The Army's Unceasing Enemy: Suicide

As the rate of suicides in the U.S. military continues to rise, presently exceeding those lives lost to combat, it is important to recognize that the Army, and its Medical Command championed numerous programs to assist Soldiers and their Families.

The Soldier

The Army G-1's response to the increase in suicide and stress on the force has included:

Improved Health Promotion

- Partnering with the National Institute of Mental Health to conduct the largest behavioral health study of risk and resilience factors among Service members.
- Increased screening efforts to improve the diagnosis and treatment of Soldiers through Pre- and Post-Deployment Health Assessments. (Soldiers receive up to five screenings for a potential behavioral health (BH) condition: prior to deployment to theater, within 30 days before returning to garrison, upon redeployment from theater, and again within 180 days of returning to garrison. Additionally each Soldier gets an annual screening.)
- Increased access to and availability of behavioral health care, decentralized behavioral health treatment down to brigade level.
- Implemented Pain Management Campaign; decreased potential adverse effects from drug interaction for Soldiers taking four or more medications.
- Implemented in-theater mild Traumatic Brain Injury (mTBI) screening.
- Initiated the development of a comprehensive Stigma Reduction Campaign Plan to address and reduce stigma relative to help-seeking behaviors for invisible wounds. The campaign will promote seeking help as a sign of strength; address the institutional elements that may create barriers to help-seeking behaviors; promote leadership involvement, education and awareness; and evaluate the outcomes of stigma related surveys to measure effectiveness. The Army is continuing efforts to synchronize with DoD and VA to identify gaps and leverage resources.

Decreased Risky Behavior

- Implemented command notification for Soldiers involved in law-enforcement incidents to secure the safety of the Soldier and mitigate the potential for high-risk behavior.
- Launched "**myPRIME,"** which is a confidential online alcohol and substance abuse risk, self-assessment tool with targeted educational modules.
- Revised policy limiting controlled substance prescriptions to six months from date of issuance.
- Implemented expanded military drug testing of commonly abused prescription drugs; beginning with hydrocodone and hydromorphone.

- Released Army Directive 2012-07 (Administrative Processing for Separation of Soldiers for Alcohol or Other Drug Abuse); expanded the period for Chapter 9 Administrative Separations and clarified separation requirements.

Improved Suicide Prevention efforts

- Completed the 2012 Army wide Suicide Prevention Stand-Down Day on 27 Sep 12. Continuing focus on Phase II activities to obtain feedback on best practices / outcomes of Phase I and assessment of the Soldier Leader Risk Assessment Tool that was administered to Soldiers.

- Launched aggressive training campaign to expand Ask, Care, Escort (ACE) – Suicide Intervention (SI) training to supplement Applied Suicide Intervention Skills Training (ASIST); currently trained over 2400 ACE-SI trainers since Aug 2011.

- Deployed an electronic App (eGuide) version of the Suicide Awareness Guide for Leaders. This e-guide is FREE and supports the suicide prevention Ask, Care, Escort (ACE) module and provides leaders with the knowledge and skills necessary to recognize suicidal risk factors, warning signs, and how to utilize the basic intervention techniques.

- Launched the Deployment Health Assessment Program website to facilitate greater access to resources and information.

- Released new Shoulder to Shoulder Suicide Prevention training video.

- Collaborated with the Military Crisis Line (VA) to develop the Army Campaign theme and promote the use of the free/confidential service (1-800-273-8255, press ‘1’ for veterans).

- Ensured Soldiers subject to investigative or legal actions are monitored for indicators of high-risk behavior or self-harm; Provost Marshal General has directed warm handoff between CID and units for Service Members under investigation.

- Conducted five HQDA-led Specialized Suicide Augmentation Response Team/Staff Assistance Team (SSART/SAT) visits since its inception in 2010.

- Collaborated with the National Suicide Prevention Lifeline/Veterans Crisis Line to develop the Army Campaign theme and promote the use of the free confidential service, (1-800-273-TALK [8255], Press ‘1’). This is the priority helpline highlighted by the Army (expanded access to Soldiers deployed in Afghanistan and Iraq).

- Updated the Comprehensive Soldier Fitness (CSF) program to include Army Civilians and Family members (CSF2) to strengthen resilience within the force

Army Medical Command is supporting the Army G-1 with specific behavioral health programs

- The Army increased the number of Behavioral Health services from 991,655 in FY07 to 1,961,850 in FY12, a 97.8% increase.

- In 2007 the Army was recording less than 4,000 Behavioral Health encounters per day. By 2011 that had climbed to slightly above 7,500 encounters per day, and during the last year the Army has increased slightly above 7,700 encounters per day.

Army Medical Command is restructuring its outpatient system of BH care into the Embedded BH model of care.

- In 2012, the Army began to implement Embedded Behavioral Health (EBH) Teams, an evidence- based behavioral health delivery model, in support of every operational Army unit. The EBH Teams provide multidisciplinary community level behavioral health care to Soldiers in close proximity to their unit area and in close coordination with unit leaders. Utilization of this model has shown statistically significant reductions in 1) acute inpatient psychiatric admissions 2) high risk behaviors and 3) Soldiers in combat units with serious BH conditions.

- EBH moves BH personnel out of large hospitals, forms them into teams, and places them in smaller clinics much closer to where Soldiers live and work in each installation. This model creates working relationships between BH providers and unit leaders to better understand the specific challenges that Soldiers face and tailor clinical services to serve them.

Army Medical Command is placing BH providers into primary care clinics across the force (BH into PCMH).

- Through the Patient Centered Medical Home initiative, the Army will place approximately 160 BH providers into clinics alongside primary care providers. This ready access to BH services will further reduce stigma and improve access to care.

The Army has begun to implement a new and powerful Information Technology (IT) system to better identify and track Soldiers with key suicide risk factors.

- The Behavioral Health Data Portal has been implemented in over 30 treatment facilities and will empower clinicians to better assess and monitor Soldiers with BH conditions that may contribute to suicide.

The Family

Child and Family Behavioral Health Information

The Behavioral Health Service Line Integration Office identified the need to establish a comprehensive, streamlined, integrated behavioral health care model, emphasizing prevention, early intervention, assessment and improved access to BH care for Army Children and Families.

The Child, Adolescent and Family Behavioral Health Office (CAF-BHO) was established and tasked in 2010 to address the behavioral health needs of Army Children and Families. Two major programs have been designed by CAF-BHO and are currently under development with proliferation priority to the 10 major deployment platforms and other identified installations. The pace of proliferation of these family member BH programs is subject to availability of funds

Child and Family Assistance Centers (CAFACs) and School Behavioral Health (SBH) Programs have been designed to implement best practices in the delivery of evidence-based care with several lines of effort to reduce barriers to care and to mitigate BH stigma. CAFACs and SBH programs provide a full spectrum of BH services to enhance mental performance and encourage resilience in Army Families and Children. Improved access to quality BH care through a coordinated and integrated effort of BH providers who understand military culture, embedding BH providers where Families and Children live, supporting cultural change in BH education, and awareness and positive attitudes towards “help seeking behaviors” serve as the foundation of the CAFAC and SBH programs. CAFAC and SBH services are aligned with the ARFORGEN and Family Composite Life Cycle and support the core concept of the “Military Family as the deployable unit”.

Child and Family Assistance Centers

CAFACs are more than just “traditional BH clinics” and have been designed using Public Health Model principles. CAFACs are operational at Joint Base Lewis-McChord (JBLM), Schofield Barracks, and Forts Bliss, Carson and Wainwright. CAFACs are in initial stages of development at Forts Bragg, Campbell, Drum, Hood and Polk. Forts Riley and Stewart are projected (minimum of 10 major deployment installations) in the future as funding becomes available. A core element in all CAFAC Program is the establishment of a Process Action Team (PAT) designed to integrate and coordinate military and civilian agencies supporting Army Families. The PAT promotes the joining efforts in caring for physical, psychological, spiritual needs of Army Families supporting improved Family relationships and quality of life.

School Behavioral Health Programs

Army school behavioral health programs are more than BH clinics in schools and parallel embedded BH programs provided for Soldiers utilizing Public Health model principles and best practice BH care standards.

School BH Programs are functioning at Bavaria, JBLM, Landstuhl, and Schofield (thru TAMC), and Forts Campbell, Carson, Meade and Bliss. Forts Bragg, Drum, Hood, Riley and Stewart are projected. An Off-Post School Pilot Program is being conducted at Tripler (goal of a minimum of 10 major deployment installations).

Traditional Child and Family Direct BH Care Services by Military Providers

Army installations continue to provide, as staffing permits, traditional Child and Family BH direct care clinical services. Multiple barriers continue to exist in providing timely, convenient, and appropriate BH care for Children and Families. Many current child-trained BH providers are unable to dedicate their practice to children's therapy due to occupying administrative positions and performing prioritized Soldier BH care. Comprehensive BH clinical services for children and adolescents are not readily available or integrated throughout the Army.

NETWORK BH Direct Care

Direct BH care continues to be provided through the TRICARE purchased care network to Army Children and Families. Access varies across catchment areas/regions and wait times can exceed 3 months at some locations. Long distance travel to see a qualified BH provider may also be a factor. Arguably some Families may choose to receive BH care via the TRICARE network, due to convenience, stigma or other reason; but, many prefer that their BH care needs are met by BH providers at Army installations who understand the unique needs and culture of the Military. At present about two-thirds of BH care is being delivered in the TRICARE purchased care network.

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Army G-1's Suicide Prevention Program information is here:
http://www.armyG-1.army.mil/hr/suicide/default.asp

OTSG/Army Medicine's list of support programs is available at:
http://www.behavioralhealth.army.mil/sprevention/index.html

A recent Washington Post interview with an OTSG/AMEDD subject matter expert is here:

"Army Works to Prevent Suicide" http://www.washingtonpost.com/video/thefold/army-works-to-prevent-suicide/2013/01/09/7ab54012-5a30-11e2-9fa9-5fbdc9530eb9_video.html

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