

# “Preventing Veteran Suicides in Florida”

## **FLORIDA SUICIDE PREVENTION SYMPOSIUM**

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# WHO ARE VETERANS?

- Age: Span the adult life cycle
- Cultures: Reflective of U.S. society
- SES: All strata
- Education: GED to post-doctoral
- Duty status: Active duty and Reserve (deployed and non-deployed), retired
- Military identity: Highly variable

# WHAT CHARACTERIZES THE VETERAN EXPERIENCE?

- Training to kill and to stay alive: Moral contradictions, balancing, decisions
- Mundane daily events
- Dramatic, traumatic events
- Challenge to be “normal” (family, friends, community)
- Pressures to conform to unit rules and military culture

# WHAT CHARACTERIZES THE VETERAN EXPERIENCE?

- Exclusive community: Reluctance to discuss problems outside of military unit
- Coping through stoicism: Minimization, denial of stress response
- Stigma against mental illness as weakness
- “External locus of control”

# WHAT CAN CONTRIBUTE TO VETERAN SUICIDE RISKS?

- Biological predisposition: Mood, anxiety, cognition, personality
- Life experiences: Prior to and resulting from military service
- Coping/adaptive skills: “Fight or flight”
- Social environment: Levels of support
- Access to suicide means: Legal/illegal substances, firearms

# WHAT IS THE PREVALENCE OF VETERAN SUICIDE?

- Unclear national veteran suicide rate: CDC National Violent Death Reporting System
- U.S. Army: 9.8/100,000 (2002), 17.5 (2006), 18.1 (2007), >19.5 (2008 to date)
- USMC: Second leading cause of mortality
- Completed suicides: 95% male; 63% firearm cause; majority are White, younger enlisted, have coexisting SAMH problems
- Non-fatal attempts: 27% female, 60% overdose, 55% coexisting SAMH problems
- Florida National Guard: One suicide since 2003

# HOW DOES THE MILITARY PREVENT SUICIDE RISKS?

- Acknowledgement: Modifying the culture of “toughness”
- Screening: Initial; prescribed periodic
- Education: Risk recognition, referral protocols, resiliency training
- Professional presence in operational units: “OSCAR” (Operational Stress Control and Readiness)
- Early intervention: “Buddy system,” combat stress first aid, after-action debriefs, rest and return rotations, personal stressor supports (e.g. financial, family health)
- Acute, sub-acute and long term interventions: “Proximity, immediacy, and expectancy”

# HOW DOES THE MILITARY PREVENT SUICIDE RISKS?

- Intensive treatment focus with return to duty priority: Attention to sleep restitution, nutrition-hydration, resiliency training reinforcement
- Management of chronic illness and disability: TDRL (individual service) and PDRL (Veterans Administration)
- Long-term monitoring: Formal and informal screening, referral protocols, treatment resources (e.g. Military OneSource), treatment procedures (CBT, medication, resiliency group therapy)
- Florida National Guard: Buddy system, 3/6 month post-deployment assessment, prompt referrals to VA when positive risk screening occurs

# HOW CAN CIVILIAN COMMUNITIES PREVENT VETERAN SUICIDE RISKS?

- History-taking: Need to routinely screen for military service, stressors, treatments
- Communications: Targeted messages
- Treatment resources: Direct care and local referral resources (emphasis on peer-led supports); attention to treatment access
- Coordination of available services (VA, social services, community SAMH, private health services) – e.g. Miami VAMC TACTICS program

# HOW CAN CIVILIAN COMMUNITIES PREVENT VETERAN SUICIDE RISKS?

- Research: Federal and private foundation grants – e.g. NIMH \$300 million for TBI-PTSD research (Waco VAMC mobile MRI)
- Volunteerism: (1) National Council for Community Behavioral Healthcare “Veterans on the Road Home” ([www.TheNationalCouncil.org](http://www.TheNationalCouncil.org)); Strategic Outreach to Families of All Reservists ([www.sofarusa.org](http://www.sofarusa.org), 617-266-2611)

- **Questions**
- **Personal observations and recommendations**
- **Discussion**