

OCTOBER 2011

Losing the Battle *The Challenge of Military Suicide*

POLICY BRIEF



Dr. Margaret C. Harrell and Nancy Berglass

Suicide among service members and veterans challenges the health of America's all-volunteer force. While any loss of military personnel weakens the U.S. armed forces, the rapid upswing in suicides among service members and veterans during the wars in Iraq and Afghanistan threatens to inflict more lasting harm. If military service becomes associated with suicide, will it be possible to recruit bright and promising young men and women at current rates? Will parents and teachers encourage young people to join the military when veterans from their own communities have died from suicide? Can the all-volunteer force be viable if veterans come to be seen as broken individuals? And how might climbing rates of suicide affect how Americans view active-duty service members and veterans – and indeed, how service members and veterans see themselves?

This policy brief has four objectives. First, it examines the phenomenon of suicide within the U.S. military community, including both the frequency of suicide and the extent to which suicide is related to military service. It outlines steps taken by the Department of Defense (DOD), the armed services and the Department of Veterans Affairs (VA) to reduce suicide in the armed forces and among veterans. It then identifies obstacles to reducing suicides further and makes recommendations to address each of those obstacles.

What We Know About Military Suicide

THE NUMBERS ARE STARK

From 2005 to 2010, service members took their own lives at a rate of approximately one every 36 hours.¹ While suicides in the Air Force, Navy and Coast Guard have been relatively stable and lower than those of the ground forces, U.S. Army suicides have climbed steadily since 2004. The Army reported a record-high number of suicides in July 2011 with the deaths of 33 active and reserve component service members reported as suicides. Suicides in the Marine Corps increased steadily from 2006 to 2009, dipping slightly in 2010. It is impossible, given the paucity of current data, to determine the suicide rate among veterans with any accuracy. However, the VA estimates that a veteran dies by suicide every 80 minutes.² Moreover, although only 1 percent of Americans have served in the military, former service members represent 20 percent of suicides in the United States.³

The U.S. military cannot avoid the stark reality of suicide entirely. Service members and veterans reflect the broader American public, which not only suffers from suicide, but also stigmatizes mental health care. Further, some service members enter military service with mental health challenges and we should not conclude that serving in the military caused these suicides. For instance, 31 percent of Army suicides are associated with factors from the years prior to entering the Army.⁴

ADDRESSING THE PROBLEM OF MILITARY SUICIDE REQUIRES UNDERSTANDING SUICIDE ITSELF AS WELL AS THE RELATIONSHIP BETWEEN SUICIDE AND MILITARY SERVICE

Although the number of military suicides has increased since the start of the wars in Afghanistan and Iraq, the prevailing wisdom has been that suicides are not linked directly to deployment.⁵ However, recent analysis of Army data demonstrates that soldiers who deploy are more likely to die by suicide.⁶ Data have long indicated definitive links between suicide and injuries suffered during deployment. Individuals with traumatic brain injury (TBI), for instance, are 1.5 times more likely than healthy individuals to die from suicide.⁷ Additional factors that heighten risk include chronic pain and post-traumatic stress disorder (PTSD) symptoms such as depression, anxiety, sleep deprivation, substance abuse and difficulties with anger management.⁸ These factors are also widely associated with deployment experience in Afghanistan and Iraq.

SOME PSYCHIATRIC EXPERTS ARGUE THAT THERE IS AN INDIRECT RELATIONSHIP BETWEEN SUICIDE AND MILITARY SERVICE DURING WARTIME

One school of thought, known as the interpersonal-psychological theory of suicide, suggests that the following three “protective” factors preclude an individual from killing oneself: belongingness, usefulness and an aversion to pain or death.⁹ Any one of these protective factors normally is sufficient

“Commit Suicide”

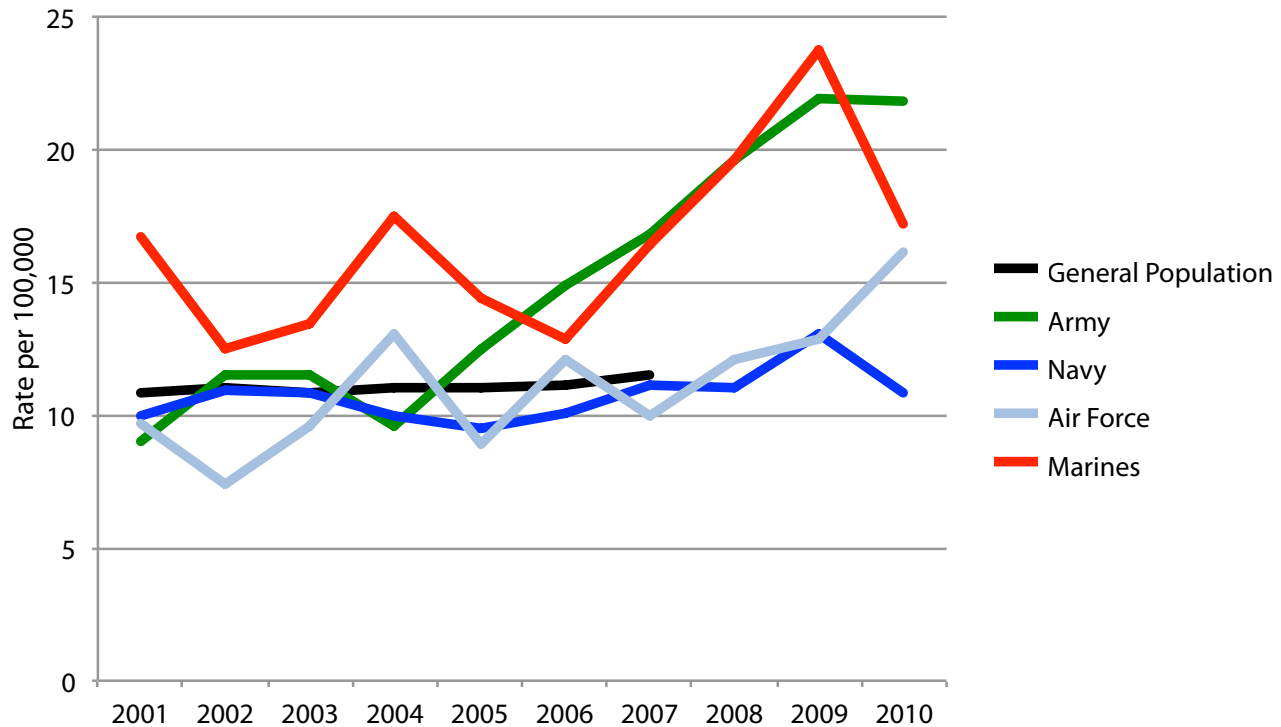
The authors of this report refrain from using the phrase “commit suicide.” The word “commit” portrays suicide as a sin or a crime, as those acts are typically “committed.” This language contributes to a stigma that prevents individuals from getting help.

The BBC takes a similar stance. See www.bbc.co.uk/editorialguidelines/page/guidelines-harm-suicide for more information.

to prevent suicide. Traditionally, military service has had a protective quality: Military service members have been less likely to die by suicide than civilians. It appears now, however, that the nature of military service – especially during wartime – may weaken all three protective factors.¹⁰ The cohesion and camaraderie of a military unit can induce intense feelings of belonging for many service members. Time away from the unit, however, may result in a reduced or thwarted sense of belonging, as individuals no longer have the daily support of their units and feel separate and different from civilians. This is especially true for Guardsmen and Reservists.

The responsibility inherent in military service, the importance of tasks assigned to relatively junior personnel and the high level of interaction among unit members establish the importance and usefulness of each unit member, particularly in an operational environment. In contrast, the experience of living in a garrison environment (for active component personnel) or returning to a civilian job (for Guardsmen, Reservists and veterans) or, worse, unemployment, can introduce feelings of uselessness. Individual accounts of military suicide both in the media and in interviews with us echo this sentiment. Over and over, these accounts show that individuals withdrew, felt disconnected from their units and their families, and perceived themselves as a burden.

TABLE 1: SUICIDE RATES BY SERVICE (2001-2010)



Sources: All data represent active duty suicide rates. Army 2001-2002, Air Force 2001-2003 and Marine Corps 2001-2005 data are from Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, *The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives* (August 2010). Army 2003-2010 data are provided by the Army Health Promotion and Risk Reduction Task Force. Navy 2001-2010 data are from the Navy Personnel Command website, http://www.public.navy.mil/bupers-npc/support/suicide_prevention/Pages/HistoricStats.aspx. Air Force 2004-2010 data are from "Air Force Long Term Active Duty Suicide Rates" (August 12, 2011), AFSPM Manager of the AFMSA/SG30Q. Marine data for 2006-2010 rates were obtained from a telephone conversation with a Marine Corps representative, September 7, 2011.

The third protective factor – an aversion to pain or death – is especially important in considering military suicide, because military service is one of the few experiences that can override this factor. Repeated exposure to military training as well as to violence, aggression and death dulls one's fear of death and increases tolerance for pain.¹¹ Thus, the very experience of being in the military erodes this protective factor, even for service members who have not deployed or experienced combat, in part because service members experience pain and discomfort from the beginning of their training.¹² By removing some of the protective factors of suicide, therefore, military service, especially during wartime, may predispose an individual toward suicide.

Efforts and Obstacles

LEADERS IN THE ARMED SERVICES AND THE VA DESERVE RECOGNITION FOR THEIR ACTIONS TO REDUCE THE RATE OF SUICIDE AMONG SERVICE MEMBERS AND VETERANS, BUT FACE PERSISTENT OBSTACLES

Senior military leaders have exerted considerable effort in recent years to acknowledge and confront the challenge of suicide. The VA and each of the military services have emphasized the development of suicide prevention programs, education about the risk of suicide and the most effective ways to prevent it. The DOD suicide prevention programs, with slogans such as "Never Leave a Marine Behind" and "Never Let Your Buddy Fight Alone,"

resonate with service members by being service-specific and embedded in their service cultures. The services ensure that the necessary tools, such as hotlines, are readily available. The VA's Veterans Crisis Line is especially important in this regard. In its first three years, the hotline received more than 144,000 calls involving veterans and saved more than 7,000 actively suicidal veterans.¹³ Obstacles remain nonetheless.

MILITARY PERSONNEL TRANSFERS COMPLICATE EFFORTS TO HELP INDIVIDUALS STRUGGLING WITH MENTAL HEALTH ISSUES

Permanent change of station (PCS) moves are a feature of military life. Yet, such moves make it difficult for unit leaders to recognize and understand the unique mental health issues of their people, and for service members and military family members to obtain consistent mental health care. When military personnel arrive at a new unit, unit leaders are often unaware of particular service members' personal challenges. Further, because professional organizations license mental health care providers on a state-by-state basis, a geographical move across state lines can preclude continued care from the same provider. When a care provider and a service member (or a military family member) invest in developing a care relationship, and that relationship is severed by a move, patients are often reluctant to begin treatment anew.

Recommendation: The services need to ensure that information about a service member's mental health well-being is transferred when that individual moves. When a unit commander has significant concerns regarding a departing member, he or she should discuss these issues with the receiving commander. Congress should establish a federal pre-emption of state licensing such that mental health care can be provided across state lines for those instances in which military service members or family members have an established pre-existing care relationship.

ARMY PERSONNEL TRANSFERS OCCUR TOO SOON AFTER DEPLOYMENT

Army units returning home from deployment experience tremendous turnover, as individuals leave the unit for their next assignments. Because rotations do not occur immediately prior to or during deployments, individuals typically transfer to their next assignments during the post-deployment time frame. This lack of unit stability following a deployment has unfortunate implications for individuals struggling with reintegration. Leaders most familiar with the troops and most likely to recognize atypical or risk-taking behavior are gone. New leaders are less likely to interpret misbehavior by otherwise good soldiers as a warning sign. Recognizing the importance of unit stability, the Marine Corps has directed that Marines must remain assigned to their deploying unit for 90 days following deployment.¹⁴

Recommendation: The Army should establish a unit cohesion period following deployment.

COMMANDERS ARE NOT ALWAYS AWARE WHEN SUBORDINATES ARE THE SUBJECT OF AN INVESTIGATION

A significant number of suicide victims were coping with legal problems.¹⁵ Yet, even though the notification of a criminal investigation is sometimes a suicide trigger, criminal investigators do not usually contact commanders when they inform a service member that he or she is the subject of an investigation.¹⁶ The Air Force has recognized this phenomenon and now coordinates its investigators and commanders more effectively. Air Force guidance underscores that the investigating agency and unit leaders share responsibility for the safety and well-being of individuals under investigation. Further, if individuals appear emotionally distraught or agitated, investigators will release them only to unit leaders. Army investigators began informing commanders of individual investigations in 2011, but this practice is not followed consistently. Other services' investigators do not regularly involve commanders.

Recommendation: The Army, Navy, Marine Corps and Coast Guard should ensure that investigators inform unit commanders of ongoing investigations, and that investigators work with unit leaders to ensure the safety and well-being of members under investigation.

THE MENTAL HEALTH SCREENING PROCESS FOLLOWING DEPLOYMENT IS FLAWED

As service members return home from deployment, they complete a post-deployment health assessment (PDHA). As part of this assessment, they are asked questions about their physical and mental health, such as, “Did you encounter dead bodies or see people killed or wounded during this deployment?” and “During this deployment, did you ever feel that you were in great danger of being killed?” There are also self-evaluative questions, such as, “Are you currently interested in receiving information or assistance for a stress, emotional or alcohol concern?” While we do not question the contents of the assessment, its administration has been problematic.

A 2008 study found that when Army soldiers completed an anonymous survey, reported rates of depression, PTSD, suicidal thoughts and interest in receiving care were two to four times higher as compared to the PDHA.¹⁷ Likewise, our interviews with veterans uncovered numerous accounts of returning service members whose unit leaders advised them to fabricate answers. Individuals across all services have been told, “If you answer yes to any of those questions, you are not going home to your family tomorrow.” This may be factually correct, but it neglects to inform service members of the implications of answering untruthfully – namely, that they will have difficulty receiving treatment or compensation for mental health problems that appear after their service. As an improvement, the 2010 National Defense Authorization Act requires trained medical or behavioral health professionals to conduct the

PDHA evaluations individually and face-to-face,¹⁸ in the hope that service members will respond honestly to a trained health professional.

Recommendation: Unit leaders should encourage members to complete the PDHA truthfully and should underscore that a truthful answer will allow them to link any future mental health problems requiring treatment to their military service.

A CULTURAL STIGMA ATTACHED TO MENTAL HEALTH CARE PERSISTS IN THE ARMED SERVICES

The health and survival of service members hinges on the removal of the stigma associated with mental health care. This stigma exists in both military and civilian culture. In the military, it prevents many service members from seeking help to address mental health care issues; 43 percent of soldiers, sailors, airmen and Marines who took their own lives in 2010 did not seek help from military treatment facilities in the month before their deaths.¹⁹ The percentage of service members seeking help has improved – from 40 percent in 2008 and 36 percent in 2009 to 57 percent in 2010 – but the stigmatization of mental health care remains an issue.²⁰ Military leaders recognize the importance of removing this stigma. Indeed, recently retired Chairman of the Joint Chiefs of Staff Admiral Mike Mullen identified the stigma of PTSD as the greatest challenge confronting troops returning from war in Iraq and Afghanistan,²¹ and other DOD leaders at the highest levels have urged service members to seek mental health care as needed. Nevertheless, the stigma persists.

This culture is unlikely to change quickly. Leaders have not provided sufficient guidance about how to remove the stigma associated with depression and suicidal thoughts, and they have not consistently disciplined service members who belittle or ridicule members with mental health issues.²² Removing the stigma for PTSD, an invisible injury, will be especially difficult, given that some service members do not even consider

TBI, which is physically evident and recognizable, a “real injury.”²³ Yet the stigma must be removed to address and treat PTSD and TBI, both of which are linked to suicide. Further, despite policies to provide military memorial or burial to members who die by suicide, some commanders decline to provide their families this benefit. Anecdotal accounts suggest that these commanders sometimes believe that military memorials or funerals may seem to endorse or glamorize suicide. Although isolated, such denials of military remembrance disproportionately reinforce the stigma of mental health problems, particularly when these instances receive media coverage.²⁴

Recommendation: Military leaders must eliminate the stigma associated with mental health care, hold unit leaders accountable for instances in which individuals are ridiculed for seeking treatment, and ensure that military funerals or memorials are provided to all otherwise eligible service members who die by suicide.

MILITARY HAZING PERSISTS

One to two percent of military suicides, and four to five percent of military suicide attempts, involve hazing in the unit or military workplace.²⁵ This is a small percentage, but unacceptable nonetheless. In congressional testimony, senior military officers recently underscored that service policies prohibit hazing behavior.²⁶ The services have also court-martialed individuals for hazing, but isolated instances persist.

Recommendation: Service leaders must ensure that not only their policies but also their cultures prohibit hazing and abuse, and that the armed services do not harbor abusive leaders.

THE NUMBER OF CARE PROVIDERS IS INSUFFICIENT

There is a national shortage of mental health care and behavioral health care professionals, a factor linked to higher rates of suicide. According to

the VA, suicide rates decreased by 3.6 deaths per 100,000 in seven regions²⁷ where staff numbers increased to levels recommended in the 2008 *Veterans Health Administration Handbook*.²⁸ Sixteen regions are still not manned to these levels, however. Additionally, the Army has only 80 percent of the psychiatrists and 88 percent of the social workers and behavioral health nurses. With respect to psychologists, 93 percent of positions are filled.²⁹

Military hospital commanders have temporary authority to hire psychologists and social workers and behavioral health nurses on an as-needed basis, but a shortage of care providers precludes them from easily filling that gap. This shortage is a national issue, which affects the availability of care providers for the DOD and the VA. It also affects veterans’ families, who seek treatment from the civilian health care system to cope with the strain of reintegration.

Recommendation: Congress should permanently establish expedited or direct hire authority allowing military hospitals to hire behavioral health care providers.

LEGAL RESTRICTIONS PREVENT MILITARY LEADERS FROM DISCUSSING PRIVATELY OWNED WEAPONS

Forty-eight percent of military suicides in 2010 occurred with privately owned weapons.³⁰ Multiple studies indicate that preventing easy access to lethal means, such as firearms, is an effective form of suicide prevention.³¹ However, the 2011 National Defense Authorization Act (NDAA) prohibits anyone within the DOD from “collect[ing] or record[ing] any information relating to the otherwise lawful acquisition, possession, ownership, carrying, or other use of a privately owned firearm, privately owned ammunition, or another privately owned weapon by a member of the Armed Forces or civilian employee of the Department of Defense” unless that individual lives on a military installation.³² The current law does allow military leaders to discuss privately owned weapons with

service members who appear to be a threat to themselves or others, but commanders cannot ask a severely depressed individual about personally owned weapons if that individual denies that he or she is considering harming himself or herself.

Recommendation: Congress should rescind the NDAA 2011 restriction on discussing personally owned weapons so that unit leaders can suggest to service members exhibiting high-risk behavior, acting erratically or struggling with depression that they use gunlocks or store their guns temporarily at the unit armory. Given this change in law, unit leaders should engage both at-risk service members and their family members, and encourage them to obtain gunlocks or to store privately owned weapons out of the household.

Leaders are best able to help their troops when they know if individuals are struggling.

THERE IS EXCESS PRESCRIPTION MEDICATION IN THE MILITARY COMMUNITY

Misuse of prescription medication is another obstacle to addressing the problem of military suicide. Approximately 14 percent of the Army population is currently prescribed an opiate.³³ Forty-five percent of accidental or undetermined Army deaths from 2006 to 2009 were caused by drug or alcohol toxicity,³⁴ and 29 percent of Army suicides between 2005 and 2010 included drug or alcohol use.³⁵

Data collected from civilian populations indicate that adults aged 18-34 are the most likely to have attempted drug-related suicides,³⁶ and that 58.9 percent of drug-related suicide attempts resulting in visits to an emergency room involve psychotherapeutic drugs.³⁷ Another 36 percent of emergency room visits for suicide attempts involve pain medications.³⁸ If we anticipate similar rates among military service members, it is important

to address the excess prescription medicine among military service members. Yet, there is no opportunity to do so. When military doctors prescribe an alternative medication or dosage from what a service member was previously prescribed, there is no request made for the service member to return the remainder of his or her prior medication. Instead, military doctors dispense additional medications, because only law enforcement personnel can conduct “take-back” programs for medications. On January 26, 2011, the Army Vice Chief of Staff requested that the Drug Enforcement Administration (DEA) permit the Army’s military treatment facilities and pharmacies to accept excess prescription medicine for disposal.³⁹ The request was denied.

Recommendation: The DEA should grant the DOD authority to accept and destroy excess prescription medication from military service members. Given this authority, the Office of the Army Surgeon General should initiate an effort with the Navy, Air Force and Coast Guard surgeon generals to develop policies and practices regarding how best to account for, and regain possession of, excess prescription medications.

UNIT COMMANDERS HAVE LIMITED VISIBILITY INTO SERVICE MEMBERS’ MEDICAL PROBLEMS

Leaders are best able to help their troops when they know if individuals are struggling. Yet protected health information laws have precluded medical professionals from sharing information with the chain of command.⁴⁰ Unit leaders can better help soldiers when the commanders are aware of significant problems. Proponents of behavioral health privacy laws, however, voice concern that military personnel will not seek help if they know that commanders will be informed.⁴¹ Consistent with this concern, health care providers should keep most medical information private. However, when behavioral health professionals believe that an individual is at high risk for killing one’s self, they should inform the relevant commander. The Army

has recently encouraged doctors to share information with commanders when doctors observe a soldier “at potential risk to themselves.”⁴² Nonetheless, it is unclear whether military behavioral health care providers are consistently following this suggestion.

Recommendation: Behavioral health care providers should inform the unit commander when a service member is at high risk for suicide. The armed services should develop specific guidance for unit commanders on how to interact with individuals after receiving this information.

INFREQUENT INTERACTION AMONG DRILLING GUARDSMEN AND RESERVISTS LIMITS UNIT LEADERS’ ABILITY TO RECOGNIZE AND HELP SUBORDINATES STRUGGLING WITH MENTAL HEALTH ISSUES

The DOD approach to suicide prevention depends heavily on what experts refer to as “gatekeeper strategies.” The Army, for example, asserts that “[t]here is no other aspect of [its suicide prevention] that is more important for preventing negative outcomes than the vigilance of the individual commander, supervisor, Soldier, law enforcement agent or program/service provider. Leaders, supervisors, and ‘Buddies’ represent the first level for surveillance of high risk behavior.”⁴³

Although medical and academic experts identify gatekeeper approaches as one of the most promising strategies,⁴⁴ the limitations of this approach are notable for the Guard and Reserve, where there are long monthly gaps between drill periods when leaders and peers do not have the opportunity to watch for warning signs. Yet studies indicate that even the smallest amount of contact can reduce the risk of suicide.⁴⁵ These findings suggest that even postcards or text messages from unit leaders between drill weekends can help prevent suicides.

Recommendation: The DOD should address weaknesses in gatekeeper-based programs for drilling Guard and Reserve units. Specifically, Guard

The true number of veterans who die by suicide is unknown.

and Reserve units should develop a leadership communication plan that addresses the stresses on units and details the frequency and method (written, electronic or telephone) by which small unit leaders should remain in contact with their subordinates. Leaders should pay closer attention to this communication following a deployment.

THE NATIONAL GUARD HAS TOO MANY SUICIDE PREVENTION PROGRAMS

Assessing which suicide prevention strategies are effective requires systematic efforts to understand military suicide. Yet these efforts are thwarted by the existence of too many programs. Suicide prevention programs in the National Guard are a decentralized multitude that the Adjutant General (TAG) of each state and U.S. territory initiates and manages. This grassroots solution is inefficient given that, while some states had more suicides than others, overall the Army National Guard averages slightly more than one suicide per state annually. Although the individual programs may use evidence-based approaches, it will be difficult to demonstrate which suicide prevention programs are effective with the military community or efficacious in reducing suicide, because the small numbers do not support rigorous analysis. Even more important, these programs risk reduction or elimination due to dwindling state resources.⁴⁶

Recommendation: The National Guard should reduce the number of unique suicide prevention programs, and consider adoption of a systemwide, centrally funded, prevention approach.

THE TRUE NUMBER OF VETERANS WHO DIE BY SUICIDE IS UNKNOWN

Americans must have a more complete accounting of veteran suicide. The VA estimates

that 18 veterans kill themselves every day,⁴⁷ but this number is extrapolated from extremely limited data. Specifically, states provide death data to the Centers for Disease Control (CDC) for inclusion in the National Death Index, but only 16 of U.S. states indicate veteran status in their data.⁴⁸ The number of veteran suicides from the remaining 34 states is extrapolated to estimate the overall number of veteran suicides.⁴⁹ Further, the current numbers are extrapolated from three-year-old data.

An effort is underway to match the Social Security numbers in the national death data with DOD files to identify veterans included in the data. This effort provides the capability to analyze the data and characterize the veteran victims of suicide. It will thus be possible to quantify veteran suicide and contribute an understanding of the number of suicides among post-9/11 veterans, as compared with veterans of earlier generations. This analysis could also permit an understanding of whether veterans kill themselves soon after leaving the military.

The DOD does not currently take sufficient responsibility for veteran suicide. Given the potential implications of veteran suicide for the all-volunteer force, the DOD should seek to understand which veterans, and how many veterans, are dying by suicide. In particular, the DOD, as well as the VA and the country at-large, should recognize that many veterans who left the service only shortly before they killed themselves may have suffered from unaddressed mental health wounds incurred while in service to their nation.

Recommendation: Congress should establish reasonable time requirements for states to provide death data to the CDC, and the Department of Health and Human Services (HHS) should ensure that the CDC is resourced sufficiently to expedite compilation of national death data. The DOD, the

VA and HHS should coordinate efforts to analyze veteran suicide data and should conduct these analyses annually.

UNDERSTANDING AND ADDRESSING THE CHALLENGE OF SUICIDE REQUIRES COOPERATION BEYOND THE TRADITIONAL JURISDICTIONAL BOUNDARIES FOR MANY ORGANIZATIONS, INCLUDING THE DOD, THE VA, HHS AND CONGRESS

The programs and services designed to understand and reduce service member and veteran suicide should complement one another and gain both efficiency and effectiveness from interacting synergistically. Obtaining veteran suicide data and understanding the circumstances surrounding individuals who die by suicide depends on the states and the HHS, as well as on the participation of the VA and the DOD.⁵⁰ Within DOD, the military services and components do not regularly and consistently share information. Further, the congressional committees that hold the DOD and the VA accountable are stove-piped. The House Armed Services Committee (HASC) and the Senate Armed Services Committee (SASC) interact only with DOD and generally do not address veteran suicide issues. Likewise the Senate Committee on Veteran Affairs and the House Veterans Affairs Committee, which represent veterans' interests, interact with the VA, not with the DOD.

Recommendation: The DOD, the VA and HHS should share data and information pertaining to suicide. The military services' leaders should meet regularly to discuss issues and approaches pertaining to suicide, and to share lessons learned. The Senate Committee on Veterans Affairs and the House Veterans Affairs Committee should initiate discussions with SASC and HASC, with the intent of developing provisions for the NDAA to address the problem of veteran suicide.

Conclusion

George Washington asserted, “The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive the Veterans of earlier wars were treated and appreciated by their nation.”

If Washington was correct, suicide among service members and veterans threatens the health of the all-volunteer force. Mentors and role models, including parents, teachers and, importantly, veterans, play a critical role in the enlistment decisions of young men and women. We should realize that these mentors and role models will not steer youth toward the military if they perceive damage to service members or a failure to address the mental health care needs of those who have served their country.

The military must take care of its own. Although a goal of no suicides may be unachievable, the increasing number of suicides is unacceptable. Additionally, although benefits and services available from the Veterans Health Administration will likely remain the best system of care for veterans, the DOD has moral responsibility to acknowledge and understand former service members.

America is losing its battle against suicide by veterans and service members. And, as more troops return from deployment, the risk will only grow. To honor those who have served and to protect the future health of the all-volunteer force, America must renew its commitment to its service members and veterans. The time has come to fight this threat more effectively and with greater urgency.

Help for Service Members, Veterans and Military Families

Veterans Crisis Line: 1.800.273.TALK (8255), Press 1

This collaborative effort by the U.S. Department of Veterans Affairs and the Substance Abuse and Mental Health Services Administration meets the special needs of service members, veterans and family members in personal crisis.

Dr. Margaret C. Harrell is a Senior Fellow and the Director of the Joining Forces initiative at the Center for a New American Security (CNAS). Nancy Berglass is a Non-Resident Senior Fellow at CNAS, the Director of the Iraq Afghanistan Deployment Impact Fund (IADIF) of the California Community Foundation and the Principal of Berglass Community Investment Consulting.

Acknowledgments

We wish to acknowledge the expertise of the external reviewers Dr. Rajeev Ramchand, lead author of *The War Within: Preventing Suicide in the U.S. Military* (Santa Monica, CA: The RAND Corporation, 2011) and Terri Tanielian, director of the RAND Center for Military HealthPolicy Research. We also acknowledge Bonnie Carroll, Founder and President of the Tragedy Assistance Program for Survivors, whose insights were a valuable contribution to this policy brief.

We also gratefully acknowledge our donors. The CNAS Joining Forces initiative is supported by the generosity of BAE Systems, Inc.; Health Net; JPMorgan Chase & Co.; Prudential; TriWest Healthcare Alliance; and WILL Interactive.

The views expressed herein are solely those of the authors.

ENDNOTES

1. Department of Defense, "The Challenge and the Promise: Strengthening the Force, Preventing Suicide, and Saving Lives," Final Report of the DOD Task Force on Prevention of Suicide by Members of the Armed Forces (August 2010), provides data through 2009. The 2010 data are from the Department of Defense, *Department of Defense Suicide Event Report*, Calendar Year 2010 Annual Report (September 2011).
2. Department of Veterans Affairs, *Fact Sheet: VHA Suicide Prevention Program, Facts About Veteran Suicide* (March 2010).
3. Ibid.
4. Sandra A. Black et al., "Prevalence and Risk Factors Associated with Suicides of Army Soldiers 2001-2009," *Military Psychology* 23 no. 4 (July 2011), 433-451.
5. This relationship has not been evident in prior analyses and is not evident in suicide data from the Navy, Air Force, Marine Corps or Coast Guard.
6. Sandra A. Black et al., "Prevalence and Risk Factors Associated with Suicides of Army Soldiers 2001-2009."
7. Department of Veterans Affairs, Memorandum from Deputy Under Secretary for Health for Operations and Management, "Recent VHA Findings Regarding TBI History and Suicide Risk" (October 29, 2009).
8. Sandra A. Black et al., "Prevalence and Risk Factors Associated with Suicides of Army Soldiers 2001-2009", 442; and E. C. Harris and B. Barraclough, "Suicide as an Outcome for Mental Disorders: A Meta-analysis," *British Journal of Psychiatry* 170 no. 3 (March 1997), 205-228.
9. Thomas Joiner, *Why People Die by Suicide* (Cambridge, MA: Harvard University Press, 2007).
10. See the discussion of these effects in Edward A. Selby et al., "Overcoming the Fear of Lethal Injury: Evaluating Suicidal Behavior in the Military through the Lens of the Interpersonal-Psychological Theory of Suicide," *Clinical Psychology Review* 30 no. 3 (April 2010), 298-307.
11. Craig J. Bryan et al., "Challenges and Considerations for Managing Suicide Risk in Combat Zones," *Military Medicine* 175 no. 10 (October 2010), 713-718; and Edward A. Selby et al., "Overcoming the Fear of Lethal Injury."
12. C. J. Bryan et al., "A Preliminary Test of the Interpersonal-Psychological Theory of Suicide Behavior in a Military Sample," *Personality and Individual Differences* 48 no. 3 (February 2010), 347-350.
13. Text refers to period from July 2007 to March 2010. Department of Veterans Affairs, *Fact Sheet: VHA Suicide Prevention Program, Facts About Veteran Suicide*.
14. The commandant has directed a 90 day post-deployment cohesion period for every full deploying unit, absent approval from a general officer to move individuals.
15. Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, *The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives* (August 2010), indicates that 35 percent of Navy suicides had discipline or legal problems (22), 39 percent of Air Force suicides had legal problems (23), and 43 percent of Marine suicides were pending disciplinary action (29). The Army HP/RR/SP Report indicates that 34 percent of 2009 Army suicide victims had legal issues. U.S. Army, *Health Promotion Risk Reduction Suicide Prevention Report* (August 2010), 24.
16. The Air Force includes such notification in their suicide prevention strategy, requiring investigators to contact, person-to-person, an airman's commander, first sergeant or supervisor. This policy was begun in 1996, when evidence indicated that more than 30 percent of Air Force active-duty suicide victims had legal problems and were under investigation. U.S. Air Force, *The Air Force Suicide Prevention Program: A Description of Program Initiatives and Outcomes*, AFPAM 44-160 (April 2001).
17. Christopher H. Warner et al., "Importance of Anonymity to Encourage Honest Reporting in Mental Health Screening After Combat Deployment," *Archives of General Psychiatry* 68 no. 10 (October 2011), 1065-1071.
18. The National Defense Authorization Act for FY 2010, Public Law 111-84, sec. 708.
19. Fifty-seven percent of DOD suicides were seen at a military treatment facility in the month prior to their deaths. Department of Defense, *Department of Defense Suicide Event Report*, Calendar Year 2010 Annual Report (September 2011), 23.
20. Department of Defense, *Department of Defense Suicide Event Report*, Calendar Year 2009 Annual Report (2010), 29; and Department of Defense, *Department of Defense Suicide Event Report*, Calendar Year 2008 Annual Report (2010), 26.
21. Stephanie Gaskell, "Stigma of Posttraumatic Stress Disorder Is Greatest Challenge of Returning Troops: Mullen," *Daily News* (April 19, 2010).
22. See, for example, the following news article for a publicized account of such ridicule: <http://www.q13fox.com/news/kcpq-suicide-rate-spiking-at-joint-base-lewis-mcchord-20110817,0,1023250.story>.
23. The authors interviewed veterans who did not mention their own TBI in response to the question, "Were you physically wounded during deployment?" When interviewees mentioned TBI in subsequent conversations, they would typically explain that their initial answer only included "real injuries."
24. See, for example, <http://www.q13fox.com/news/kcpq-widow-blames-husbands-suicide-on-9th-deployment-20110822,0,2525957.story>.
25. Two suicides in 2008 and 5 suicides in 2009 involved unit or workplace hazing, as did 23 suicide attempts in 2008 and 27 suicide attempts in 2009. Department of Defense, *Department of Defense Suicide Event Report*, Calendar Year 2009 Annual Report (2010): 35, 150.
26. MG Thomas P. Bostick, U.S. Army, Deputy Chief of Staff, G-1; RADM Anthony M. Kurta, U.S. Navy, Director, Military Personnel, Plans and Policy; LtGen Robert E. Milstead Jr., U.S. Marine Corps, Deputy Commandant for Manpower and Reserve Affairs; and Lt Gen Darrell D. Jones, U.S. Air Force, Deputy Chief of Staff for Manpower and Personnel, each affirmed during the House Armed Services Committee hearing "Current Status of Suicide Prevention Programs in the Military," on September 9, 2011, that their service specifically prohibits hazing. The generals and admiral were responding to a question by Congresswoman Judy Chu, whose nephew, LCpl Harry Lew, was a victim of suicide after being hazed by fellow Marines in Afghanistan.
27. The Veteran Health Administration (VHA) is a subordinate organization to the Veterans Administration. The VHA is divided into 23 regions called Veterans

Integrated Service Networks.

28. Department of Veterans Affairs, *Veterans Health Administration Handbook 1160.01* (September 11, 2008).

29. Army personnel numbers are as of July 2011, from communication with Army Medical Command representative (September 29, 2011).

30. Another 14 percent occurred with military-issue weapons. Both statistics from Department of Defense, *Department of Defense Suicide Event Report*, Calendar Year 2010 Annual Report, 15.

31. J. John Mann et al., "Suicide Prevention Strategies: A Systematic Review," *JAMA* 294 (October 2005), 2064-2074; and Tracy Hampton, "Depression Care Effort Brings Dramatic Drop in Large HMO Population's Suicide Rate," *JAMA* 303 (May 2010), 1903-1905.

32. The National Defense Authorization Act for FY 2011, Public Law 111-383, sec. 1062 (January 7, 2011).

33. U.S. Army, *Health Promotion Risk Reduction Suicide Prevention Report* (August 2010), 45. Also, the Army estimates that 30,401 soldiers would test positive for a medical review officer-reviewable drug, with 3,925 representing illicit use. *Ibid.*, 44.

34. *Ibid.*, 45.

35. *Ibid.*, 43.

36. 2004 data, as reported by Substance Abuse and Mental Health Services Administration, *The OAS Report: Suicidal Thoughts, Suicide Attempts, Major Depressive Episode & Substance Use among Adults* 34 (2006), 5, <http://www.oas.samhsa.gov/2k6/suicide/suicide.pdf>, as of September 9, 2011.

37. Substance Abuse and Mental Health Services Administration, *The OAS Report: Suicidal Thoughts, Suicide Attempts, Major Depressive Episode & Substance Use among Adults*, 6.

38. Substance Abuse and Mental Health Services Administration, *The OAS Report: Suicidal*

Thoughts, Suicide Attempts, Major Depressive Episode & Substance Use among Adults, 6.

39. Peter W. Chiarelli, Vice Chief of Staff, U.S. Army, letter to Joseph T. Rannazzisi, Deputy Assistant Administrator, Drug Enforcement Administration, Office of Diversion Control (January 26, 2011).

40. For example, a doctor can notify a unit that an individual is taking a prescription that precludes the use of heavy machinery, but cannot tell the chain of command that the prescription is treating depression.

41. Gregg Zoroya, "Army Suicide Prevention Efforts Raising Privacy Concerns," *USATODAY.com* (March 31, 2011).

42. Zoroya, "Army Suicide Prevention Efforts Raising Privacy Concerns."

43. U.S. Army, *Health Promotion Risk Reduction Suicide Prevention Report*, 46.

44. Mann et al., "Suicide Prevention Strategies: A Systematic Review."

45. Alexandra Fleischmann et al., "Effectiveness of Brief Intervention and Contact for Suicide Attempters: A Randomized Controlled Trial in Five Countries," *Bulletin of the World Health Organization* 86 no. 9 (September 2008), 703-709.

46. See, for example, Mark Brunswick, "Anti-Suicide Program for Military Runs Low: Shortfall Comes as Minnesota Guard Fights High Suicide Rates," *Star Tribune*, October 2, 2011.

47. Department of Veterans Affairs, *Fact Sheet: VHA Suicide Prevention Program, Facts About Veteran Suicide*.

48. The states are Alaska, Colorado, Georgia, Kentucky, Maryland, Massachusetts, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Virginia and Wisconsin.

49. Even if all states indicate veteran status, suicides will still be underreported because of the vulnerability of civilian death data to the social stigma of suicide.

50. The CDC is subordinate to the HHS.

About the Center for a New American Security



The Center for a New American Security (CNAS) develops strong, pragmatic and principled national security and defense policies that promote and protect American interests and values. Building on the deep expertise and broad experience of its staff and advisors, CNAS engages policymakers, experts and the public with innovative fact-based research, ideas and analysis to shape and elevate the national security debate. As an independent and nonpartisan research institution, CNAS leads efforts to help inform and prepare the national security leaders of today and tomorrow.

CNAS is located in Washington, and was established in February 2007 by Co-founders Kurt Campbell and Michèle Flournoy. CNAS is a 501(c)3 tax-exempt nonprofit organization. Its research is nonpartisan; CNAS does not take specific policy positions. The views expressed in this report are those of the authors and do not represent the official policy or position of the Department of Defense or the U.S. government.

© 2011 Center for a New American Security.
All rights reserved.

Center for a New American Security
1301 Pennsylvania Avenue, NW
Suite 403
Washington, DC 20004

TEL 202.457.9400
FAX 202.457.9401
EMAIL info@cnas.org
www.cnas.org

Press Contacts
Shannon O'Reilly
Director of External Relations
soreilly@cnas.org
202.457.9408

Sara Conneighton
External Relations Associate
sconneighton@cnas.org
202.457.9429

Cover image: (ISTOCK)