutual respect among employers and the community of which they are a part. The Armed Forces' suicide intervention and prevention guidelines in this compilation contribute to that purpose.

For "everybody's business" policies and practices to succeed, information useful to the ultimate recipient of crisis intervention aid needs to be disseminated to all levels and throughout all functions -- the line, the staff, and their families; the civic, academic and business community, and the general public. Readily accessible in public, institutional, and corporate libraries, adapted to and ingrained into the system, the procedures and who-does-what will help to coordinate plans and methods across the board. The letters that form part of this Introduction are relevant in that light.

Cooperation from the news media can alert employers and other entities who are not yet involved, and suggest to them opportunities for participation.

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PREFACE TO 1985 EDITION

Some of the materials now in this monograph were, in prior years, letters, articles and pamphlets I had addressed to Members of Congress and the Executive, to people in the news media, to heads of professional societies, and to others in positions of influence. In essence, I appealed for grass roots-level teamwork in suicide prevention and intervention between the Federal Government, as an employer of people, and the communities in which those people, military and civilian, lived and worked.

Prior to publication, viewpoints on the book's content were invited from the Department of Defense and field military installations in each Service, from other Federal Departments, and from crisis intervention and suicide prevention activities in the private sector. Many responded.

Formal approval of this book by any governmental or private sector institution or entity was neither sought nor offered. The book's primary purpose is to share cooperative administrative methodologies experienced by one who was a paraprofessional volunteer worker in suicide prevention and, at the same time, a career professional in the Inspector General function at a large military installation.

Any trespass by this book into the domain of mental health and social services professionals is unintentional. These writings grew out of my own experiences in the Military and Federal Civil Services' Inspector General Complaints, Administrative Investigations, and Congressional Inquiries Systems, and from my close and daily collaboration with such functions as military security, family support, legal services, social actions, and others concerned with the good and welfare of the troops, including civilian employees. In this context was an almost constant interaction and cross-feed between my career IG duties and my paraprofessional volunteer work in a community suicide prevention center.

Concerning the latter, during the late '60s - early '70s circumstances compelled me to organize and help operate a mutual assistance routine between a community suicide prevention center and nearby military installations. The procedure worked, and the lessons learned are woven into the fabric of this book. In the current context, comparable methods can support recommendations made in the United States Air Force Office of Special Investigations (USAF OSI) report on Suicide Among Active Duty USAF Members and initiatives in the United States Army 1985 Suicide Prevention Plan and implementing Programs.

MATERIAL WRITTEN BY THE AUTHOR IN THIS WORK IS INFORMATIVE ONLY. IN NO WAY WHATSOEVER SHOULD THESE WRITINGS BE CONSTRUED AS PROFESSIONAL GUIDANCE IN ANY MENTAL HEALTH DISCIPLINE.

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Meyer (Mike) Moldeven
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April 26, 1993

Secretary of Defense
Pentagon
Washington, D C

Dear Secretary of Defense:

(The opening sentence cited a number of suicides in a military organization. Identification of the facility is not relevant to the intent of this book and has been deleted.)

There is one aspect of organizing around (suicide intervention and prevention) -- all-services-wide -- that deserves review at command level and, if a covering rule or management system exists, that it be publicized throughout the services and in civilian communities adjacent military installations.

Normally, a military person with an intolerable personal problem tries to get relief from within the system of which he or she is part, e.g., a buddy, family support services, chain-of-command, personnel staff, the IG, etc.. Many personal problems are not job related, but because of the victim's inability to cope, spill over and affect "job." When the person is in a suicidal crisis, realizes that help is urgently needed, and wants such help, he or she will not hesitate to contact whomever can provide it, if not from within the system then from outside.

Unless the military administrative system has changed on this point, a suicidal military person, or a suicidal member of his or her family who seeks help from within the system, believes that a record of the contact will be made. The "record" transforms to stigma and a potential threat to present job and future career. "Records," more often than not, compel the person in a suicidal crisis to look elsewhere. Elsewhere includes the adjacent civilian community's crisis intervention resources, specifically, the suicide prevention telephone hotline where the caller need not provide identification -- they're as safe from being identified as anywhere they can be under their circumstances. The hotline worker does what can be accomplished quickly to keep the caller from slipping deeper into crisis and acting out a threat to suicide. They listen, offer nonjudgemental feedback, and *together* with the caller, explore options.

Almost invariably, when a civilian community crisis worker (telephone hotline or face-to-face) needs information on options unique to military life to help a suicidal military member or someone in his or her immediate family, the source is the nearest base's health care, personnel, or other administrative functions Very often, when contacts with base officials occur and the worker has the name of a suicidal caller, confidentiality is literally vital; being tagged in the base's records as someone who phoned an off-base crisis center carries almost certain exposure to military authority, and might well add the final straw.

If it's accepted that the military base and its adjacent civilian community should cooperate in suicide intervention, then the civilian and military agencies need mutually accepted procedures to do the job. If a community's crisis resource has one set of procedures for cooperation from the Navy, another for the Marine Corps, and still others for the Army and the Air Force, confusion mounts and collaboration suffers. This is especially true when the situation is tight and there isn't much time to keep a suicide threat from becoming an act. To the telephone hotline worker in a suicide prevention center it makes no

difference whatsoever if the person on the other end of the line is a soldier, sailor, airman, marine -- or civilian. On the other side of the scale, however, is the we-take-care-of-our-own turf, and that, to the suicidal person, is meaningless.

I hoped that, by now, military bases would have been further along in collaborating with adjacent civilian suicide prevention resources and that such teamwork would be reflected in base and community media. How else would a military person or a member of his or her family on the edge of a life-death decision for themselves know where to go or whom to phone, especially where their privacy and confidentiality would be respected -- if they decided to take a chance to continue living? Is a city telephone directory listing for the local crisis center enough?

Agreements, procedures and contact points for military-civilian teamwork in suicide prevention deserve to begin on a county, metropolitan, or other regional basis, rather than in single-base to community understandings, especially where the area has bases representing different services. When all the services in an area have maximum understanding among themselves about collaborating with community suicide intervention resources, it will optimize the support they and their people *as individuals* can ask for from that resource, and the help that the hotline worker can offer to them. In effect, when a civilian suicide hotline has been appealed to for help by a military member/family member, the crisis worker will have clearly written, mutually agreed upon procedures for communications and actions with each base in the area. All concerned will have been trained, tested, and *know* to the greatest degree possible who is going to do what. With present computer networking capabilities the resources indices in such guides can be readily maintained current and widely disseminated throughout a region and on and among military installations.

The opinions in this letter are my own, and are based on my experiences as a civilian IG-type and suicide prevention hotline volunteer in the late '60s/early 70s (and hassling the bureaucracy on this subject into the mid-80s.) I am not now associated with any mental health profession or military organization -- strictly a private citizen. It may be that what I've suggested already exists or, conversely, that it isn't justified; I don't know, but I would be remiss not to present my views for your consideration.

Respectfully,

s/Moldeven

OFFICE OF THE SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

1 JUN 1993

(Force Management
and Personnel)

Mr. Meyer (Mike) Moldeven
Post Office Box 71
Del Mar, CA 92014-0071

Dear Mr. Moldeven:

Thank you for your letter of April 26, 1993, to Mr. Les Aspin, regarding suicide prevention programs in the Department of Defense.

Your letter prompted a review of policy in the Department of Defense on suicide prevention. The Department of Defense does not address suicide prevention in its directive on Health Promotion. That directive was published March 11, 1986, and is in need of revision. The Department is reviewing and revising that directive and a suicide prevention section will be added. We will address in the development of that section the issues you raised in your letter to Mr. Aspin.

Thank you for your interest and continued concern in this important mental health area.

Thanks!

Sincerely,

Nicolai Timenes, Jr.
Principal Director
(Military Manpower and Personnel Policy)

cc:
OASD(HA)

Tel.: (619) 259-0762

Meyer Moldeven
P. O. Box 71
Del Mar CA 92014-0071

August 26, 1993

Assistant Secretary of Defense/Health Affairs
Department of Defense
The Pentagon
Washington, D. C. 20301

This is in reference to the attached copy of letter, 1 June 1993, from Nicolai Timenes, Principal Director (Military Manpower and Personnel Policy) indicating that a section on *suicide prevention* will be added to the DoD directive on Health Promotion.

I am gathering material for an update to my 1987 book *Suicide Prevention Programs in the Department of Defense*. In that the product of my efforts will find its way into public, military, and institutional libraries, and serve as a resource at suicide prevention centers and private practitioners , the proposed addition to the DoD Health Promotion directive would be an invaluable part of my project.

I would deeply appreciate a copy of the approved DoD statement on suicide prevention and any other material on suicide intervention and prevention that would be useful in this regard. Thank you considering this appeal.

Sincerely,
s/Moldeven

(Reply not received as of date this book was printed. M.)

Reducing Stigma of Mental Illnesses Could Reduce Suicides

By Staff Sgt. Kathleen T. Rhem, USA
American Forces Press Service

ARLINGTON, Va., May 8, 2000 -- The continuing social stigma attached to mental illness is the biggest obstacle mental health experts face in helping patients, reducing suicide rates -- and in the military, improving the fighting force.

"I think there's no question that the main impediment to psychiatric care is the stigma," Johns Hopkins University psychiatrist Dr. Kay Redfield Jamison said May 2. "We have good treatments for the major psychiatric illnesses. What's difficult is getting people to recognize that they have a problem ... and to set aside the stigma or work around it."

The Baltimore professor put the spotlight on mental health as the latest speaker in a year-long women's health seminar series co-sponsored by the Women in Military Service to America Memorial Foundation, DoD and the Department of Veterans Affairs. The monthly noontime brown-bag lunch presentations are held at the Women in Military Service to America Memorial at Arlington National Cemetery here.

Jamison said she draws insight from her own experiences as a military "brat." Her father was an Air Force scientist and pilot who struggled with manic-depression.

"The major way [mental illness] was treated was to go to the Officers Club and drink. Alcohol was very heavily subsidized by the Air Force," she said. "At that time, had he sought treatment, there is no question he would have been out of the service."

Mental illness is of particular concern to the military because the military population is statistically younger than the general population. "Mental illness is a disease of youth. That's why suicide is such a problem among young people," Jamison said. "Major psychiatric illnesses tend to kick in around the time of puberty and escalate after that. The average age of bipolar disorder to kick in is 17 or 18. Depression has a slightly later onset ... the early 20s."

Depression is at least twice as common in women as in men, she noted, but men and women are equally likely to suffer from bipolar disorder.

"Nearly one person in five will suffer a major depressive disorder," said Jamison, who recalled her personal battle with bi-polar disorder for the audience. She stressed mental illness is highly treatable and that, while things aren't fully enlightened, they've changed a lot since her father's military days.

"The tragedy of having mental illness go untreated doesn't have to happen any more," she said.

Dr. (Army Lt. Col.) E. Cameron Ritchie agreed. She's the director of mental health policy and women's issues for the Office of the Assistant Secretary of Defense for

Health Affairs and was at Arlington, too.

"We have been trying very hard in the military and in the civilian world to destigmatize mental health," she said. "One way to do this would be to have people who have struggled with depression and bipolar disease come forward, but that's very hard to do.

"I have a number of patients who are very successful in the military, but would I ask any of them to come forward and tell their story? No. Not if they're hoping to get another job; not if they're hoping to be promoted," Ritchie said. "Perhaps if they've recently retired. There is still such a stigma about the treatment of mental illnesses."

She said the suicide rate in the United States is about 20 per 100,000 people every year. The suicide rate in DoD is somewhat lower -- about 12 to 14 per 100,000, she noted.

Both experts praised the Air Force's suicide prevention program and an underlying premise: If you need mental health treatment, you're more courageous to seek it than avoid it, she said.

Jamison said the Air Force treats suicide and mental illness as servicewide command problems as well as medical ones. She said the service took recommendations for suicide prevention from the Centers for Disease Control and put them into effect and established a central database to determine the circumstances of suicide attempts and suicides.

"In addition, the top military personnel in the Air Force sent an e-mail out to everyone saying the really courageous thing to do and the correct thing to do if you suffer from any type of psychiatric disorder is to reach out and get help," she added.

Ritchie pointed to the Air Force's focus on suicide and mental health treatment command- and four-star-level issues. "They've worked with their community services, their alcohol and drug control programs and their chaplains, so there's better communication," she said. "They've also put a high emphasis on confidentiality of mental health records, so people can be seen without worrying about who's going to find out about it."

The Air Force has the lowest suicide rate of the services, and that fact hasn't escaped DoD's attention. A working group is looking at ways to reduce suicides throughout the department and it's drawing from the Air Force's success.

One of the issues the working group is studying is record keeping. "Traditionally, we keep data on those who commit suicide but not those who attempt suicide. But we know an attempted suicide is a high risk factor for suicide," Ritchie said. "After a completed suicide there's supposed to be a 'psychological autopsy.' But even in the Army, which took the lead in psychological autopsies, they were only being completed in about 50 percent of the cases."

Among other things, a psychological autopsy seeks to determine individuals' state of mind before they died. "We need data about why people commit suicide so we can take it back and look at our prevention programs," she explained.

Efforts are also under way to improve confidentiality of mental health records. Ritchie said the Navy and Air Force post mental health entries into members' main medical records, while the Army maintains them in separate records. Either way, commanders technically can request access to the records, and this makes many service members apprehensive about seeking treatment, she said.

In reality, service members might not need to worry about this too much. "I've never had a commander request records," Ritchie said.

DoD is also trying to keep pace with changes in civilian medical policies. In October 1999, President Clinton signed an executive regulation limiting release of medical records. The new regulation "prevents doctors, hospitals, health plans and other covered entities from releasing identifiable health information without a patient's written consent for purposes unrelated to treatment, payment, or priorities like public health."

"Every American has a right to know that his or her medical records are protected at all times from falling into the wrong hands," Clinton said Oct. 29. "These standards represent an unprecedented step toward putting all Americans back in control of their own medical records."

Ritchie said this has changed one important thing in the military system. "If there's a court-martial pending and people needs treatment, they can go seek treatment and not fear that those records are going to be used against them," she said.

Privacy walks a fine line in the military. The command has a valid need to know if a service member is dangerous to himself or others or to unit readiness or security, but these are extreme circumstances, Ritchie said. "Usually, at that point, the person is admitted to the hospital and the command knows that," she said.

"The problem is, the average person doesn't know what they can come talk about without it being revealed," she said. "Then one of three things can happen. They'll go downtown instead of the military [medical] system, they'll go see a chaplain, or they won't see anybody. Sometimes suicide is the result."

Ritchie said she emphasizes to service members that mental health professionals are discreet, and that it's in their own best interest to seek treatment before a situation becomes critical.

"If it's a self-referral, nobody else needs to know," she said. "If, however, the situation worsens to the extent it affects their job or personal life and it comes to the commander's attention through a [police] report, their job is a lot more in jeopardy."

Related Sites of Interest:

- *American Psychiatric Association at www.psych.org*
- *American Psychological Association at www.apa.org*
- *National Alliance for the Mentally Ill at www.nami.org*
- *National Institute of Mental Health at www.nimh.nih.gov*

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Aug 1, 1985

Director, Division of Health Services
U. S. Department of Labor
Washington, D. C. 20210

Dear Director:

I have just received a letter dated July 12, 1985 from your Departmental Office of Information and Public Affairs stating that your Division has a considerable amount of material on suicide prevention. The letter was in response to one I had written, copy enclosed for ready reference.

The Army is extending their suicide prevention programs to include their civilian employees, in effect, a potentially beneficial employer-employee relationship. It's hard to say at this time where this could lead in public and private sector counterpart programs.

I am now doing research in preparation to a follow on to my original handbook on MILITARY-CIVILIAN TEAMWORK IN SUICIDE PREVENTION, and hope to explore the employer-employee context. Your material on suicide prevention can be most useful to me for this purpose. If any of your studies, statistics, etc. are available for distribution to researchers/writers I would deeply appreciate being provided copies. Further, if your Department is engaged in research on this subject, it would be most helpful to me to know what projects are under way or planned, to the extent that such information can be made available.

Thank you for whatever you can do for me in this regard. An early reply would be most welcome.

Sincerely,

(s/Moldeven)

No reply
M.

Editorial

MILITARY MEDICINE, Vol 135, No 6, June 1970, pg 500

Suicide Prevention in the Military

In our studies of situational, family, and social components we found that suicidal behavior was inextricably woven into the fabric of family behavior patterns, with difficulties experienced by the entire family in meeting their socially appropriate roles, tolerating growth and separation, and in handling and controlling sexual and aggressive drives. The suicidal person, in particular, was scapegoated within the family, made the object of agression and rejection, and given both overt and covert messages to commit a self-destructive act, with inadequate opportunities to retaliate and be aggressive in return.

Bearing in mind that our experiences were based upon a civilian population, we wonder, nevertheless, whether the findings do have relevance for the problems of suicide in the Services. The military is not the only family of the GI, and it would be an oversimplification to consider it so, but, for the time being, the service is his family. We therefore recommend that the Armed Forces look at themselves and their role in the presence and prevention of suicidal behavior. We believe that suicide is a function of the entire social milieu the soldier is in. This includes the military, but also his actual family and the matrix of social and interpersonal relationships which may still be active and effective, despite a physical separation of a thousand miles or more.

We found that the part played by the family or significant others in the GI's civilian life in the suicidal behavior could be utilized therapeutically. We also found that the danger of suicide became activated by the presence of a crisis, either within the suicidal person or in his milieu, with a destructive and scapegoating reaction by the family to the situation. Induction into the military service certainly creates the potentially emotionally hazardous situation described by Klein and Lindemann[1] which is productive of such a crisis. It is also no accident, we suggest, that suicidal behavior in the military is frequently associated with going AWOL or even visiting the home on official leave.[4] It is well known that the GI not only goes AWOL *from* the service, but *to* some other place, most often home. Such behavior can best be understood as an interaction involving the suicidal soldier, his family and the military.

These considerations apply to attempts, mostly manipulative ones, committed by enlisted men, especially those newly admitted. However a similar conceptual approach might help in the understanding and hopeful prevention of completed suicides, which in the Army are more often committed by the older man, the commissioned and non-commissioned officers.[5] Among the precipitants in these cases are personal problems and retirement. In our experience, suicidal attempts following retirement in civilian life are intimately related to the intolerance of those in the home for the new change in status and activities.

It is easy to apply such labels as sociopaths, character disorders, and psychotics to the suicidal soldier, and look at his act pejoratively. However, suicidal behavior may also reflect a breakdown of social integration or a lack of cohesion between the GI and the military, which is more widespread than the number of suicidal threats, gestures, and serious attempts alone. Suicide may be worth examining as a symptom of a wider discontent.

Treatment measures have often been effective. Offenkrantz, Church, and Elliot[3] for example, met the "emotional blackmail" of a suicidal threat or attempt by counter-black-

mail. The suicidal GI was told that if he attempted suicide his family would lose whatever benefits they would have otherwise obtained, and he would be court martialed. Although seemingly harsh, this treatment is realistic, with some similarity to Glasser's "Reality Therapy." In addition, it provides that clear structure and understanding of the situation, which are almost always absent in the background of the suicidal person. This method worked, we believe, because it was an appropriate form of crisis intervention.

We wonder how often a more sensitive and understanding approach is aborted for fear that it would seem unmilitary. This is well presented in a short story by James Moffett.[2] An army colonel breaks through his concern with his image before the men under his command and his fear of appearing unmanly, and prevents a suicide by showing a private, who was about to jump from a tower, that he (the colonel) cared and wanted him to live.

We have three suggestions about suicide prevention that follow from these reflections. First, we recommend that the families of AWOL or presuicidal soldiers be brought in when possible, and their role in the disturbed situation assessed. The same family approach can be applied when a suicidal threat or attempt has already taken place. We realize the practical difficulties as well as theoretical objections to this proposal, but we wonder whether the approach can be tried out on an experimental basis in one or two installations.

Second, we realize that the Army is cognizant of some of the social changes taking place, just as it was sensitive to the movement towards desegregation, and, therefore, may permit some greater measure of freedom of expression and room for dissenting opinions. We are not advocating disobedience or any breakdown in discipline. Disagreement is not revolt but, on the contrary, can lead to an improvement in morale and functioning, and perhaps alter such pathological forms of aggressive reactions as suicide.

Our third and final suggestion is to explore the feasibility of setting up a twenty-four hour suicide prevention service in a military installation, comparable to those which have proven effective in Los Angeles, and, in fact, throughout the world. It would be a preventive service, geared to those who are unhappy, depressed, and suicidal, and who want help for their condition, not for those looking for an "out."

These three suggestions are based upon the premise, first, that suicide does not occur in a vacuum but is related to the social setting the person is in; and, second, that the possibility of suicide is reduced if other avenues of legitimate aggressive discharge are open, and if there are other persons to whom one can turn, especially during a crisis.

We believe that the methods we have used in understanding and treating suicidal behavior are worth trying for the suicide problem in the Army. The principles of good mental hygiene apply to both civilian and military life.

MILTON ROSENBAUM, M.D.
JOSEPH RICHMAN, PH.D.

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