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Personnel—General

Suicide Prevention and Psychological Autopsy

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SUMMARY of CHANGE

DA PAM 600-24

Suicide Prevention and Psychological Autopsy

This new Army pamphlet explains procedures for preventing suicide and for conducting a psychological autopsy.

Personnel—General

Suicide Prevention and Psychological Autopsy

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History. This UPDATE printing publishes a new Department of the Army pamphlet.

Summary. This pamphlet explains the policies and procedures for establishing the Army Suicide Prevention Program and for conducting a psychological autopsy.

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Proponent and exception authority. Not applicable.

Interim changes. Interim changes to this pamphlet are not official unless they are authenticated by The Adjutant General. Users

will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

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Glossary

RESERVED

Chapter 1 Introduction

1-1. Purpose

This pamphlet sets forth policy and procedures for establishing the Army Suicide Prevention Program (ASPP) and conducting psychological autopsies. It provides guidance for all suicide prevention activities of the Army and for any psychological autopsies. It provides the rationale, circumstances of use, and guidance for reporting of psychological autopsies.

1-2. References

a. Required publications.

(1) AR 195-2, Criminal Investigation Activities. (Cited in paras 2-4i(1) and 3-7d.

(2) AR 600-63, Army Health Promotion Program. (Cited in para 5-1a.)

b. Related publications. A related publication is merely a source of additional information. The user does not have to read it to understand this regulation.

(1) DA Pam 600-70 (United States Army Guide to the Prevention of Suicide and Self-Destructive Behavior).

(2) AR 40-216, Neuropsychiatry and Mental Health.

(3) AR 600-8-1, Army Casualty and Memorial Affairs and Line of Duty Investigations.

(4) DA Pam 600-70, U.S. Army Guide to the prevention of Suicide and Self-Destructive Behavior.

1-3. Explanation of abbreviations and terms

Abbreviations and special terms used in this publication are listed in the glossary.

Chapter 2 Suicide Prevention

2-1. The Army Suicide Prevention Program

Suicide prevention must be the business of every leader, supervisor, soldier, and civilian employee in the Army. To facilitate this effort, a coordinated program for suicide prevention is needed at every Army installation and separate activity.

2-2. Suicide Prevention Task Force

a. Each installation establishes a committee to plan, implement, and manage the local ASPP. The membership of this committee will be tailored to meet local needs.

b. Installation commanders may assign the suicide prevention mission to the installation Health Promotion Council or may elect to establish a separate Suicide Prevention Task Force (SPTF) to function as a subcommittee of the Health Promotion Council. When using the Health Promotion Council to manage the ASPP, care must be taken so that suicide prevention does not take a second place to other responsibilities of the council. Responsibilities of the council members, with respect to suicide prevention, must be clearly established.

c. The SPTF should consist of the following personnel or their local equivalent:

(1) The Director of Personnel and Community Activities (DPCA).

(2) The Director of Plans and Training (DPT).

(3) Installation and division chaplains.

(4) The Director of Health Services (DHS).

(5) The division surgeon.

(6) The Chief, Community Mental Health Service.

(7) The division mental health officer.

(8) The public affairs officer (PAO).

(9) The civilian personnel officer (CPO).

(10) The provost marshal.

(11) Commander or special agent-in-charge of supporting U.S.

Army Criminal Investigation Division Command (USACIDC) element.

(12) The staff judge advocate (SJA).

(13) The Alcohol and Drug Control Officer (ADCO).

(14) The Army community services officer (ACS).

(15) A representative of the post family member schools.

(16) Other installation and community agencies as needed.

2-3. Functions of the Suicide Prevention Task Force

The Suicide Prevention Task Force will—

a. Coordinate program activities and the suicide prevention activities of the command, interested agencies, and persons.

b. Evaluate the program needs of the installation and make appropriate recommendations to the commander.

c. Review, refine, add, or delete items to the program based on an on-going evaluation of needs.

d. Develop awareness training about installation suicide prevention activities and identify appropriate forums for training.

e. Evaluate the impact of the pace of training and military operations on the quality of individual and family life in the total military community.

f. Recommend command policy guidance about training and operations issues to assure that soldiers and their leaders have sufficient opportunity for quality family life.

g. Be aware of publicity generated with respect to suicides in the community and develop public awareness articles for publication.

h. Meet at the discretion of the task force presiding officer.

i. In the event of a suicide, review the results of the psychological autopsy to look for the possible causes of the suicide and, if necessary, evaluate the prevention effort and make recommendations to the commander.

j. Coordinate with civilian support agencies as necessary.

2-4. Functions of the Suicide Prevention Task Force members

The following list of specific functions for task force members and other installation staff agencies is provided as a guide for the efficient operation of the SPTF.

a. The Director of Personnel and Community Activities—

(1) Serves as the presiding officer of the Suicide Prevention Task Force and coordinate the efforts of task force members.

(2) Serves as the point of contact for program information and advice to the commander and to major subordinate commands.

(3) Integrates suicide prevention into community, family, and soldier support programs as appropriate.

b. The Director of Plans and Training—

(1) Serves as the task force presiding officer in the absence of the DPCA.

(2) Informs the task force of the current training and operational requirements of the command and estimates the impact of their requirements on the quality of life within the area served by the task force.

(3) Develops policy to assure that the impact of the pace of operations on individual and family quality of life be considered in planning for all training and operational requirements.

c. Division and installation chaplains—

(1) Advise installation and unit commanders on moral and ethical issues and other stress factors that may result in an increased number of people at risk.

(2) Assure that all chaplains within the command are trained to identify individuals who may be at increased risk of suicide and make an appropriate referral. This training will be conducted with the assistance of local mental health officers.

(3) Provide the training expertise that will assist the command in the education-awareness training process. Unit chaplains will be the cornerstone of the effort to provide and will assist unit level suicide prevention training for leaders, supervisors, soldiers, and civilian employees. Chaplains will advise and assist other staff members and task force members in satisfying identified training needs in this area.

d. The Director of Health Services—

(1) Assesses and advises the installation commander on stress factors that may result in increased numbers of persons at risk.

(2) Provides mental health officers to train other trainers in the post education—awareness program.

(3) Assures that the training provided by chaplains and other staff agencies such as ACS and the Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) is appropriate.

e. The division surgeon—

(1) Assures that division health care providers are trained in crisis intervention techniques using periodic in-service education.

(2) Serves as liaison with the Medical Department Activity (MEDDAC) Mental Health Service and the Division Mental Service.

(3) Coordinates training activities with the division and installation chaplains.

f. The Army Community Services Officer—

(1) Serves as the staff officer responsible for the Family Member Suicide Prevention Program.

(2) Continues operation of advocacy and out-reach programs dealing in areas of stress and family violence.

(3) In coordination with SPTF and PAO, heightens public awareness of the support and helping mechanisms available within the community.

(4) Conducts appropriate in-service training to maintain the level of awareness of ACS staff members including volunteers who routinely assist soldiers, civilian employees, and family members who might be at risk of suicide.

(5) Emphasizes support agencies and mechanisms during family member orientations and other appropriate briefings.

(6) Serves as the specific task force participant responsible for coordinating with civilian support agencies.

g. The Public affairs officer coordinates the community awareness needs of the task force.

h. The provost marshal—

(1) Ensures that military police forces respond to potential suicide situations discretely and cautiously to avoid increasing stress (Normally the use of emergency equipment (lights or sirens) would be inappropriate).

(2) Provides feedback information to the task force, as appropriate, on any suicide related events that may have occurred on post.

(3) Reinforces instruction presented at the U.S. Army Military Police School concerning identification of persons at risk for suicide, and emphasizes that actions taken by military police in the line of duty may cause some people to be at increased risk of suicide. An example might be a teenager who has been arrested for shoplifting and is greatly embarrassed about his or her behavior. Awareness training, using the assistance and advice of chaplains and mental health professionals, may be conducted at in-service training and professional development classes.

(4) Establishes liaison with local civilian police agencies, as appropriate, to coordinate community suicide prevention programs and procedures.

i. Commander or special agent-in-charge of the supporting USACIDC element—

(1) Investigates all suicides or suspected suicides (see AR 195-2).

(2) Establishes liaison with local civilian police agencies, as appropriate, to obtain information regarding suicide related events involving military personnel, their families, or civilian employees, which may have occurred off-post, and provide such information to the task force. Such liaison activity will be in compliance with applicable statutes of the local civilian community.

(3) As allowed by appropriate regulations, provides the task force extracts from the Criminal Investigation Division (CID) reports of investigation (including psychological autopsy), which may be useful in understanding the reasons for a suicide and in formulating future prevention plans.

j. The staff judge advocate provides suicide prevention awareness training for the personnel of the staff judge advocate and trial defense service personnel using the advice and assistance of the

chaplains and mental health professionals. Trial defense service personnel and legal assistance officers may assist soldiers, family members, and, in certain circumstances, civilian employees who are in crisis, not only from administrative and legal actions, but also from other causes. The administrative and legal actions initiated against some persons may cause them to be at increased risk of suicide. Identifying persons at risk of suicide and referring them to the proper support person or agency is crucial.

k. The civilian personnel officer—

(1) Assures that local programs take into consideration the needs of the civilian work force.

(2) Is responsible for coordinating the training for civilian managers and supervisors.

l. The alcohol and drug control officer—

(1) Advises the commander as to the impact of alcohol and drug abuse on suicide risk.

(2) Assures that the Alcohol and Drug Abuse Prevention and Control Program staff are trained in suicide risk identification factors and in the management of suicidal clients.

m. Commanders—

(1) Coordinate and conduct awareness training for subordinate leaders.

(2) Assure that subordinates are aware of assistance agencies.

(3) Refer individuals who are identified as having personal or emotional problems to an appropriate source of help. It is essential that commanders follow through to assure that the problem is either resolved or continuing help is being provided.

(4) Send a representative of the Family Member School System to the SPTF. The Family Member School System representative should coordinate training for school personnel in identifying and referring individuals at risk for suicide.

2-5. Strategy

a. The strategy and supporting elements of the ASPP are based on the premise that suicide prevention will be accomplished by leaders through command policy and action. The key to the prevention of suicide is positive leadership and deep concern by supervisors of military personnel and civilian employees who are at increased risk of suicide.

(1) Once identified as being at increased risk, military personnel will be referred to appropriate helping agencies such as the Community Mental Health Service (CMHS) or emergency room of the medical treatment facility and tracked by the unit commander to assure problem resolution.

(2) Civilian employees identified to be at increased risk will be encouraged to seek assistance from appropriate civilian agencies.

b. Leaders must know their subordinates and assure that timely assistance is provided when needed. Installation commanders must emphasize the importance of suicide prevention through the publication of command letters, directives, and instructions as appropriate.

c. It is the Army's goal to prevent suicide for soldiers, family members, and civilian employees. However, it must be recognized that in some people, suicidal intent is very difficult to identify or predict, even for a mental health professional. Some suicides may be expected even in units with the best leadership climate and most efficient crisis intervention and suicide prevention programs. Therefore, it is important to redefine the goal of suicide prevention as being suicide risk reduction. Suicide risk reduction consists of reasonable steps taken to lower the probability that an individual will commit acts of self-destructive behavior.

d. The ASPP provides a systematic framework in which commanders may work to lower the risk of suicide for soldiers, family members, and civilian employees. This will lead to lower suicide rates in the Army and will impact significantly on the loss of life and productivity that can result from suicidal behavior.

2-6. Signs of depression and immediate danger signals

a. Depression is characterized by the following symptoms:

(1) Poor appetite or significant weight loss or increased appetite or significant weight gain.

- (2) Change in sleep habits, either excessive sleep or inability to sleep.
- (3) Behavioral agitation or a slowing of movement.
- (4) Loss of interest or pleasure in usual activities or decrease in sexual drive.
- (5) Loss of energy or fatigue.
- (6) Complaints or evidence of diminished ability to think or concentrate.
- (7) Feelings of worthlessness, self-reproach, or excessive guilt.
- (8) Withdrawal from family and friends.
- (9) Drastic mood swings.
- (10) Sudden change in behavior.
- b.* Immediate danger signals are—
 - (1) Talking about or hinting at suicide.
 - (2) Giving away possessions or making a will.
 - (3) Obsession with death, sad music or sad poetry. Themes of death in letters or art work.
 - (4) Making specific plans to commit suicide and access to lethal means.
 - (5) Buying a gun.

Chapter 3 Program Elements

3-1. Education

- a.* Every member of the Army family has the potential to come in contact with a person who is at increased risk of suicide. Crucial steps in the suicide prevention process are an awareness of the variables and life stress events that put individuals at risk and the signs and symptoms of a person at risk. Therefore, as a first priority, leaders, managers, and supervisors at all levels will receive training in suicide risk identification and suicide prevention.
- b.* Ultimately, all members of the Army family should have a level of awareness that will enable them to identify problems and refer co-workers, friends, and family members who are in crisis to an appropriate source of help.
- c.* Training in stress management and coping skills is of great value in the overall prevention effort.
- d.* Inherent in sustaining a prevention program, is the continued use of judicious, low-key community awareness activities. Community awareness includes—
 - (1) Publication of existing military and civilian crisis hot line numbers in local media.
 - (2) Publication of articles on stress, depression, family violence and abuse, substance abuse, and the identification of agencies that can help.
 - (3) The amount and type of community awareness activities will be tailored to the needs of the community as evaluated by the SPTF. Units may coordinate with unit chaplains and the CMHS regarding appropriateness and content of this type of information in unit newsletters.
 - (4) Media items may need to be published prior to periods or events that are likely to produce a higher than normal incident of suicide (for example, the summer moving months of July and August have a higher incidence of suicide).

3-2. Identification and crisis intervention

- a.* Leaders and other individuals who are aware of suicide risk factors can facilitate early identification and intervention for persons in crisis. Early involvement is a critical factor in suicide risk reduction.
- b.* Leaders, supervisors, and other members of the Army community who are in frequent, close contact with others are often in the best position to identify persons at risk. Intervention may include listening, referring, and taking the person to a helping agency.
- c.* Persons who express suicidal thoughts will, at their request, be taken directly to a mental health professional. Law enforcement and

medical personnel should be summoned to the scene if the individual declines assistance. It is important to understand that prevention is not solely accomplished by awareness and identification. Intervention includes alteration of the conditions which produced the current crisis, treatment of any underlying problem that contributed to suicidal thoughts, and long term follow-up to assure problem resolution.

d. Medical treatment facility (MTF) emergency rooms and urgent care rooms are the primary 24-hour crisis intervention facilities on most Army installations. Procedures for continuous crisis intervention services should be well defined by the MTF and included in the ASPP.

e. At installations that do not have 24-hour access to military emergency room care, the installation or community will provide for continuous crisis intervention services.

f. Maximum use should be made of crisis "hot" lines, which may exist in the civilian community. Publication of these numbers through military means should be coordinated with the civilian agency providing the service. Where available, data on military use of crisis hot lines should be collected and analyzed by the SPTF.

3-3. Suicide risk management team (SRMT)

a. Army divisions and other large activities with adequate support should consider establishing a suicide risk management team (SRMT). This is an optional element of the ASPP. The SRMT will actively monitor the progress of soldiers identified as suicidal and at high risk. The team is charged with the responsibility of addressing the medical and administrative needs presented by high risk cases.

b. The SRMT will convene immediately during a suicide crisis at the request of the battalion or separate company commander. Its function is to assist the commander in assessing the situation, determining appropriate courses of action, directing immediate inter-agency and interstaff actions, and advising the commander. Team intervention will include taking actions necessary to provide for the immediate welfare of families who have suffered a suicide or suicide attempt.

c. The SRMT will not become involved in rescue or emergency lifesaving operations with respect to suicide attempts. These activities will be left to military police and medical personnel who are trained in emergency procedures. It is the role of the SRMT to address those problems and issues that precipitated the suicide attempt and to deal expeditiously with them.

3-4. Objective of the suicide risk management team

- a.* Non-divisional installations and communities should substitute appropriate non-divisional or community staff officers.
- b.* The SRMT intervenes in suicide attempts with a goal of preventing suicides. The SRMT will be composed of—
 - (1) The division surgeon.
 - (2) The division psychiatrist.
 - (3) The battalion or separate company commander.
 - (4) A representative of the division chaplain.
 - (5) A representative of the Assistant Chief of Staff G1 (personnel) (G1/AG).
 - (6) A representative of the staff judge advocate.
 - (7) A representative of the provost marshal.
 - (8) A representative of the Alcohol and Drug Control Office (ADCO).
 - (9) A representative of the Army Community Services Office (ACS).

3-5. Functions of members of the SRMT

- a.* Battalion and separate company commanders—
 - (1) Convene, through the division surgeon, the SRMT when soldiers within the command are identified as a suicide risk.
 - (2) Institute procedures within the battalion or company to facilitate the identification, evaluation, and medical evacuation (if necessary), of soldiers at increased risk of suicide.
 - (3) Maintain an active and close liaison with other members of the SRMT on matters affecting members of the command.

(4) Coordinate any necessary administrative action required by members of the command who have attempted suicide.

b. The division surgeon—

(1) Assumes primary responsibility as the SRMT coordinator.

(2) Develops and manages case files on identified high risk individuals.

(3) Provides active multidisciplinary coordination for the medical, administrative, and legal needs of the suicidal individual, utilizing to the fullest extent possible the offices provided by other team members, medical treatment facilities, and existing human resource agencies.

(4) Serves as the primary point of contact during a suicide crisis for battalion and separate company commanders to convene the SRMT.

(5) Institutes all necessary management procedures internal to division and executes, as necessary, memorandums of understanding with medical treatment facilities to assure that an immediate and appropriate response to a suicide attempt is achieved.

(6) Provides for collection, evaluation, and dissemination of all data pertaining to attempted suicides or suicide related behavior. The release of information must adhere to the protection of the privacy rights of family members and the military interest. Although deceased persons have no right to privacy, their family members are protected under the Privacy Act.

(7) Coordinates the use of medical assets in the training of stress management, suicide prevention, and family advocacy subject matters.

c. The division psychiatrist

(1) Serves as the alternate coordinator in crisis situations in the absence of the division surgeon, and as the principal point of contact with medical treatment facilities as a member of the SRMT.

(2) Provides for the clinical evaluation, treatment and disposition of military personnel who may be at increased suicide risk.

(3) Provides for training in stress management, suicide prevention, and family advocacy subject matters.

(4) Provides battalion and separate company commanders information about soldiers who may be at increased risk of suicide, when it is necessary for the commander to take action to protect a soldier, and convene the SRMT if suicide is imminent.

(5) Develops and disseminates an epidemiologic profile that will serve as a standard by which members of the chain of command can identify potential suicides.

(6) Assists the division surgeon in the collection and analysis of suicide related behavioral data.

d. The division chaplain representative—

(1) Meets with the division surgeon during a suicide crisis upon request.

(2) Develops policies and procedures for unit chaplains to assure an active monitoring of high risk soldiers and provide for chaplain intervention during a suicide crisis.

(3) Provides immediate pastoral assistance to families who have suffered a suicide or suicide attempt.

(4) Assists the division surgeon in providing training to soldiers in stress management, suicide prevention, and family advocacy subject matters.

e. The G1/AG (personnel) representative—

(1) Meets during a suicide crisis when requested by the division surgeon.

(2) Supports the division surgeon in the collection, analysis, and dissemination of suicide related behavioral data.

(3) Formulates letters of instruction, regulations, etc., as required, to prescribe appropriate procedures and activities which foster suicide prevention and intervention.

(4) Advises other team members on career implications, courses of action, etc., regarding soldiers identified as potential suicides.

(5) Coordinates with the battalion or separate company commander concerned, and provides advice or administrative assistance as required.

f. The provost marshal representative—

(1) Meets during a suicide crisis when requested by the division surgeon.

(2) Ensures that procedures are established for immediate notification of the division operations center, the division surgeon, and the appropriate commander during instances when suicides or family members suicides are imminent or have occurred. Also coordinates directly with medical treatment facilities in crisis situations (emergency rooms) as appropriate or necessary.

(3) Provides for immediate protection and well being of soldiers or family members at high risk for suicide until unit or medical personnel are on the scene.

g. Representatives of the adjutant general, staff judge advocate, alcohol and drug control officer, and army community services officer—

(1) Meet during a suicide crisis when requested by the division surgeon.

(2) Provide advice and assistance to the division surgeon within their areas of administrative or professional expertise on matter pertaining to suicide risks or attempts.

3-6. Followup treatment

The permanent prevention of suicide for an individual at risk depends upon treatment of the underlying disorder (such as depression), and the alteration of conditions that produced the current crisis. Effective treatment depends on the availability of mental health professionals (psychiatrists, psychologists, psychiatric nurses, and social workers) who are properly trained for the population they serve.

3-7. Postvention activities

a. Postvention activities involve the therapeutic work with survivor victims of a dire event such as suicide. A suicide creates an adverse impact on the morale and readiness of a military unit. Often a great sense of guilt is experienced by leaders and others who may have known or felt they should have known that the victim was experiencing difficulty. In an attempt to continue "business as usual", such feelings may be ignored or submerged by both the organization and individuals. Such practices delay the healing process and prolong the impact on unit readiness.

b. ASPPs will make provisions for the concentration of mental health and chaplain resources to provide assistance as required to an organization and its members following a suicide of a soldier or civilian employee. Open discussion with a mental health officer allows survivors to express feelings of loss, grief, embarrassment, guilt, and anger over the possible suicide of a loved one.

c. The loss of a family member, especially the loss of a child due to suicide, is perhaps the most difficult form of death for survivors to accept. On top of their grief over the death of a loved one, families of suicide victims often experience shame, humiliation, and embarrassment. Other common reactions are fear, denial, anger, and guilt, all of which combine to produce one of the most difficult crisis a family will ever experience. At these times the complete resources of the military community must be mobilized to assist the family. The ASPP will make explicit provisions for assisting families who have experienced such a loss to the extent permitted by applicable laws and regulations.

d. The psychological autopsy required by AR 195-2 provides an excellent opportunity for postvention activities. This procedure brings a mental health officer into early and direct contact with the survivors of a suicide victim and facilitates bereavement counseling. This counseling not only speeds the recovery of survivors but may also prevent new suicides among the affected group.

Chapter 4 Family Member Suicide Prevention

4-1. Family Member Suicide Prevention Program

a. The Family Member Suicide Prevention Program (FMSPP) will be implemented by Army Community Services (ACS). This

program includes suicide prevention education for Army family members and referral to other helping agencies as needed. Suicide prevention for family members is not a separate ACS mission or program. Suicide prevention is an integral and inherent part of the family violence prevention programs of the Family Advocacy Program (FAP) and other ACS programs.

b. ACS programs, which include suicide prevention will be coordinated with the overall suicide prevention efforts of the installation and the Army. It is inappropriate for ACS to provide crisis intervention services for suicidal individuals, except as it may surface under the provisions of ACS services. ACS crisis intervention will be limited to referral to the MTF or CMHS. ACS personnel will not provide counseling or clinical services to any individual or family where suicide may be a concern. Such individuals or families will be referred to the MTF or directly to the CMHS. Specific roles and functions for supporting installation suicide prevention programs are discussed in the following paragraphs.

4-2. Program development

a. Program development should be based on existing military and civilian family and social service resources. Personnel who are in contact with military families at particular stress points such as permanent change of station (PCS) moves, financial difficulties, significant losses, domestic violence, and who find services for exceptional family members can provide input on needs, available services, and target groups for community awareness efforts.

4-3. Education awareness

a. The FMSPP is designed to promote an understanding of the potential for suicide in the community. The installation ACS officer will conduct an education awareness program for Army family members to help them recognize the signs of increased suicide risk and to learn about referral sources for friends and family members. Educational programs will focus on three groups—parents, teens, and spouses.

b. Education awareness efforts will include the following:

(1) Distribution of information materials at strategic places such as hospital waiting rooms, schools, youth activity (YA) centers, commissaries, laundrettes, snack bars, in-processing centers, civilian personnel centers, installation health fairs, and in welcome packets.

(2) Presentations about suicide prevention to interested community and military groups such as parent-teacher organization meetings, newcomers orientations, and mayors' program meetings.

(3) Production and distribution of guides to soldier and family support services available and how to use them.

4-4. Staff suicide prevention training

a. ACS professionals and volunteers who come in contact with soldiers and family members will receive training in suicide prevention. Training may be obtained through any or all of the following:

(1) The ACS course and the Family Advocacy Staff Training (FAST) course.

(2) In-service and contracted training.

(3) Review of professional books and journals, pamphlets, and video and audio cassette training programs.

b. Training for other community staff supporting the suicide prevention mission such as YA, child development services (CDS) as well as key family support group representatives and contact persons will be coordinated by the ACS Officer. Assistance in conducting this training may be sought from military mental health officers, chaplains, and other community assets.

4-5. Development of support groups

Family support groups should be developed as a part of the FMSPP. The best primary prevention is an informed community that demonstrates care and concern for its members by assuring that families are accepted into the mainstream of community life. This acceptance reduces the frustration and depression that can lead to suicidal

thoughts, feelings, and plans. The degree of stress a family experiences with a problem is directly related to their belief that they can solve the problem or get help that they need. Support groups can reduce family isolation and provide the support, nurturing, and assistance the family needs in time of distress.

4-6. Focus on family life education

Family life education can improve family functioning and reduce potential problems by providing services such as—

a. Child development and parenting classes.

b. Communication skills workshops.

c. Assertiveness training.

d. Stress management training.

e. Financial management assistance.

Chapter 5 Psychological Autopsy

5-1. General

a. A psychological autopsy will be conducted according to the criteria and procedures specified by AR 600-63. The purpose of the psychological autopsy is to—

(1) Provide the victim's commander with information about the death.

(2) Enable the unit and the Army to develop future prevention programs and lessons learned so that soldiers and family members are better served.

b. It is not intended that the psychological autopsy be used to assign blame when a suicide occurs. Commanders should not take a fault finding approach to investigating suicides or suicide attempts. While understanding and publicizing the lessons learned is helpful, it is important that senior commanders are supportive towards unit commanders when a suicide occurs. Such an approach will speed the recovery of the unit following a suicide and will promote combat readiness.

c. The use of the psychological autopsy in the Army has grown beyond its original function—the clarification of equivocal deaths. The retrospective analysis of deaths serves to increase the accuracy of reports and will promote the epidemiological study of suicide in the military population. A review of the status of the victim with those who had a special relationship with the victim prior to the act (that is, supervisors, co-workers, physician, relatives, and friends) will provide a source of information for future prevention actions.

d. Finally, the psychological autopsy brings a mental health officer into direct contact with survivors of a suicide victim, which facilitates bereavement counseling.

e. The intention of the victim determines whether a death is classified as suicide rather than an accident. In an equivocal case, it is difficult to evaluate the deceased's intentions, either because the factual circumstances of the death are incompletely known, or because the deceased's intentions were ambivalent, partial, inconsistent, or not clear.

f. The psychological autopsy is a thorough, retrospective investigation of the intention of the victim relating to his or her being dead. The information for the autopsy is obtained by interviewing individuals who knew the victims actions, behavior, and character well enough to report on them.

g. At present there are at least two distinct questions that the psychological autopsy can help to answer, as follows:

(1) Why did the individual do it? When the mode of death is clear and unequivocal, the psychological autopsy can serve to enhance our understanding of the factors that lead to the act. When the mode of death is clear, but the reasons for the manner of dying remain puzzling, the psychological autopsy is a reconstruction of the motivations, philosophy, psychodynamics, and existential crisis of the decedent.

(2) What is the most probable mode of death? When the cause of death can be clearly established but the mode of death is equivocal,

the purpose of the psychological autopsy is to establish the mode of death with as much accuracy as possible.

5-2. Operational criteria for the classification of suicide (OCCS)

The OCCS that follows were developed to provide a standard definition of suicide for purposes of conducting a psychological autopsy.

a. Self-inflicted. There is evidence that death was self-inflicted. Pathological (autopsy), toxicological, investigatory, and psychological evidence, and statements of the decedent or witnesses may be used for this determination.

b. Intent. There is evidence (explicit and/or implicit) that at the time of injury the decedent intended to kill self or wished to die and that the decedent understood the probable consequences of his or her actions.

- (1) Explicit verbal or nonverbal expressions of intent to kill self.
- (2) Implicit or indirect evidence of intent to die such as the following:
 - (a) Preparations for death, inappropriate to or unexpected in the context of the decedent's life.
 - (b) Expressions of farewell or desire to die, or acknowledgment of impending death.
 - (c) Expressions of hopelessness.
 - (d) Efforts to procure or learn about means of death or rehearse fatal behavior.
 - (e) Precautions to avoid rescue.
 - (f) Evidence that decedent recognized high potential lethality of means of death.
 - (g) Previous suicide attempt.
 - (h) Previous suicide threat.
 - (i) Stressful events or significant losses (actual or threatened).
 - (j) Serious depression or mental disorder.

5-3. Motivation for suicide

a. The psychological autopsy should address the motivation for suicide. The reasons, motives, and psychological intentions of suicidal persons are quite complex. Some of the prominent mental trends in suicidal persons are—

- (1) A wish to escape from mental or physical pain.
 - (2) A fantasy of eternal rest or life with a loved one.
 - (3) Anger, rage, revenge.
 - (4) Guilt, shame, atonement.
 - (5) A wish to be rescued, reborn, start over.
 - (6) A wish to make an important statement or communication.
- b.* Destructive ideas or impulses that are ordinarily well controlled or mostly unconscious can be activated or released under the influence of emotional stress, physical exhaustion, or alcohol.

5-4. Role of intent

a. Suicide implies a direct connection between the victim's intention, self-destructive action, and subsequent death. Uncertainty about the correct certification of death results when—

- (1) The victim's intention was ambivalent, with coexisting wishes both to live and to die,
- (2) The self-destructive action itself was inconclusive,
- (3) death followed the action after a considerable delay.

b. Intention is variable in degree, not all or nothing. The concept of intention signifies that the individual understood, to some degree, his or her life situation and the nature and quality of the proposed self-destructive action.

5-5. Classification of suicides by intent

a. One classification system that incorporates the notion of degree of intention and that may be used in the autopsy is as follows:

- (1) First-degree suicide: deliberate, planned, premeditated, self-murder.
- (2) Second-degree suicide: Impulsive, unplanned, under great provocation or compromising circumstances.
- (3) Third-degree suicide: victim placed his or her life in jeopardy

by voluntary self-injury, but we infer the intention to die was relatively low because the method of self-injury was relatively harmless, or because provisions for rescue were made. The victim was "unlucky" enough to die.

b. The following are two other categories of self-inflicted death that are not typically classified as suicide because the intention to die cannot be established.

(1) Self-destruction when the victim was psychotic or highly intoxicated from the effects of drugs or alcohol. These circumstances suggest impaired capacity for intention.

(2) Self-destruction due to self-negligence. This last category of death has been described as subintentioned death. A subintentioned death is a death in which the decedent plays some partial, covert, or unconscious role in his or her own demise. Evidence for this ambivalence toward life may be found in a history of poor judgment, excessive risk-taking, abuse of alcohol, misuse of drugs, neglect of self, a self-destructive life-style, a disregard of prescribed life-saving medication, and in other actions where the individual fosters, facilitates, exacerbates, or hastens the process of his or her dying. In terms of the traditional classification of modes of death (natural, accident, suicide, and homicide), some instances of all four types can be subsumed under this category, depending on the particular details of each case.

5-6. Lethality

a. The psychological autopsy should also address the issue of the lethality of the suicidal behavior. Although the victim's intention to die is the factor used to classify his or her death as a suicide, the amount of lethality involved may be used to discriminate among the various degrees of suicide. Lethality is the probability that the suicidal behavior would result in death.

b. Consideration of the lethality involved permits an evaluation of the individual's drive to self-imposed death. All suicides threats, gestures, attempts, and completed suicides should be rated for their lethality.

c. The lethality of the victim's behavior, whether or not it results in death, may be judged to be in one of four classes: high, medium, low, or absent. This may be accomplished using the lethality of Suicide Behavior Rating Scale at table 5-1. The numerical scale will be used to rate the lethality of the suicidal behavior of the victim. The lethality rating will be the number of the statement that best characterizes the suicidal act. Lethality will then be characterized as being high, medium, low, or absent.

d. The lethality rating derived from the scale in table 5-1 relates to the classification system based on degree of intention (para 5-5) as follows:

- (1) A first-degree suicide would require a high lethality rating. There is no doubt as to the victim's intention to die.
- (2) A second-degree suicide may be either rated as high or medium in lethality. The victim knew that the suicidal behavior would likely result in death, however, the act was impulsive and unplanned.
- (3) A third-degree suicide would be rated as being either medium or low in lethality.
- (4) Suicidal behavior resulting in a subintentioned death would always be rated as low in lethality.
- (5) Where the capacity for intention is absent or where the victim played no role in effecting his or her own death, it may be said that lethality was absent in the victim's behavior.

Table 5-1
Lethality of suicide behavior rating scale

Lethality:: Absent

Rating:: 0

Statement:: Death is impossible result of the "suicidal behavior."

Lethality:: Low

Rating:: 1

Statement:: Death is improbable. If it occurs it would be a result of secondary complications, an accident, or highly unusual circumstances.

Table 5-1
Lethality of suicide behavior rating scale—Continued

Lethality:: Low

Rating:: 2

Statement:: Death is improbable as an outcome of the act. If it occurs it is probably due to unforeseen secondary effects. Frequently the act is done in a public setting or reported by the individual involved or by others. While medical aid may be warranted, it is not required for survival.

Lethality:: Low

Rating:: 3

Statement:: Death is improbable as long as first aid is administered by the victim or other agent. The victim usually makes a communication or commits the act in a public way or takes no measures to hide self or injury.

Lethality:: Medium

Rating:: 4

Statement:: Death is a fifty-fifty probability directly or indirectly, or in the opinion of the average person, the chosen method has an equivocal outcome.

Lethality:: Medium

Rating:: 5

Statement:: Death is the probable outcome unless there is "immediate" and "vigorous" first aid or medical attention by the victim or other agent. One or both of the following are true:

(a) Makes communication (directly or indirectly).

(b) Performs act in public where he or she is likely to be helped or discovered.

Lethality:: High

Rating:: 6

Statement:: Death would ordinarily be considered the outcome to the suicidal act, unless saved by another agent in a "calculated" risk (for example, nursing rounds or expecting a roommate or spouse at a certain time). One or both of the following are true:

(a) Makes no direct communication

(b) Takes action in private

Lethality:: High

Rating:: 7

Statement:: Death is the highly probable outcome. "Chance" intervention and/or unforeseen circumstances may save the victim. Two of the following conditions also exist.

(a) No communication is made

(b) Effort is put forth to obscure act from helper's attention.

(c) Precautions against being found are instituted.

Lethality:: High

Rating:: 8

Statement:: Death is almost a certainty regardless of the circumstances or interventions by an outside agent. Most of the people at this level die quickly after the attempt. A very few survive through no fault of their own.

5-7. Death investigation team

a. In the Army, the psychological autopsy will be conducted by a mental health officer and provided to the commander of the local U.S. Army criminal investigation activity for inclusion in the report of investigation of the death. In difficult cases where the command desires a more extensive investigation, consideration will be given to forming a death investigation team. This is a multi-disciplinary approach involving the collaboration of a pathologist or other medical officer with mental health officers in the areas of psychiatry, psychology, psychiatric nursing, and social work, and a law enforcement officer.

b. The developers of the psychological autopsy procedure have emphasized that an outline or accumulation of postmortem data alone is not a psychological autopsy. The information must include the personal responses of each member of the death investigation team. Team members will report in their areas of expertise and participate in mutual exchanges of information. The completed

report should represent a consensus of the views of the team members.

5-8. Procedure for psychological autopsy

a. Whether it is conducted by a single mental health officer, or by a complete death investigation team, the psychological autopsy typically consists of interviews of persons who knew the deceased (such as spouse, parents, children, neighbors, supervisor, coworkers, friends, and physicians) in an attempt to reconstruct the lifestyle of the deceased. This will usually be done jointly with a law enforcement officer to facilitate mutual access to persons and records. In the investigation, an attempt is made to obtain relevant information about any psychiatric idiosyncrasies or the presence of any suicide warning signs the victim may have voiced.

b. The following information should be gathered by the investigating officer or team:

(1) Life history.

(2) Psychiatric-psychological data.

(3) Clues to or communications of suicide intent.

(4) Recent life events.

(5) Miscellaneous data that may be relevant to the death, but not necessarily psychological in nature (for example, physical evidence from the scene of the death).

c. As a preliminary step in conducting a psychological autopsy, the mental health officer should review the following data:

(1) Inpatient and outpatient medical records.

(2) Physical autopsy (necropsy) report including toxicology results.

(3) Military police and Criminal Investigation Division investigation results.

(4) Line of duty investigation report.

(5) Any records existing in the Community Mental Health Service, hospital departments of psychiatry and social work, Alcohol and Drug Abuse Prevention and Control Program, Army Family Advocacy Program, or other Army programs.

5-9. Psychological autopsy report

The following is a guide for preparing psychological autopsy reports and should be used unless there are special considerations. The categories below should be included.

a. *Identifying information.*

(1) Name.

(2) Rank/Grade.

(3) SSN.

(4) Age/Date of Birth.

(5) Sex.

(6) Race.

(7) Marital Status (married, single, divorced, widowed, separated).

(8) MOS.

(9) Unit/Station.

(10) Level of Education

(11) Home Address (where victim was living at time of death).

b. *Method.* Method of gathering information and identification of sources contacted.

c. *Details of death.*

(1) Date/Time (provide date and time of suicidal act and death if different).

(2) Location (address and description, that is, friend's house, parents home, victim's off-post residence, motel, and so forth).

(3) Method.

(4) Details of discovery.

(5) Provisions for rescue (describe).

(6) Note (contents).

(7) Communication of suicidal intent.

(8) Acts of violence that accompanied the suicidal act.

(9) Other details.

d. *History of prior suicide attempts.*

(1) Dates and description of prior attempts and threats.

(2) Provisions for rescue.

(3) Circumstances surrounding suicide attempts.

e. Physical autopsy (necropsy) results.

- (1) Cause of death.
- (2) Blood alcohol and other toxicology results.
- (3) Describe any evidence of disease process.
- (4) List and explain significant abnormalities.

f. Personality and lifestyle.

(1) Basic personality (relaxed, intense, jovial, gregarious, withdrawn, outgoing, morose, bitter, suspicious, angry, hostile, combative, mild-mannered, other).

(2) Describe the victim's recent changes in mood or symptoms of mental illness.

(3) Describe the victim's recent changes in behavior such as eating, sleeping, sexual patterns, drinking, driving, taking pills, social relationships or hobbies.

(4) Stress reactions as follows:

- (a) Describe the victim's normal reaction to stress.
- (b) Describe the typical patterns of stress reactions.
- (c) State recent losses, if any.

(5) Interpersonal relationships as follows:

(a) Describe the victim's interpersonal relationships (few, casual, or intense)

(b) State recent uncharacteristic behavior of the victim such as withdrawal from friends, gambling, spending, promiscuity, and fights.

(c) Describe the victim's friendship group.

(d) Describe the manner in which his or her time was spent.

g. Marital/dyadic relationship history.

- (1) Marital status.
- (2) Category of dyad trouble.
- (3) Nature of dyad trouble.
- (4) Number and length of marriages.
- (5) Current living arrangements.
- (6) Number, age, and sex of children.
- (7) Where do children live.
- (8) Changes in relationship with spouse or children.
- (9) Threats of or actual divorce or separation.
- (10) Recent deaths in family.
- (11) History of abusive behavior
- (12) Overall quality of current relationship
- (13) Dating history.

h. Family of origin history.

(1) Describe parent's marital history.

(2) Family medical history.

(3) History of family member psychiatric hospitalizations and treatment.

(4) Family suicide history.

(5) Number, ages, and sex of siblings.

(6) Family history of sexual abuse or other forms of child abuse or family violence.

(7) Family history of alcoholism or other substance abuse.

i. Family history. Death history of victim's family (suicides, cancer, other fatal illnesses, accidents, ages of death, and other details).

j. Past problems. Describe any trouble, pressures, tensions, or anticipated problems during the past year.

(1) List and describe any observed or expressed symptoms of depression.

(2) List and describe any observed immediate danger signals.

k. Work history.

(1) State the victim's occupation.

(2) State the victim's level of satisfaction from work (excellent, good, fair, or poor)

(3) State the victim's employment history (job loss, promotion, or retirement)

l. Military history.

(1) Time in service.

(2) Time in grade.

(3) Months assigned to present unit.

(4) Date of last PCS.

(5) Date of pending PCS.

(6) Date of last DEROS.

(7) Awards.

(8) Uniform Code of Military Justice (UCMJ) actions (Article 15s, courts-martial).

(9) Pending unfavorable personnel actions (Bars to reenlistment, weight control program, other).

m. Medical history.

(1) Describe significant illnesses and treatment.

(2) Describe recent loss or change in health status.

(3) Describe any injuries, accidents, or hospitalizations.

(4) List current medications and history of compliance.

(5) HIV positive or not.

n. Psychiatric history.

(1) Hospitalizations, psychotherapy, or other therapy.

(2) If so, when and for how long.

(3) Describe the diagnosis and nature of treatment.

(4) Describe victim's use of psychotropic medications or sleeping pills.

(5) State evidence of a personality disorder or difficulties.

o. Alcohol history.

(1) Describe role of alcohol or drugs in the victim's overall life style and death.

(2) State the victim's usual alcohol consumption.

(3) Identify the victim's behavior changes when drinking and drunk.

(4) State the evidence of addiction to alcohol, and include the number and dates of detoxifications.

(5) State when and where the victim was enrolled in the Alcohol and Drug Abuse Prevention and Control Program.

p. Drug abuse history.

(1) Identify drugs the victim used, if any.

(2) State if the victim was addicted to drugs.

(3) State the number and dates of detoxifications.

q. Financial status. Describe the victim's financial situation (recent losses, business successes or failures).

r. Legal history.

(1) Describe the victim's legal actions, if any.

(2) State the victim's criminal record (number and length of jail or prison terms, nature of the offenses).

(3) State if the victim was absent without leave (AWOL) or a deserter at the time of the suicide. Provide dates of AWOL or desertion.

(4) State if the victim had been accused of sexual misconduct or other sexual deviations.

s. Recent agency contacts. List and describe all contacts with any of the following agencies during the past year.

(1) Mental health.

(2) Chaplain.

(3) Physician.

(4) Legal Assistance (to the extent no privileged information is involved).

(5) Army Emergency Relief (AER).

(6) Army Community Services.

(7) Family Advocacy Program.

(8) Alcohol and Drug Abuse Prevention and Control Program.

(9) Civilian agencies.

t. Indications of increased suicide risk.

(1) List and describe any observed or expressed symptoms of depression.

(2) List and describe any observed immediate danger signals. Describe the response of the observer to the danger signals.

u. Duty Performance if any.

(1) Work or assignment related problems.

(2) Problems in accepting Army life.

(3) Recent changes in duty performance

(4) Accidents.

(5) Problems with personal hygiene/appearance.

(6) Problems with being late, or missing work.

(7) Problems with the quality of work.

(8) Relationship problems with superiors, peers and/or subordinates.

(9) State the victim's display of emotional state as seen by others in the work environment.

v. Assessment of intention.

(1) State the role of the victim in his or her own demise.

(2) Determine the rating of lethality (see table 5-1 for lethality of Suicide Attempt Rating Scale.)

(3) State if the victim reasonably expected and wished to die as a result of his or her suicidal behavior.

w. Summary and conclusions.

(1) State whether in the opinion of the investigator or death investigation team, this death was a suicide.

(2) Estimate the victim's subjective state at the time of suicide.

(3) If this death was a suicide, determine classification (first, second, or third-degree suicide, subintentioned death).

(4) State the most probable reasons for the victim's decision to commit suicide (factors immediately contributing to the suicidal behavior, precipitating events).

(5) State if the victim's commander supervisor, or the medical system identified a problem before the suicide took place,

(6) State if the suicide was—

(a) A bad outcome following reasonable command attention and medical care, or

(b) The product of a system failure or inadequate medical care.

(7) State what actions, if any, could have been taken by those who had a special relationship with the victim (supervisors, co-workers, physician, family, and friends) that would have led to the anticipation and prevention of this suicide? State what could have been done to lower the risk of suicide in this case?

(8) Provide comments, special features, lessons learned, and usefulness, and relevance of available suicide prevention training materials in this case.

5-10. Special considerations

For each method of suicide explore the following:

a. Gun shot.

(1) The victim's knowledge, experience, and training with firearms.

(2) The victim's history of handling weapons recklessly or cautiously.

(3) The victim's prior firearms accidents.

(4) The victim's recent purchase of a firearm.

b. Overdose.

(1) State the victim's knowledge of drugs and their potential dangers (prescribed or street drugs and the amount).

(2) Were there premature refill requests?

(3) Was the victim ever seen under the influence of drugs?

(4) What was his or her behavior under the influence of drugs?

(5) Was there a history of prior overdoses and how were they treated?

(6) Was the victim careless in the use of medications, taking more than prescribed?

(7) How did the victim keep track of pill intake?

(8) What were other sources of pills?

c. Hangings or asphyxia.

(1) Explore for sexual involvement.

(2) How was the victim clothed?

(3) When found, state if pornographic material or sexual apparatus was nearby.

(4) State the victim's known sexual activity (deviance, reading material, interests, knowledge of asphyxia techniques and experience with rope).

d. Jumping, drowning, vehicular death.

(1) State the reason for the victim to be at the place of death.

(2) With respect to the specific method, state his or her habitual behavior.

Glossary

Section I Abbreviations

ACS

Army Community Services

ADAPCP

Alcohol and Drug Abuse Prevention and Control Program

ADCO

Alcohol and Drug Control Officer

ADT

active duty for training

AER

Army Emergency Relief

AG

Adjutant General

ASPP

Army Suicide Prevention Program

AWOL

Absent Without Leave

CDS

Child Development Services

CID

Criminal Investigation Division

CMHS

Community Mental Health Service

CPO

civilian personnel officer

DEROS

Date Eligible for Return from Overseas

DHS

Director of Health Services

DPCA

Director of Personnel and Community Activities

DPT

Director of Plans and Training

FAP

Family Advocacy Program

FAST

Family Advocacy Staff Training

FMSPP

Family Member Suicide Prevention Program

G1

Assistant Chief of Staff (Personnel)

MACOM

major Army command

MEDDAC

medical department activity

MTF

Medical Treatment facility

MOS

military occupational specialty

OCCS

operational criteria for the classification of suicide

PAO

public affairs officer

PCS

permanent change of station

RC

Reserve Component

ROI

report of investigation

SJA

staff judge advocate

SPTF

suicide prevention task force

SRMT

suicide risk management team

UCMJ

Uniform Code of Military Justice

USACIDC

U.S. Army Criminal Investigation Command

YA

youth activities

Section II Terms

Equivocal death

Cases in which the available facts and circumstances do not immediately distinguish the mode of death are called "equivocal death." A death is equivocal when ambiguity or uncertainty exists between any two or more of the four modes.

Mental health officer

Those trained mental health professionals who are credentialed or licensed as psychiatrists, clinical or counseling psychologists, social workers, or psychiatric clinical nurse specialists.

Mode of death (also known as manner of death)

Four categories of death: natural, accident, suicide, and homicide; the initial letters of each make up the acronym NASH. The four modes of death have to be distinguished from the many causes of death such as gunshot wound or a disease process. When the mode of death is unknown, a fifth category, "undetermined," is often used.

Postvention

Those actions taken after an incident of suicidal behavior that serve to moderate the effects of the event on the survivors of a person who has committed or attempted suicide.

Psychological autopsy

Attempts to clarify the nature of death by focusing on the psychological aspects of the death. Its primary purpose is to understand the circumstances and state of mind of the victim at the time of death. The procedure involves the reconstruction of the life style and circumstances of the victim, together with details of behaviors and events lead to the death of the individual.

Suicide attempt

All overt act of self-destructive behavior that does not result in death.

Section III Special Abbreviations and Terms

There are no special terms.

Unclassified

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