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IN REPLY REFER TO
1720
CDC
28 Sep 12

CDC Policy Memo 5-12

From: Chief Defense Counsel of the Marine Corps
To: Distribution List

Subj: IDENTIFYING AND RESPONDING TO CLIENTS AT-RISK FOR SUICIDE

Ref: (a) JAGINST 5803.1D
(b) MCO 1720.2
(c) CDC PM 4-12 - DSO FY 13 Training Plan
(d) CDC Policy Memo 6-11- CDC's CIRs

Encl: (1) Suicide Assessment Mnemonic
(2) Tools to Cope with Stress Memorandum
(3) Columbia Suicide Severity Rating Scale

1. Purpose. To continue to emphasize the Marine Corps Defense Services Organization's (DSO) commitment to effectively recognizing and responding to clients at risk for suicide by formalizing our well-established procedures that have saved several clients in distress over the past few years and to build upon those procedures to help prevent future suicides.

2. Discussion.

a. Suicide is a very complex problem.¹ Many interacting factors are involved and there are usually warning signs that precede the suicide, but they are not always easy to detect. Due to the nature of the relationship between a defense counsel and a client, the defense counsel may be in a unique position to recognize the combination of warning signs leading up to a suicide. As advocates, we must work aggressively to identify and to aid our clients who are at risk for suicide. The risk for our clients is great - more than forty percent of Marines who have died by suicide in the last several years were facing or recently resolved a military or civilian legal issue. Within the DSO, these statistics represent the loss of several of our clients, both prior to and after trial, to suicide. I am confident that those numbers would be higher without the caring and professional intervention of the Marines assigned to the DSO who have followed our procedures to get help for their troubled clients. We must continue to incorporate suicide prevention into our practice of law and ensure that our clients receive the care and help they need.

b. The DSO has been committed to reducing suicides. Three years ago, my predecessor began working with the Headquarters Marine Corps (HQMC) Suicide Prevention Office to increase

¹ The HQMC Suicide Prevention Office has provided tremendous assistance in drafting this policy memo.

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the DSO's awareness of the heightened risk of our client base. In the spring of 2010, the Chief Defense Counsel (CDC) convened the first all-hands DSO Training Conference in part to discuss and train on this issue. The HQMC Suicide Prevention Office provided a class to all members of the DSO. Shortly thereafter, the Judge Advocate General of the Department of the Navy revised Rule 1.14 of our Rules of Professional Conduct, reference (a), authorizing a defense counsel to make a limited disclosure to get mentally-troubled clients help. In the intervening years, the DSO has continued to aggressively train on this topic and raise awareness throughout the legal community.² The results of this training have been inspiring, with defense counsel from Afghanistan to Quantico and every location in between taking effective action to get help for their clients by talking openly with their clients about suicide, being vigilant for warning signs, and making limited disclosures as necessary to get their clients more help. Unfortunately, we continue to lose clients to suicide and three clients have taken their own lives in the last three months alone.

c. Recognizing the need to do more to help our clients in distress, the Regional Defense Counsel (RDC) and I recently met with our counterparts from the other services to see what we can learn from their practice in this area. Each service reported seeing an increase in clients at-risk for suicide and explained their services and legal communities' approaches to the problem. Each, like the Marine Corps and the DSO, has made suicide awareness and prevention a focus of training and general officer leadership attention. Each defense organization, like ours, emphasizes the importance for counsel to openly discuss this issue with their clients, and when required, seek support from their clients' commands. The Air Force introduced us to their practice, which we will adopt, of counseling every client, using a standard form to assist the counsel and clients in discussing this difficult topic.

3. Policy.

a. The policies set forth below are a compilation of lessons learned over the last three years from our successes and failures with at-risk clients, conversations with our sister services, and guidance provided by the HQMC Suicide Prevention Office. It is essential for us all to be acutely aware of the risk factors for suicide behavior and the warning signs of suicide. The risk factors for suicide behavior include the following: family history, history of psychiatric hospitalization, previous suicide behavior, multiple/chronic personal losses, history of developmental trauma (e.g., abuse, neglect, family violence, early bullying, victimization), history of violence, low self-esteem/high self-hate, psychiatric illness, substance abuse, physical illness, exposure to suicide behavior, impulsivity, aggression, and perfectionism. Warning signs of suicide include the following: feelings of hopelessness, rage, anger, seeking revenge, acting reckless or engaging in risky activities, feeling trapped, withdrawing from friends and family, anxiety, agitation, inability to sleep, sleeping all of the time, dramatic changes in mood, feeling like there is no reason to live, and feeling no sense of purpose in life. Enclosure (1) and the Leaders Guide to Managing Marines in Distress, available at <http://www.usmc-mccs.org/leadersguide>, provide additional information to assist you.

² Suicide awareness has been a training topic at literally every CDC or Regional Defense Counsel training program and both the CDC and the Staff Judge Advocate to the Commandant of the Marine Corps (SJA to CMC) discuss this issue at every SJA Conference and at all Article 6 and site visits.

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b. Training. Training forms the foundation upon which defense counsel build suicide awareness and the ability to recognize situations in which they need to intervene. Suicide awareness and prevention must be trained at every level and is a top priority. Reference (b) requires all Marines to attend suicide prevention training annually. Officers are required to attend the officer module of Never Leave a Marine Behind Suicide Prevention Training. DSO members will conduct the following additional training:

(1) In accordance with reference (c), RDCs shall train all defense counsel and legal services specialists in the region once per quarter and one of the training blocks must be on suicide awareness and prevention.

(2) RDCs will report monthly on training efforts to address suicide within their respective regions.

(3) CDC will report to SJA to CMC quarterly on efforts to address suicide within the DSO.

(4) CDC will meet at least twice a year with HQMC Suicide Prevention Office to discuss the DSO's efforts to prevent suicide.

(5) Prior to the November 2012 SDC training event, every member of the DSO will review the Leaders Guide to Marines in Distress, available at <http://www.usmc-mccs.org/leadersguide>, and be prepared to discuss this Guide at the SDC training.

(6) At the November 2012 SDC training events, all DSO members will be trained on the use of enclosure (1).

(7) All Defense Counsel Orientation Courses will include a period of instruction on dealing with at-risk clients and this policy memo.

(8) As part of the new defense counsel checklist, new counsel will review this policy memo with their SDC.

(9) The Defense Counsel Assistance Program (DCAP) will record suicide prevention training on the at-risk client database maintained on the DSO SharePoint.

c. Regular Interaction with Clients. Defense counsel and legal services specialists need to be aware of suicide risks and warning signs with all clients. Incorporating the following practices is essential to being able to assist with suicide prevention and will be conducted with all clients who are detailed to a defense counsel.

(1) During the initial meeting with the client, defense counsel will provide enclosure (2) to every client and discuss it with the client. Enclosure (2) will be printed on colored paper in order to distinguish it from the other client intake forms. The discussion of this handout needs to set the tone for open discussion of this topic for the duration of the attorney-client relationship.

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(2) Ask the client at each meeting how they are doing and record the response in the case file. Additionally, make a note of your assessment of the client's mental health after each meeting.

(3) Explore the client's history and inquire about the risk factors and warning signs of suicide behavior.

(4) Statistics show that approximately 50% of those who die by suicide are legally intoxicated at the time of death. Accordingly, defense counsel must candidly discuss the extent to which a client uses or abuses alcohol and note this in the file.

(5) According to a 2009 study conducted by the National Center for Injury Prevention and Control, of suicides among former or current military personnel, 39% had a diagnosed mental health problem and 26% were receiving mental health treatment. Defense counsel must ask clients about previous mental health problems and current mental health treatment.

(6) Be alert to the client's current words, actions, and demeanor for risk factors and warning signs of suicide. Utilize the mnemonic found in enclosure (1), "IS PATH WARM?," to help identify risk factors and warnings signs of clients at-risk for suicide and use enclosure (3) to ask your client about those risk factors and warning signs in a safe, evidence based manner.

(7) During the early stages of the client representation, identify sentencing witnesses and discuss with the client if these individuals provide a support structure for the client. When conducting interviews with these witnesses, inquire about their observations and assessments of the client in order to help identify any potential suicidal issues.

(8) Continually assess clients for suicide risk.

(9) Make contact information readily available. All defense counsel are required to post the contact numbers for the local mental health unit next to their telephones and these numbers will also be posted in all branch office waiting rooms. In many cases, just knowing that one person cares is enough to reduce suicide risk.

c. Actions in Response to a Suicidal Client. If a client talks of suicide, death, or a desire to die, listen intently to your client and get as much information as you can. Ask questions, take notes, pay attention to the details, never assume that the client is joking or malingering, and do not leave the client alone until these issues are resolved. If you determine that your client is at risk of suicide, you need to do everything in your power to prevent the client from taking his/her own life. Follow these steps and remain with the client until the client is properly handed over to an informed, responsible member of your client's command or a qualified mental health professional:

(1) Do not leave your client alone until this issue is resolved;

(2) At the earliest point in this process, but without leaving your client unattended, contact your supervisory attorney for assistance. In accordance with reference (d) there is an immediate

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requirement to notify the RDC and CDC of any suicide behavior by a DSO member or a DSO client. In many instances, this notification will occur while the client is still in the defense counsel's office;

(3) Ask your client to contact a responsible member the client's command, in the defense counsel's presence, in order to request help from a mental health provider;

(4) Ask your client for permission for you to contact a responsible member of the client's command, in the client's presence, in order to request help from a mental health provider;

(5) Ask your client to contact a mental health provider, in the defense counsel's presence, for assistance;

(6) Ask your client for permission for you to contact a mental health provider, in the client's presence, for assistance;

(7) Ask your client to tell the command representative and/or mental health provider the things that raised your concern about suicide or ask the client for permission for you to reveal those communications to the command representative and/or mental health provider;

(8) If your client does not consent to the above, in accordance with Rules 1.6 and 1.14³ of reference (a), make a determination of whether you reasonably believe "that the client has diminished capacity, is at risk of substantial physical, financial, or other harm unless action is taken and cannot adequately act in the client's own interest" and whether you are permitted to reveal information about the client to the extent necessary to protect the client's interests. If necessary, consult a mental health provider about the case without revealing the identity of your client:

(a) If you determine that you are justified within the rules found in reference (a), contact an appropriate command representative and/or mental health provider and inform him/her that you have concerns that your client is suicidal and, to the extent necessary, the reasons why you have those concerns;

(b) If you determine that you are not justified within the rules found in reference (a) to reveal attorney-client communications and to seek mental health assistance for your client, ensure that your client has the required mental health assistance points of contact, encourage your client to seek assistance voluntarily, and then follow up with your client within 24 hours to assess the situation; and

³ Rule 1.14 specifically states that "[w]hen taking protective action pursuant to paragraph b, the covered attorney is impliedly authorized under Rule 1.6a to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests. The footnote to comment 5 of Rule 1.14 further states, "[t]hat a client expresses intent to take his/her own life may indicate that he/she lacks sufficient capacity to make adequately considered decisions in connection with the representation." It should also be noted that Rule 1.6 requires a covered attorney to "reveal information relating to the representation of a client to the extent the covered attorney reasonably believes necessary: (1) to prevent reasonably certain death or substantial bodily harm"

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(9) Document your discussions with the client and actions that you took in a memorandum for the file. This should normally be done after you have successfully handed your client over to a mental health provider or an informed, responsible member of your client's command.

d. Actions in Response to a Client Suicide.

(1) As soon as possible, the immediate supervisory defense counsel will meet with the defense counsel in person to ensure that the defense counsel has the necessary support to deal with this traumatic event. The CDC and RDC will provide support as needed.

(2) CDC will notify SJA to CMC.

(3) CDC and RDC will consult with the SDC and defense counsel within one week of the incident to assess lessons learned.

4. Conclusion

a. It is your duty to ensure that your clients receive the help they need. You are in a very unique position and are privy to some of your clients' innermost thoughts. Treat each client's situation with the gravity it deserves and always be mindful that your client may be considering suicide. Together, we will continue to work to prevent the tragic loss of Marines through suicide.

b. This CDC Policy Memo is effective immediately.



J. G. BAKER

Distribution List:

SJA to CMC

Legal Chief of the Marine Corps

LSSS OICs

All members of the DSO

Joint Defenders Committee

This mnemonic has been created to help assess individuals for immediate suicide risk (American Association of Suicidology, 2006; Berman, 2006). The mnemonic is an easily memorized question, "IS PATH WARM?" Each letter corresponds with a risk factor noted as frequently experienced or reported within the last few months before suicide. The specific risk factors are:

Suicide Ideation: Does the client report active suicidal ideation or has she written about her suicide or death? Does the client report the desire to kill herself? Does she voice a desire to purchase a gun with the intention of using the gun to kill herself? Does she voice the intention to kill herself with a gun, weapon, or car that she currently has in possession or can gain access to?

Substance Abuse: Does the client excessively use alcohol or other drugs, or has she begun using alcohol or other drugs?

Purposelessness: Does the client voice a lack or loss of purpose in life? Does she see little or no sense or reason for continued living?

Anger: Does the client express feelings of rage or uncontrolled anger? Does she seek revenge against others whom she perceives have wronged her or are at fault for her current concerns or problems?

Trapped: Does the client feel trapped? Does she believe there is no way out of her current situation? Does the client believe death is preferable to a pained life? Does the client believe that no other choices exist except living the pained life or death?

Hopelessness: Does the client have a negative sense of self, others, and her future? Does the future appear hopeless with little chance for positive change?

Withdrawing: Does the client indicate a desire to withdraw from significant others, family, friends, and society? Has she already begun withdrawing?

Anxiety: Does the client feel anxious, agitated, or unable to sleep? Does the client report an inability to relax? Just as important, does the client report sleeping all the time? Either can suggest increased risk of suicide or self-harm.

Recklessness: Does the client act recklessly or engage in risky activities, seemingly without thinking or considering potential consequences?

Mood Change: Does the client report experiencing dramatic mood shifts or states?

DATE

MEMORANDUM

From: Detailed Defense Counsel, (insert local DSO office)

To: Defense Client (insert name)

Subj: TOOLS TO COPE WITH STRESS

1. Legal troubles are often very stressful, but there a number of healthy ways to cope with this stress. Several resources are readily available to help you overcome the stress and uncertainty that you may be experiencing. I have listed some of the options below. We will discuss these options today and you should know that not all of the services that are available from the various sources provide you with confidentiality; however, if you are having difficulties dealing with stress or having thoughts of suicide, you need to seek help from a qualified individual right away.

a. **National Suicide Prevention Lifeline (NSPL)** is a nationwide network of crisis centers. If you are ever feeling desperate, alone, or hopeless, you can call the NSPL at **1-800-273-TALK (8255)**. NSPL is a free, confidential, 24-hour hotline available to anyone in suicidal crisis or emotional distress.
<http://www.suicidepreventionlifeline.org/>

b. **Base Mental Health** (insert local contact info) provides licensed psychologists, psychiatrists, and social workers. In addition to you seeking services on your own initiative, if certain individuals, including members of your chain of command or me, believe that you are a danger to yourself, we can recommend to your commander that you be referred for a mental health evaluation.

c. **DStress Line** is available to active duty, Reserve, families, loved ones, and former Marines who are located in certain areas. The line provides counseling for any stress related issues including work, personal, relationship, financial, and family. It is available 24 hours a day, seven days a week and is staffed with former Marines. The service is free and confidential. **1-877-476-7734**.

d. **Military One Source (MOS)** provides telephonic, online and face to face counseling. MOS is provided by DoD at no cost to active duty, Reserve, and their families. The service is private and confidential; however, your identity must be verified for their internal records only. **1-800-342-9647**
<http://www.militaryonesource.com/MOS/About/CounselingServices.aspx>

e. **Chaplains/Clergy** (insert local contact info) have confidentiality and are trained to help you with the problems you are facing, including spiritual counseling. There is an absolute privilege for all information confided in a chaplain or clergy as a formal act of conscience or faith.

2. **REMEMBER: You are a valuable person and a member of the Marine Corps Family and we are committed to providing you services and support during this stressful time. If you are having issues, please do not hesitate to ask for help.** I can help you get in contact with a qualified counselor or you can seek help directly. If you have any questions concerning this information, please call me at (insert contact info).

X. X. XXXXXXXXXXXX

Encl (2)

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Lifetime/Recent Version

Version 1/14/09

*Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.;
Burke, A.; Oquendo, M.; Mann, J.*

Disclaimer:

This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.

*Definitions of behavioral suicidal events in this scale are based on those used in **The Columbia Suicide History Form**, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M. A., Halberstam B. & Mann J. J., Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First [Ed.] Standardized Evaluation in Clinical Practice, pp. 103 -130, 2003.)*

For reprints of the C-SSRS contact Kelly Posner, Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; inquiries and training requirements contact posnerk@childpsych.columbia.edu

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Encl (3)

SUICIDAL IDEATION		Lifetime: Time He/She Felt Most Suicidal	Past 1 month
<p>Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.</p>			
<p>1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <i>Have you wished you were dead or wished you could go to sleep and not wake up?</i></p> <p>If yes, describe:</p>		<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>
<p>2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/commit suicide (e.g., "I've thought about killing myself") without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. <i>Have you actually had any thoughts of killing yourself?</i></p> <p>If yes, describe:</p>		<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>
"Now, I'd like you to think about the time in your life when you were feeling the most suicidal. During that time..."			
<p>3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it... and I would never go through with it." <i>Have you been thinking about how you might do this?</i></p> <p>If yes, describe:</p>		<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>
<p>4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having <u>some intent to act on such thoughts</u>, as opposed to "I have the thoughts but I definitely will not do anything about them." <i>Have you had these thoughts and had some intention of acting on them?</i></p> <p>If yes, describe:</p>		<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>
<p>5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. <i>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</i></p> <p>If yes, describe:</p>		<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>
INTENSITY OF IDEATION			
<p>The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.</p> <p>Lifetime - Most Severe Ideation: _____ Type # (1-5) Description of Ideation</p> <p>Recent - Most Severe Ideation: _____ Type # (1-5) Description of Ideation</p>		Most Severe	Most Severe
<p>Frequency <i>How many times have you had these thoughts?</i> (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day</p>		_____	_____
<p>Duration <i>When you have the thoughts how long do they last?</i> (1) Fleeting - few seconds or minutes (4) 4-8 hours/most of day (2) Less than 1 hour/some of the time (5) More than 8 hours/persistent or continuous (3) 1-4 hours/a lot of time</p>		_____	_____
<p>Controllability <i>Could/can you stop thinking about killing yourself or wanting to die if you want to?</i> (1) Easily able to control thoughts (4) Can control thoughts with a lot of difficulty (2) Can control thoughts with little difficulty (5) Unable to control thoughts (3) Can control thoughts with some difficulty (0) Does not attempt to control thoughts</p>		_____	_____
<p>Deterrents <i>Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?</i> (1) Deterrents definitely stopped you from attempting suicide (4) Deterrents most likely did not stop you (2) Deterrents probably stopped you (5) Deterrents definitely did not stop you (3) Uncertain that deterrents stopped you (0) Does not apply</p>		_____	_____
<p>Reasons for Ideation <i>What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?</i> (1) Completely to get attention, revenge or a reaction from others (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (2) Mostly to get attention, revenge or a reaction from others (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (0) Does not apply</p>		_____	_____

SUICIDAL BEHAVIOR (Check all that apply, so long as these are separate events; must ask about all types)		Lifetime		Past 3 months	
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, as a result of act. Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is any intent/desire to die associated with the act, then it can be considered an actual suicide attempt. There does not have to be any injury or harm , just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. Have you made a suicide attempt? Have you done anything to harm yourself? Have you done anything dangerous where you could have died? <i>What did you do?</i> <i>Did you _____ as a way to end your life?</i> <i>Did you want to die (even a little) when you _____?</i> <i>Were you trying to end your life when you _____?</i> <i>Or Did you think it was possible you could have died from _____?</i> Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)? (Self-Injurious Behavior without suicidal intent) If yes, describe:		Yes No <input type="checkbox"/> <input type="checkbox"/> Total # of Attempts _____	Yes No <input type="checkbox"/> <input type="checkbox"/> Total # of Attempts _____		
Has subject engaged in Non-Suicidal Self-Injurious Behavior?		Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>		
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act (if not for that, actual attempt would have occurred). Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything? If yes, describe:		Yes No <input type="checkbox"/> <input type="checkbox"/> Total # of interrupted _____	Yes No <input type="checkbox"/> <input type="checkbox"/> Total # of interrupted _____		
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything? If yes, describe:		Yes No <input type="checkbox"/> <input type="checkbox"/> Total # of aborted or self-interrupted	Yes No <input type="checkbox"/> <input type="checkbox"/> Total # of aborted or self-interrupted		
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)? If yes, describe:		Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>		
Suicidal Behavior: Suicidal behavior was present during the assessment period?		Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>		
		Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:	
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; medical hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; medical hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death		Enter Code _____	Enter Code _____	Enter Code _____	
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care		Enter Code _____	Enter Code _____	Enter Code _____	

Additional Questions

<p><u>Legal Troubles</u> <i>Are you currently facing any legal troubles?</i> *Within military structure or outside</p> <p><i>If yes, how have these circumstances impacted you/your family?</i></p> <p>Additional Information:</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>
<p><u>Financial Troubles</u> <i>Are you experiencing any financial troubles?</i> If yes:</p> <p><i>Do these concerns feel overwhelming or unmanageable?</i></p> <p><i>Sometimes a person can feel that others close to them (e.g., family) would be better off financially if the person were no longer alive. Have you experienced this?</i></p> <p><i>Is this financial stress or hardship the worst crisis you have ever experienced?</i></p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p>
<p><u>State of Service</u> (pre-deployment, post-deployment, etc) Pre-deployment ___ Post-deployment ___ Multiple deployments ___</p> <p><i>Are the thoughts/behaviors we talked about related to your _____?</i> (e.g., pending deployment)</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>
<p><u>Marital or Relationship Stress</u> <i>Are you having any marital or relationship stress or problems?</i> *Ask about domestic violence.</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>
<p><u>Drug or Alcohol Use</u> <i>Do you use drugs or alcohol?</i></p> <p><i>Do you have a history of drug or alcohol abuse?</i></p> <p>Additional Information:</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p>
<p><u>Pain</u> <i>Are you experiencing pain – chronic or intermittent?</i></p> <p>Additional Information:</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>