

Rising Suicides Stump Military Leaders

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The U.S. military doesn't need September's Suicide Prevention Month to realize it has a problem within its ranks.

The increase in suicide deaths is one of the most distressing issues facing military leaders who want to reduce the rates among active-duty service members. More than 2,000 of them have killed themselves in the past decade, including 295 last year compared with 153 in 2001.

Despite their best suicide-prevention efforts, reducing the number of military suicides has been a frustrating challenge, military leaders acknowledged earlier this month at a congressional hearing in Washington, D.C. Recent efforts have included increasing at-risk service members' access to mental health professionals, while reducing the stigma attached to mental health care. Internet outreach, including "video chats," has also shown some promise.

The difficulty, however, is in identifying which initiatives work best and deciphering the multiple triggers that can lead to suicide within the armed services, which accounts for a small fraction of the total number of people who serve.

The most commonly identified risk factors and "stressors", according to the leaders who testified, are relationship issues, work-related problems, financial pressure, legal concerns, alcoholism and substance abuse.

Defense Department statistics indicate that since January, 2001, 2,293 active-duty service members have taken their own lives, including the ones who never deployed overseas. By comparison, 6,139 service members have died in Afghanistan and Iraq in the same period.

On the brighter side, the number of service members who killed themselves in 2010 declined slightly to 295 from 309 the year before, according to the "The DoD Suicide Event Report," which was released last week.

About a third of last year's service members had told at least one person they planned to kill themselves, according to the report.

Despite conventional wisdom, military suicides are not necessarily linked to overseas deployments. For the first time, however, there's evidence of an increase in suicides among those who have had more than one deployment, Army Deputy Chief of Staff Maj. Gen. Thomas Bostick testified.

Historically, suicides have spiked after periods of "great drawdown" in the active-duty force, particularly in the Navy, said Rear Adm. Anthony Kurta, director of Navy military personnel.

"The next year, we often see a spike in our suicide rate," he said. "So we've seen that three times over the past 20 years. So it makes us remain ever vigilant as we go into a period now here of potential end-strength reductions."

Pending military budget cuts worry Rep. Joe Wilson, R-S.C., chairman of the House Armed Services personnel subcommittee. "I am very concerned those stressors will only get worse in the coming months as debate regarding cuts to the Department of Defense budget intensifies."

Treatment: 'It's Not One Solution Fits All'

Despite the myriad of suicide-prevention programs developed in the past few years, military leaders say, there are too few ways to measure them properly to determine which ones work and which don't.

"It's very, very difficult to assess the effectiveness of the programs," Bostick said. "I think some are very early, some are still in the progress of piloting and, because it's not one solution fits all, we really need to come at this at multiple levels from multiple directions. It is very, very complex."

Each service has developed its own strategy and programs for preventing suicide. For example, the Marine Corps has set up a call center run "by Marines, for Marines," said Lt. Gen. Robert Milstead Jr., Marine Corps deputy commandant for manpower and reserve affairs.

"Marines, when we call a number, if we get a social worker or someone, they're going to know it's not a Marine. But when there's a Marine there or someone that talks Marine, then they'll open up," he said, referring to a call center run "by Marines for Marines."

Military leaders say such "telehealth" programs -- treatment over the phone or Internet video chat -- are especially promising because they allow mental health professionals to reach service members stationed in remote or rural areas who might not have access to a health care facilities.

"There is an imbalance between where the people who need services live, and where the people who provide psychological help are located," said Dr. Jamie Adler, chief of clinical telehealth of the National Center for Telehealth and Technology (T2).

Alder said telehealth is especially useful when providers are temporarily overwhelmed by the numbers of people they need to help, such as after a deployment.

"When service members come home after deployment, they come in large groups, and are supposed to come do screenings," Adler said in an interview. "A lot of facilities they come back to don't have enough personnel to do face-to-face screenings."

To mitigate this, Adler said, some facilities will set up individual sound booths in a gymnasium, for instance, to allow professionals from a variety of different areas to dial in, and meet the "surge of need" to do these mental health screenings.

Adler said a number of studies that have looked at the comparison between service provided via video chat and face to face show that the outcomes tend to be about the same.

Dr. Mark Reger, T2 deputy director and leader of its suicide research team, said smartphone apps fall within the scope of telehealth.

"Many soldiers or warriors have a smartphone in their pocket 24/7," he said. "It's a tool where we can reach them where they are, whenever they need services."

He said there are apps related to common breathing tools that coach individuals with symptoms of post-traumatic stress disorder or mild traumatic brain injury, or link them to Web resources.

Telehealth also makes receiving mental health care more discreet.

"What we found is, if you have an alcohol problem, you probably don't want to run to your squad leader and tell him about it," Bostick said at the hearing.

"We're finding some great success in the virtual world with tele-behavioral health," he said, "Where we're able to allow the individual to talk virtually to some of these behavioral health specialists and have the privacy but get the care that they need."

Telehealth programs could be especially helpful for veterans or inactive reservists who are geographically removed from the support network provided by military installations, and have limited access or reduce access to health care and the oversight of a full-time chain of command.

"We've partnered with the Department of Vet Affairs to address the issue of reserve component service members in rural areas by really enhancing the whole concept of tele-behavioral health," Bostick testified.

"And this is a very interesting concept which will allow, via Internet connection, for someone who might be in crisis or have a problem to talk directly with a behavioral health specialist and get care. And preliminary results suggest that it's a very acceptable means to provide care."