

Calendar

may

May 25: First Annual Symposium on Crisis Intervention, Baltimore, MD. Justin Stapleton at jstapleton@santegroup.org or www.thesantegroup.org.

May 25: Bipolar Affective Puerperal Psychosis: NIMH Mood & Anxiety Disorders Program Distinguished Lecture Series, Bethesda, MD; sponsored by NIH. For more information, contact Holly Giesen: (301) 435-8982 or by email: giesenh@intra.nimh.nih.gov.

May 27-28: Suicide & Youth: Protecting Our Greatest Asset! Winnipeg, Manitoba. Mood Disorders Association of Manitoba at (204) 786-0987 or SPEAK at (204) 831-3610.

May 27-29: Mental Health Europe 2004 Conference, "Education for Change", Nova Gorica, Slovenia. International conference on education and prevention in the field of mental health. +386 1 23 078 32, mateja.trpin@sent-si.org or <http://www.wfmh.org/world/europe/mheconf.html>.

May 27-30: 16th Annual American Psychological Society Convention, Chicago, IL. (202) 783-2077 or www.psychologicalscience.org.

june

Jun 2-4: 13th Intl. Conference on Safe Communities, Prague, Czech Republic. www.safecommunities.ca/events.htm, +420-224-942-575 or safe@cbtravel.cz.

Jun 6-9: World Health Organization 7th Conference on Injury Prevention and Safety Promotion, Vienna, Austria. www.safety2004.info.

Jun 9-11: Cultural Diversity in Crisis Work: Opportunities and Challenges. Mississauga, Ontario, Canada. www.saintelizabeth.com/documents/CWSBBrochure2004final_001.pdf

Jun 9-12: National Mental Health Association Annual Meeting, "Justice for All - Fighting for America's Mental Health," Washington, DC. (703) 684-7722 or www.nmha.org.

Jun 24: Maine Youth Suicide Prevention Program Steering Committee Meeting, Augusta, ME. Contact Cheryl.M.DiCara@state.me.us.

Jun 24-27: National Association for Rural Mental Health 2004 Annual Conference, "The Changing Faces of Rural Mental Health," Boulder, CO. www.narmh.org, narmh@facts.ksu.edu or (320) 202-1820.

july

Jul 12-13: SAMHSA training event, "Women Across the Life Span: A National Conference on Women, Addiction and Recovery," Baltimore, MD. www.ncsacw.samhsa.gov.

Jul 14-15: SAMHSA training event, "Putting the Pieces Together: 1st National Conference on Substance Abuse, Child Welfare and the Dependency Court," Washington, DC. www.ncsacw.samhsa.gov.

Jul 28-Aug 1: American Psychological Association 112th Annual Meeting, Honolulu, HI. (800) 374-2721 or www.apa.org.

august

Aug 8-13: XXVIII International Congress of Psychology, Beijing, China. www.icp2004.psych.ac.cn or XianoLan FU with Chinese Psychological Society at +86-10-6202-2071.

Aug 15-17: Third Global Conference on the Promotion of Mental Health and Prevention of Mental and Behavioral Disorders, Auckland, New Zealand. www.mentalhealth.org.nz.

Aug 25-28: 10th European Symposium on Suicide and Suicidal Behavior; "Research, Prevention, Treatment and Hope," Copenhagen. www.suicideprevention.dk or suicide_prevention@ics.dk.

Aug 26: Maine Youth Suicide Prevention Program Steering Committee Meeting, Augusta, ME. Cheryl.M.DiCara@state.me.us.

september

Sep 8-12: NAMI (National Alliance for the Mentally Ill) 2004 Annual Convention, Washington, DC. www.nami.org/template.cfm?section=convention.

Sep 9: Maine Youth Suicide Prevention Program Action Committee Meeting, Augusta, ME. Cheryl.M.DiCara@state.me.us.

Sep 10: 2nd Annual World Suicide Prevention Day. Sponsored by the International Association of Suicide Prevention and the World Health Organization. Details to follow.

Sep 12-16: "Scaling the Summit: Suicidal Behavior in Diverse Cultures," Durban, South Africa. www.med.uio.no/iasp.

Sep 14-18: American Sociological Association Annual Meeting, San Francisco, CA. (202) 833-3410, ext. 305 or www.asanet.org.

Sep 17-18: Survivor Support Group Facilitator Training, Santa Fe, NM. Sponsored by AFSP. (888) 333-AFSP or www.afsp.org.

Sep 21: National Advisory Mental Health Council (NAMHC), NIH, Bethesda, MD. Dr. Jane Steinbert at (301) 443-5047 or jsteinbe@nih.gov.

Sep 22-24: "Suicide Prevention in the New Millennium: Advancing the Illinois Strategic Suicide Prevention Plan," Springfield. Sherry Bryant at sher44@msn.com or www.ilsp.net.

october

Oct 19-24: 51st Annual Meeting of the American Academy of Child and Adolescent Psychiatry; Washington, DC. (202) 966-7300 or www.aacap.org.

Oct 20-23: Canadian Association for Suicide Prevention Conference, Edmonton, Alberta. Sean Jones at (780) 436-0983 ext. 229 or casp@buksa.com or www.buksa.com/casp.

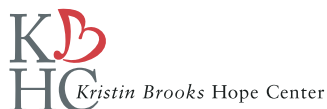
Oct 28: Maine Youth Suicide Prevention Program Steering Committee Meeting, Augusta, ME. Cheryl.M.DiCara@state.me.us.

november

Nov 6-10: American Public Health Association 132nd Annual Meeting, Washington, DC. 202-777-2479.

Nov 10-13: World Psychiatric Association International Congress: Treatments in Psychiatry-An Update, Florence, Italy. www.wpa2004florence.org.

Nov 11: Maine Youth Suicide Prevention Program Action Committee Meeting, Augusta, ME. Cheryl.M.DiCara@state.me.us.



2001 N. Beauregard St., 12th Floor
Alexandria, VA 22311

Non-Profit Organization

Coming Next
Month:

Youth, incarceration
and suicide

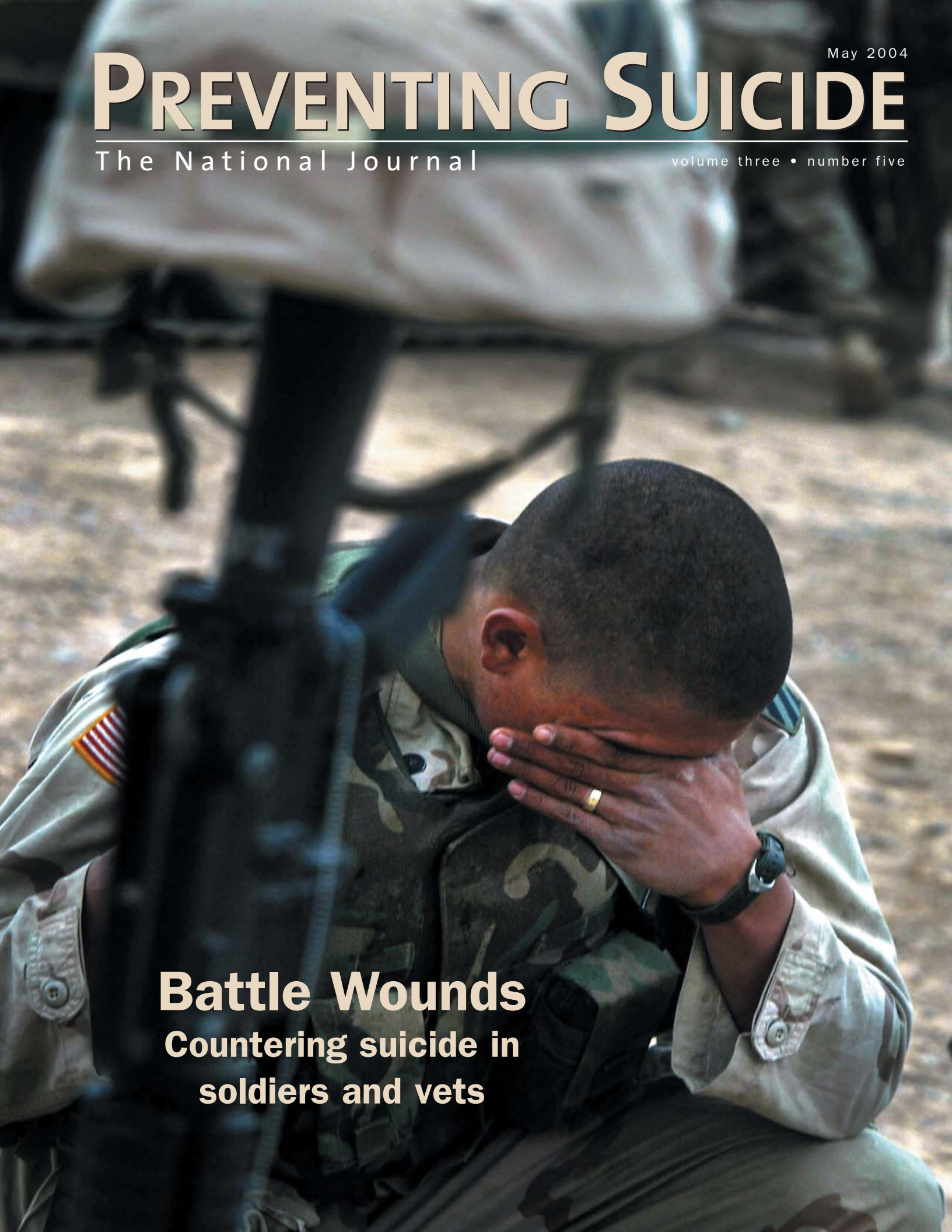
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May 2004

PREVENTING SUICIDE

The National Journal

volume three • number five



Battle Wounds
Countering suicide in
soldiers and vets



H. Reese Butler II, *Publisher*, with devoted companion Budweiser Rio.

Let us show our future soldiers how well they will be treated by the way we minister to our current troops and veterans.

From the Desk of the Publisher

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.

- George Washington

May is Mental Health Month, sponsored by the National Mental Health Association. Memorial Day also occurs in May – a time to honor those who gave their lives to protect freedoms we enjoy.

It can be difficult to gaze into the eyes of veterans when considering what they might have suffered during the trauma of war. What comes to mind is the image of Gen. Patton slapping the shell-shocked soldier. It reminds me how far we have yet to go to change perception of mental illness – and thereby reduce suicides in the military. Some who served in combat lost much of themselves even though they didn't lose their lives. They have returned home deadened and numbed to emotion, wracked with survivor guilt and horrific images of what they witnessed.

Today there are 26 million living veterans of U.S. military service. So given a 10.7 per 100,000 current rate for suicide among the U.S. population-at-large, there could be nearly 3,000 veteran suicides this year alone. Considering age, sex and other factors that can predispose veterans to self-harm, there may be many more.

On Memorial Day, let's not just parade down Main Street, U.S.A., for our military men and women. Let's honor them in a greater sense with willingness to help living veterans conquer challenges they face. This includes guaranteeing that all receive proper mental health care, screening and treatment. It also includes ensuring that mental health professionals are trained and sensitized to unique issues that affect veterans and can predispose some of them to suicidal ideation and acts. Let us show our future soldiers how well they will be treated by the way we minister to our current troops and veterans.

Also this month is a review of "A Secret Best Not Kept," a documentary by Dara Berger. Her film was screened during the New York International Independent Film and Video Festival on April 27, as well as at the AAS conference in Miami, and at the 2nd Annual Collaborative Crisis Centers Conference in Chicago last month. This landmark documentary chronicles the survivor movement and gives what I feel is one of the best overviews of the journey of suicide survivors and attempters ever put on film.

Finally we are pleased to announce that KBHC has contracted with the National Mental Health Association (NMHA) to administer the National Hopeline Network. This move will help streamline one of the most visible programs in suicide prevention with the country's largest mental health advocacy organization, with more than 350 affiliates and 300,000 plus members. NMHA has embraced suicide prevention as a key goal to which it has pledged significant resources.

While we regret the loss of our staff in this process, we know that the future of the Hopeline Network is in good hands – and the chance of 1-800-SUICIDE going silent is reduced. We hope you will join us in thanking former KBHC staff for efforts they put forth in the battle against suicide. We wish them well in the future and hope the experience with KBHC has prepared them to fight even tougher battles.

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Supporting Our Troops in Word and Deed

Paul Quinnett, Ph.D.

It has been said that the measure of a civilization can be taken in how well or poorly it treats those at the sunrise of life and those at the sunset of life. Another measure of national integrity is how well or poorly that society treats its warriors during and after the battle.

As a nation we are good at supporting the troops when the shooting begins. We rally around them. We let them know we appreciate them and respect them for their valor. We thank them for their sacrifices, and we honor those who die.

But when the war ends things change. A soldier is not always a soldier. Once out of uniform, once discharged, a soldier returns to life as a civilian. And, should he or she need mental health services, it is often in the public or private sector where those services will be sought first.

It would be wrong to assume that just because we have a vast Department of Veterans Affairs hospital system that a) those services meet the needs of all veterans, or that b) those services are “accessible and acceptable” to all veterans. For reasons they can best explain, many veterans do not seek out mental health services through VA outpatient or inpatient services.

Thus, if we are to adequately address the needs of our returning civilian-soldiers we must acknowledge the vast wreckage of the current mental health system (if it can be called a system), and work quickly and aggressively, and with the same measure of commitment to task we so admire in our military personnel, to recover and rebuild this vital health care delivery system.

The time is now, the bill is the Sen. Paul Wellstone Mental Health Equitable Treatment Act of 2003 and your action to support this bill supports the troops.

Paul Quinnett (U.S. Army, 1960-1963) comes from a long line of non-career military civilian-soldiers: great grandfather (Civil War), father and three uncles (WWII), older brother (U.S. Army, Cold War), and younger brother (U.S. Army, Vietnam). Except for the combat death of one uncle, no member of this extended family ever experienced a service-connected injury or disability, and none has ever sought or received medical services from the Department of Veterans Affairs.

Thomas E. Ellis, Psy.D., A.B.P.P.

On Cuts in Funding for Mental Health Services

“It’s important to take any opportunity to get across the message that people are not getting access to adequate mental health care: Funding has dropped off. There’s an outrageous gap in our society between medical and mental health services; it’s not being addressed for the most part, although the President’s New Freedom Commission report is an important step.

There used to be a mental health center in every three or four counties nationwide. A couple of years ago the biggest one in our state (West Virginia) declared bankruptcy.

One thing we know regarding suicide prevention is that mental illness can be treated. It’s important to get policy makers and politicians to realize that people are suffering out there – and there’s no outcry.

You can’t really eliminate a public health problem by just treating the casualties. You have to get at the root causes by addressing societal problems, domestic violence, parenting and other issues. The surgeon general’s report on suicide alluded to this. But we just have to keep harping on it.”

Ellis is professor of psychology at Marshall University in Huntington, W.Va.

“Preventing Suicide/The National Journal” devotes space to letters from its readers. Address letters “To the PSNJ Editor” and include a daytime address, phone number and email. Send to letterstotheeditor@hopeline.com or to Kristin Brooks Hope Center, 2001 N. Beauregard St., 12th Floor, Alexandria, VA 22311. The journal reserves the right to edit letters to meet its style and length requirements.

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“Preventing Suicide/The National Journal” (ISSN 1546-7376) is published monthly by the Kristin Brooks Hope Center / National Hopeline Network. Production and subscription costs are covered by a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) through September 2004.

About this cover:

Soldiers at risk – In Baghdad an American soldier fights back tears at a memorial service for a comrade in arms who died in action in April 2003. Just five months out of basic training, the 19-year-old victim was killed when the armored



personnel car he was riding in was hit by a rocket-propelled grenade. The overwhelming emotion soldiers experience in combat can leave physical and mental scars that, when combined with other predisposing factors, may increase risk for suicide.

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SPRC Boosts Support to States



The Prevention Support Team at the Suicide Prevention Resource Center (SPRC) is growing, with Louisa Holmes and Lidia Bernik joining the team in April. One of the core functions of SPRC, Prevention Support involves both responding to requests for assistance and proactively reaching out to support suicide prevention efforts in all 50 states.

Louisa and Lidia stepped into their new roles when Dr. Ramya

Sundararaman was promoted from prevention specialist to prevention support coordinator. Louisa was promoted from within SPRC, and Lidia works in the offices of one of SPRC's partners, SPAN USA. They will cover states and special populations previously assigned to other prevention specialists.

"We increased the team to be more proactive with states, and to develop more resources which will help states, territories, tribes and communities increase their capacity for prevent suicide," says Sundararaman. In addition to more efforts in state outreach, SPRC is working to develop web resources for each state, and producing new prevention support resource materials." ■

Meet the SPRC Prevention Specialists

Ramya Sundararaman, M.D., M.P.H.

Prevention Support Coordinator
Email: rsundararaman@edc.org

Special issues she addresses:

- First responders
- Epidemiology
- Surveillance

Before joining SPRC:

Managed the Suicide Prevention Program for the Massachusetts Department of Public Health. Has presented on a wide array of suicide prevention and epidemiology issues at national and state conferences.



Education:

Received her medical degree from the University of Dar es Salaam in Tanzania. Also holds a master's in public health from the Harvard School of Public Health, and certification in injury prevention from Johns Hopkins School of Public Health.

Other:

Co-chairs the Massachusetts Coalition for Suicide Prevention which developed the Massachusetts Strategic Plan for Suicide Prevention. Originally from India, Sundararaman has lived in the Middle East, Africa and Canada.

Ramya works with:

Arizona • California • Colorado • Delaware • Hawaii • Iowa • Kansas • Maryland • Missouri • Montana • Nebraska • Nevada • North Dakota • Pennsylvania • South Dakota • Utah • Virginia • Washington, D.C. • West Virginia • Wyoming

Ellen Freedman, M.P.H.

Senior Prevention Specialist
Email: efreedman@edc.org

Special issues she addresses:

- Youth suicide including school-based programs
- Social marketing
- Means restriction

Before joining SPRC:

Worked as a public health consultant and compiled the Massachusetts Suicide Prevention Resource Guide for the Massachusetts Department of Public Health, May 2003. Also was director of the Childhood Injury Prevention Program for the Boston Public Health Commission from 1990-1999. Chaired the Greater Boston SAFE KIDS Coalition.



Education:

Received her master's in public health from Boston University with certification in international public health. Bachelor of arts in sociology from Colby College.

Other:

Mother of three children and a certified yoga instructor.

Ellen works with:

Alabama • Connecticut • Florida • Georgia • Kentucky • Maine • Massachusetts • Mississippi • New Hampshire • North Carolina • Rhode Island • South Carolina • Tennessee • Vermont

with Staff Expansions

Christopher Le, M.A.

Prevention Specialist
Email: cle@edc.org

Special issues he addresses:

- Native Americans
- Middle-aged men

Before joining SPRC:

Served in AmeriCorps in Colorado, and has worked in school districts in Houston and New York City.

Previous projects include working with emotional intelligence and immigrant populations, implementing technology into after-school programs, and designing gender and technology classes for Teachers College.



Education:

Received master of arts in instructional design and education from Teachers College, Columbia University in 2002, and B.F.A. in theatre design from the University of Evansville in 1999.

Other:

A first-generation American, emigrating from Vietnam by way of Texas. A sound designer for theatre companies in New York City and Boston, and a burgeoning photographer.

Christopher works with:

Arkansas • Illinois • Indiana • Louisiana • Michigan • Minnesota • New Jersey • New Mexico • New York • Ohio • Oklahoma • Texas • Wisconsin

Louisa Holmes, B.A.

Prevention Specialist
Email: lholmes@edc.org

Special issues she addresses:

- Correctional
- Gay, lesbian, bi-sexual and transgender (GLBT) suicide

Before joining SPRC:

Worked with the startup Experience Music Project in Seattle, recruiting and hiring hundreds of new staff members for new music museum. Worked with San Francisco Unified School District to develop and



implement mentoring programs and career pathways for school students. Also worked at the Castle School in Boston, a residential school for adolescents with emotional and behavioral problems.

Education:

Earned degrees in political science and English from Seattle University.

Other:

Enjoys traveling and listening to music.

Louisa works with:

Alaska • Idaho • Oregon • Washington

Lidia Bernik, M.H.S.

Prevention Specialist

Note that Bernik is based out of SPAN USA headquarters at 1025 Vermont Ave., N.W., Washington, DC 20005, Ph: (202) 449-3600
Fax: (202) 449-3601

Email: lbernik@spanusa.org

Special issues she addresses:

- Survivors
- Elderly populations
- Advocacy
- Prevention support in Spanish



Before joining SPRC:

Program director for SPAN USA. Also completed two internships at the New York Hospital - Cornell Medical Center Westchester Division in a day treatment program for those with severe anxiety disorders or personality disorders.

Education:

Received master of health science in mental health from the Johns Hopkins Bloomberg School of Public Health. Earned bachelor of science in human service studies from Cornell University.

Other:

Enjoys movies, novels, dancing and playing volleyball. A survivor of her older sister's suicide

SPRC staff members above can be reached at:

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Education Development Center, Inc.
55 Chapel St.*

Newton, MA 02458-1060

Phone: 877-GET-SPRC (438-7772)

Fax: 617-969-9186

Web: www.sprc.org

A Secret Best Not Kept

A film review by H. Reese Butler II

A Secret Best Not Kept, feature-length documentary film by Dara Berger, producer and director. (Say It Out Loud Productions, Inc., New York, N.Y. \$29.95 DVD, \$24.95 VHS. www.sayitoutloud.com)

“You need to talk to each other about your loss and pain. ...You will ask, ‘Why?’ a million times, and you need to ask the question.”

- Suicide survivor Iris Bolton, on losing a loved one to suicide

“A Secret Best Not Kept” is the first feature-length documentary film by suicide survivor Dara Berger. The film’s website, www.sayitoutloud.com, offers the following introduction: “A thirteen-year old girl’s life is shattered on a summer day when she comes home to find her mother has committed suicide. Eighteen years later, she embarks on a journey in search of answers. Through in-depth interviews with attempters, survivors, doctors and politicians, she not only finds the truth but something she never expected. The film is the story of her journey through grief and acceptance, and a call to arms for change in public health policy and the way suicide is viewed by everyone.”

There have been many films and documentaries on the subject of suicide and survivors of suicide, but this is the first to chronicle the survivors movement and capture the grassroots movement catapulted by the efforts of survivors Jerry and Elsie Weyrauch (founders of SPAN USA), Iris Bolton (The Link), Al and Mary Kluesner (SAVE), Dale and Dar Emme (Yellow Ribbon Campaign), and so many more. Berger is among the latest to join that movement. Nineteen years after her mother’s suicide, Berger has made this documentary about surviving suicide.

The film is an amazing glimpse into the world of the suicide survivor movement that has led the advocates from Reno, Nev., the site of the first national conference to develop a national strategy for suicide prevention, right through to the sixth annual SPAN USA survivors’ day in Washington, D.C. (the first time it was held at the Lincoln Memorial).

Most people have no idea about the process to develop the political will to make policy changes in our federal government. This film shows the small incremental steps that have been taken on behalf of suicide prevention and the results they have achieved. With many players in the effort to pass a bill on mental health parity – such as the late Sen. Paul Wellstone, Sens. Pete Dominici, Harry Reid, and Ted Kennedy – it is amazing that no one has captured this process before Berger. Thank goodness she has, so the results will be forever remembered – by a broad spectrum

of people, not just those who fought in the trenches and slogged up and down the corridors of Capitol Hill.

In addition to covering the movement and the advocates who led that movement, Dara takes the bold step of interviewing survivors of suicide attempts. While a stigma is attached to people who die by suicide and those who survive them, the attempters are in a class by themselves. These are brave souls who stand up and risk all to teach others that they do not need to attempt nor die by suicide. There is help; they got it; they survived and are glad they did. Susan Rose Blauner, one of these people, gave a chilling account of her ordeal and a great guide to finding

a way out of the abyss in a landmark book (reviewed in PSNJ in January/February 2003) titled, “How I Survived While My Brain Was Trying to Kill Me.”

The viewer of Berger’s film will learn about a movement that is shaping the future of mental health care in America. This documentary is inspirational and revealing in so many ways. You can learn how to effect political change, how to accept

the most horrific of all deaths, how to live in the moment and know that the person sitting next to you on a bus may be in quiet desperation wanting to die – and how you can help make a difference. ■



Film maker Dara Berger is a New York City-based producer and director, and founder of Say It Out Loud Productions, Inc. Her company specializes in documentary films and shorter form video projects with an emphasis on ventures that educate or stimulate dialogue on meaningful issues.

Film reviewer H. Reese Butler II is the publisher of “Preventing Suicide/The National Journal.”

Battle Wounds

- ◆ *Sleeping with a loaded weapon.*
- ◆ *Being surrounded by unpredictable rocket, mortar and sniper attacks.*
- ◆ *Not knowing who the enemy is.*
- ◆ *Gathering body parts after a fellow soldier steps on a land mine.*

These are among the horrific experiences of war, of day-to-day life in a combat zone. They can leave their mark on soldiers, not only in physical but also mental scars that may last a lifetime. Those scars combined with other factors can create a potential for suicide.

Recent news reports about the rising incidence of suicide in the U.S. military – among both active-duty enlisted and reservists as well as recently discharged personnel – highlight the precarious mental condition of some soldiers returning from battle.

More than 130,000 U.S. troops began coming home from Iraq and Afghanistan in January 2004. Nearly that many more will rotate into those countries to replace departing troops in what has become the largest mobilization of American military personnel in more than a decade.

Not since Vietnam has exposure to combat violence been as great for U.S. troops as what they may be encountering in Iraq and Afghanistan. Returning troops bring with them both physical and emotional battle wounds.

So chances are good that crisis interventionists along with civilian psychologists, social workers, physicians, law enforcement, clergy and others will begin to encounter returning soldiers and newly “minted” veterans in coming months.

Some of them may be suicidal, like Lt. Brandon Ratliff, a six-times decorated Army reservist. He took his life in March after unsuccessfully fighting Columbus city officials for an expected promotion when he returned from service in Afghanistan. Ratliff was executive officer of a reserve surgical team on the front lines; his duties included retrieving wounded soldiers from the battlefield. “I didn’t think that I’d have to fight over there and come back and fight these guys,” Ratliff is quoted as saying in a March 19 story by the Associated Press. A coworker and friend attributes Ratliff’s anger about his work to depression he suffered after his return. “He had seen children die,” she said as reported by AP.

Suicidal veterans could also include those like Green Beret William Howell, who shot himself March 14 outside his home in Monument, Colo., after city police officers ordered him to drop his weapon. Howell, 36, had been following his wife around the front yard with a handgun. He left three children.

Or like Jeremy Shannon Seely, who survived three years in the Army – including one year in Iraq – but lived just days after returning home. Seely was found dead Jan. 17 of an apparent suicide at a motel in Clarksville, Tenn., near the 101st Airborne Division’s base at Fort Campbell, Ky. By his bed were jugs of soda pop, antifreeze and drain cleaner.

Stressors can overwhelm

After the terrorist events of Sept. 11, 2001, Americans can perhaps better grasp the lingering mental effects of feeling under siege, of having personal safety threatened by fear-provoking terrorism.

Continued on page 6, Battle Wounds ▶

24

Soldiers who killed themselves in Iraq since the beginning of Operation Iraqi Freedom (as of 3/26/2004). Additional cases that appear to be suicide are under investigation.

7

Soldiers who killed themselves after returning home from Iraq (as of 3/26/2004). This number may be higher because additional deaths are under investigation.

40%

Patients at Walter Reed Army Medical Center who have post-traumatic stress disorder in addition to physical injuries.

17.3

Rate of suicide per 100,000 for the Army. This is higher than the Army’s overall rate of 11.9 from 1995 to 2002. Assuming this 17.3 rate is lower than the rate for civilians (see below) can be misleading because military admission protocol should screen out many people with underlying psychiatric problems that can contribute to suicide.

21 per 100,000

The rate of suicide among civilians age 18 to 34 (the age range of many soldiers).

26 million

Living veterans of U.S. military service. Only 7.2 million of these – or just over one quarter – are enrolled for treatment through the Department of Veterans Affairs medical system.

130,000

U.S. troops returning from Iraq and Afghanistan starting in January 2004. Nearly that many more will rotate into those countries to replace departing troops. This is the largest mobilization of American military personnel in more than a decade.

2,988

U.S. soldiers in Iraq who have been wounded in action (as of 4/2/2004). About two thirds of these sustained injuries serious enough so as not to be returned to duty within 72 hours.

634

U.S. soldiers who have been killed in Iraq (as of 4/7/2004). About 70 percent of these were killed in action; the remaining are classified as non-hostile casualties by the Department of Defense.

About the author of this series: Denise M. Pazur is an award-winning communications practitioner and contributor to this publication.

Continued from page 5, *Battle Wounds*

But unless someone has served in a military combat zone, they may not fully appreciate what war can do to the psyche – particularly of those who are already vulnerable because of underlying emotional disorders.

“In some ways, stress is stress – especially for those who have experienced assault, rape, snipings, air accidents,” says Lawrence Lehmann, M.D., chief consultant for mental health with the Department of Veterans Affairs. “But there are frightening and terrible things that happen in war. It’s different in combat. You yourself may actually have to shoot back.”

Lehmann cites a similarity among military combat veterans and those serving on police and fire forces.

“Your buddy is killed or injured even though you’re there to try to help them,” he notes. “Your mandate is to help, to protect and serve people. There’s a commonality.”

At-risk troops can be vulnerable to violent outbursts – including self-directed violence – in the early stages of “reintegration” to home life as a civilian or as an enlisted soldier back in the States.

Reintegration is a time of change, when shifting responsibilities and different stressors can weigh heavy on a soldier’s mind. Sometimes their stress is based in unrealistic expectations for homecoming, according to military reintegration counselors.

Simple pleasures like rest, showers, money, sex, leave, shopping, food and alcohol are baseline expectations of returning troops. Yet some of these may go unfulfilled. The result can be frustration, stress, anxiety and depression.

And while military reintegration training programs are in place for all those those coming home, that training can’t actually solve problems but can only spur personnel to seek appropriate help when problems do arise.

Mental Illness Prevalent Among Veterans

In fiscal year 2001, 21.3 percent of veteran patients received mental health care. Of those who received care, more than 700,000 veterans were treated in specialized mental health programs – four times more than those who required this treatment in fiscal year 1999 to 2000. Both depression and schizophrenia are highly prevalent among veterans, as is PTSD.

Source: Statement of Robert H. Roswell, M.D., Under Secretary for Health, Department of Veterans Affairs in an address on mental health given on July 24, 2002, to the U.S. Senate Committee on Veterans’ Affairs

THE FRIEND Thomas Cook, 35

“I believe he never left Vietnam in his head because he always talked about dreams he kept having about Nam. One day he locked himself in the basement and started drinking. When the police came after being called by his wife, he just stated that he was tired and shot himself in the head.”

Gary Parker on his “very close friend,” an ex-Marine and Vietnam combat veteran who took his life in 1984. Parker and Cook worked together for about two years as police officers for the Department of Defense.

Editor’s Note: These are verbatim excerpts of real stories of veterans who took their lives, as told by family members and friends. Reprinted with permission of www.suicidewall.com

Not all vets tap VA services

Those working in suicide prevention in the civilian sector shouldn’t assume that the mental health needs of soldiers and veterans are being fully met by the Department of Defense or the Department of Veterans Affairs (VA).

While the military and VA have placed renewed emphasis on mental health and suicide prevention in recent years, veterans are free to choose services outside of those provided by VA. Many do.

Additionally, the Department of Veterans Affairs is undergoing a restructuring to realign services through its CARES plan, or Capital Asset Realignment for Enhanced Services. CARES sets forth a vision for the next 20 years to help VA evolve from a hospital-based system to a user-friendly network focusing more on outpatient services and partnerships with the military and private sectors. That evolution brings changes in services to veterans.

Particularly vulnerable to mental health issues may be reservists and those serving in the National Guard – “weekend warriors” as they’ve come to be known. Sending these soldiers back into their families and communities without a support system in place could have distressing effects. In a recent analysis by the Boston Globe, Army reservists serving in Iraq are suffering from significantly more mental breakdowns, illnesses and accidents than enlisted soldiers. About 12 percent of 2,600 nonhostile injuries incurred by reservists in conflict zones were psychiatric in nature, the Globe found. And some mental health issues may not become apparent for months or even years after service.

Women are also vulnerable, as their numbers serving in Iraq and Afghanistan represent the largest pool of women ever to serve simultaneously in a combat zone. While deployed they endured capture by enemy forces such as the highly publicized story of Pvt. Jessica Lynch. Women also are sustaining severe wounds similar to those of their male counterparts, including loss of limbs from suicide bombings and mortar attacks. Stressors unique to their sex can include unplanned pregnancies and sexual trauma resulting from assault.

Also vulnerable to mental health issues are soldiers who return home with physical reminders of war – a prosthetic leg, a wheelchair, a missing hand.

“Of the people at Walter Reed (Army Medical Center), 40 percent of those (physically) injured have PTSD (post-traumatic stress disorder),” says Lehmann. “They may have physical injuries of other kinds, but they also have mental health issues.”

THE BROODER Gladney “Wayne” Carter, 51

“He tried the best he could to forget everything about Vietnam but the reality of it was that he never could. He did the best he could, but had several spells of depression. He got married right after Vietnam and had three children. It was very hard for my father to show emotion – he had been taught to hold it all in.”

Daphne Jones on her father. An Army marksman in Vietnam, Carter, a native of Doyline, La., earned two bronze stars. He died of a gunshot wound to the chest in on New Year’s Day 1999.

Call to action

What can crisis interventionists and other civilians involved in suicide prevention do to better understand and assist veterans and their families?

First, they can ask if military service occurred, and under what circumstances including combat exposure.

Second, they should acquire a better understanding of and appreciation for the soldier's experience.

"And listening to the vet. Listening to what the issues are, the real human issues," Lehman says.

Those human issues may be as commonplace as marital or financial difficulties, child-rearing challenges and loneliness. Or they could be as critical as undiagnosed post-traumatic stress disorder, survivor guilt and flashbacks to the battlefield – complete with overpowering sights, sounds and smells of war. Additionally, the veteran may be numbing mental anguish with alcohol, illegal drugs or misuse of prescribed medications.

"Substance abuse is a universal lubricant for all kinds of bad things," adds Lehmann.

Barring a suicidal crisis, Lehmann suggests civilians working in suicide prevention encourage veterans and their families to tap into VA to obtain mental health services.

VA now has enhanced medical benefits, including offering two years of free health care to military personnel who recently served in a combat zone. In the past, veterans had to prove that a medical problem was connected to their military service.

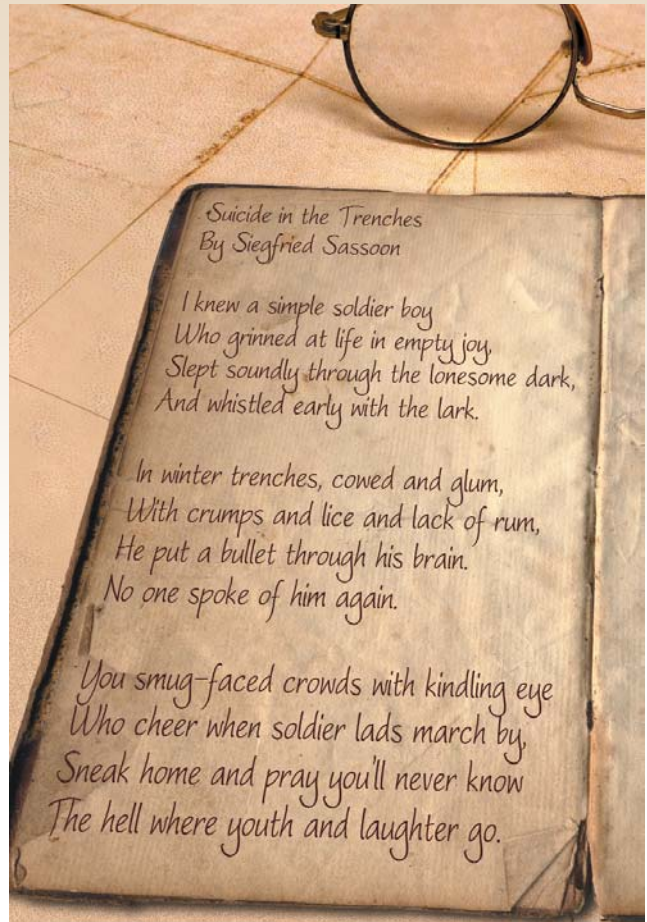
VA physicians and psychologists also have in-depth knowledge of post-traumatic stress disorder and other conditions that can predispose veterans to thoughts of suicide.

"Encourage them to contact mental health services at their local VA medical center – during regular business hours," says Lehmann. "We don't technically have ER, but we have acute triage that's 24/7."

Marty Melstrom, a psychologist with the Carl T. Hayden VA Medical Center in Phoenix, notes that tapping into VA has been recently streamlined for those returning from Iraq.

"Every eligibility department at VA now has an Iraqi Freedom coordinator whose job it is to fast track newly returning veterans into services they want or need," says Melstrom, adding that this is part of mandatory training for VA staff under the VA's "Our Turn to Serve" initiative to help Iraq veterans. "The motto is, treat first and worry about benefits and eligibility second."

Finally, Lehmann encourages crisis interventionists and others to partner with local affiliate offices of the Department of Veterans Affairs to exchange information and support one



English poet and novelist Siegfried Sassoon (1886-1967) was an officer in World War I. He expressed his conviction of the brutality and waste of war in grim and forceful verse, including this poem, first published in 1918 in *Counter-Attack and Other Poems*. New York: E.P. Dutton & Company. Reprinted with permission of Bartleby.com, Inc.

another's services related to suicide prevention. VA has facilities in all 50 states (see Learning More on page 10).

"This is the direction we're heading in – linking up to existing community resources, and doing this as sort of an ongoing public health activity," Lehmann notes. "The question becomes how to best hook up more with community environments – how to get more VA elements into non-VA organizations."

"As for the Guard and Reserves, we're trying to do outreach to them. There are limitations, but if we get ourselves invited, then we'll certainly come." ■

THE FAMILY MAN

John I. Cauthen, 37

"He slept on the floor the first month he was back and didn't talk much... He became uncharacteristically very depressed over his failing marriage ... his older sister and I (also older) were confident he would not take his own life because he said not to worry, he would never do that because he had fine healthy children (son 16, daughter 12). He was normally a very outgoing family- and civic-minded person. He loved his friends and they loved him. He was funny. He loved children. We all miss him terribly."

George M. Cauthen on his brother, who entered the Army at age 19. John Cauthen took his life with a .45 automatic pistol in 1988.

THE MOTHER

Mary Jane (Johnson) Kniatt, 34

"My mother left behind four children 5 to 14. I was 10. My father never said a thing... And I have been able to say the word 'mother' for quite a few years without crying. My father immediately remarried, and being the only girl, my life has been like a war every day to survive."

Kimberly C. (Kniatt) Usher on her mother, who took her life in 1966 by hanging in Bangkok, Thailand. Kniatt was a sergeant in the Air Force.

Scars of Service

- Adjustment difficulties
- Crying, stress, panic, loneliness
- Problem-solving, decision making, memory and cognition problems
- Irritability and anger; expression of terrible anger that may include violent outbursts
- Easy access to or familiarity with guns and other lethal weapons
- Becoming emotionally numb to survive; shutting down; active avoidance of trauma-related thoughts and feelings
- Loss of interest in activities or people; feeling detached or estranged from loved ones; dissipation of some basic human emotions like empathy; building a wall against others with lack of trust
- Marital difficulties; acts of physical and verbal violence toward partner; lack of communication in family, absence of family support
- Frequent nightmares and other sleep disturbances related to war zone traumatic stress
- Child-rearing difficulties
- Employment challenges
- Anxiety and panic disorders
- Post-traumatic stress disorder (PTSD), which is the most prevalent psychiatric disorder arising from combat; flashbacks, or triggers or intrusive thoughts that are unwelcome memories or re-experiencing of past traumatic events
- Fight-or-flight reaction to a life-threatening situation
- Numbing with alcohol or drugs; problem alcohol or drug use to cope with stress reactions
- Criminal activity to support illegal drug use
- Thoughts of suicide or suicide attempts and violent behavior
- Survivor/survival guilt – self-blame, guilt, shame
- Major depression
- Comorbid psychiatric and medical disorders and substance abuse
- Cancers or other medical conditions due to exposure to chemical agents; can include a range of toxic substances such as chemical and biological warfare agents, vaccinations for botulinum toxoid and anthrax, infectious diseases, depleted uranium, oil well fires, pesticides, chemical agent-resistant coatings (CARC) paint and a combination of these exposures
- Homelessness

Partnering to Ease

New Mexico crisis interventionists join with National Guard to prevent suicide

She's an accountant by training, but Tara Barton was scalled on in February to reach someone who was acutely suicidal. The person in crisis was the wife of a member of the New Mexico National Guard on deployment in Iraq.

Barton manages the Guard's FAC or Family Assistance Center in Rio Rancho. She and colleagues provide families throughout the state with help and support many desperately need. The FAC is new, founded in summer 2003 and slated to be open for just the duration of deployment of National Guard members, according to Barton.

"A lot of our families have never dealt with deployment before," says Barton, who assists families with all sorts of needs, from medical to schooling to things as basic as replacing a broken refrigerator – assistance that already stressed families sorely need.

Barton knows this from experience. Her husband is in the National Guard and has been serving in Iraq since February 2003. Meanwhile, she is juggling a job, house and three children, ages 8, 9 and 10. In 14 months her husband has been home for just one two-week period last November. His absence has taken its toll, just as it had for the suicidal wife with whom she spoke.

"She was having a really hard time. She sounded really desperate," recalls Barton. "I talked to her for several hours over a couple of phone calls. Finally, she admitted that she had tried suicide the prior evening."

The wife in crisis lived, but the experience spurred Barton to reach out for assistance to suicide prevention experts in New Mexico.

"I logged on to the suicide prevention website for New Mexico, and it was under construction. But I got the name of Karen Gaylord, and so I called her."

A manager with the New Mexico Department of Public Health, Gaylord and a colleague met with Barton and four other National Guard family program and command central employees to offer a "mini-workshop" on suicide prevention.

Barton applied the knowledge she gained to a March 13 "reunification" workshop for families offered by FAC. She also tapped the services of Molly McCoy Brack, professional director at Agora: UNM Crisis Center in Albuquerque.

"I spoke to them about how to recognize signs for suicide. Families are nervous about that," says McCoy Brack, recalling the anxious mood of audience members when she first entered the meeting room. ▽

THE EDUCATOR

Larry A. Dickerson, 55

"His wife tried to get him some help, but he wouldn't go. She also thought she had removed all the guns from the house. Larry had recently retired from his job as a school principal – that just seemed to make his depression worse because he had more time on his hands to think. I think he felt responsible for every man that died because he gave the orders. He never seemed to accept the fact that he was just doing what he had to do. In 26 years in the military, he was the best 2nd lieutenant I ever worked with."

Charlie Runnels on Dickerson who took his life with a gunshot to the head in 1998. Dickerson had earned a purple heart for his service in the Marine Corps.

THE SON

Paul Egan

"Paul was a good pal and a nice person but sadly the war changed this. Soon after the war he took to drugs and alcoholism, and to fund it, crime... Lonely, with only his aging parents and me to turn to, Paul was headed for disaster... Two weeks later (after his suicide) his father and mother gassed themselves in their car in their garage. With them a note: 'We're joining our son.'"

A friend and neighbor of Egan, a native of Liverpool, New York, who served in the Army and took his life in 1997.

the Pain

"They were very emotional. Some were distraught, others were crying and some had their heads on the table," McCoy Brack says, adding that speakers prior to her arrival had discussed post-traumatic stress disorder and other issues that may have been distressing to those in attendance. "There were women, children, grandparents. Some hadn't seen their loved ones in a year and a half."

When McCoy Brack began her suicide prevention talk, the audience was really engaged.

"They were glued. They asked a lot of questions. One guy in his 60s was in fatigues. He knew suicide was such a problem with Vietnam vets," says McCoy Brack. "They wanted to know how to know if someone is suicidal, how to talk to them, if bringing up suicide will put the idea in their heads."

McCoy Brack addressed all the questions – and encouraged attendees to call her crisis center. She also left literature about suicide prevention. Because all calls to the UNM Crisis Center are confidential, she can't say if Guard families have acted on her advice to phone when they need to.

What does Barton with the National Guard think is the next step for crisis interventionists and other suicide prevention workers in assisting families of troops and returning veterans?

"I learned the warning signs for suicide can be real subtle. We need to get this information out to families." ■

Contact Barton at Tara.Barton@nm.ngb.army.mil

Helping families as important as helping soldiers

How well a family is coping with their loved one's deployment to a combat zone is critical both during and after deployment. It's also vital to a soldier's mental health.

"Psychosocial crises that families may go through (while loved ones are serving in the military) can impair their functioning," says Lawrence Lehmann, M.D., chief consultant for mental health with the Department of Veterans Affairs. "And also when the service member hears about this, it adds to their stress." That can mean overload for soldiers already battling enormous stressors on the battlefield.

And when families are reunited, how well the family functioned in the soldier's absence – did the bills get paid, did the kids do OK in school, were resentments over separation kept to a minimum – will affect how families function post-deployment.

So support to families of active-duty service members is a vital element of delivering community mental health services – so that problems and potential for divorce can be avoided when families are reunited.

Attention state planners

Are Veterans at Your Planning Table?

"It's a moral and ethical imperative to embrace everyone - of all ages, all backgrounds, all races, all motivations. It's a moral imperative to have people at the table so they can speak for themselves."

- Keri Lubell, Ph.D., a CDC behavioral scientist who is studying the state planning process for suicide prevention

When state coalitions gather to devise or implement suicide prevention plans, they may embrace diverse stakeholders from both public and private sectors. Yet veterans organizations may be overlooked.

"As many states are working to expand their suicide prevention programs to address needs across the lifespan,

having diverse groups – including returning veterans – could be valuable to state planners. It is an opportunity for state suicide prevention planners to examine how they might be able to help veterans," says Keri Lubell on engaging veterans groups in state planning for suicide prevention.

Why is it that veterans may be overlooked in the state planning process – or in the overall delivery of services for suicide prevention?

"There's a sense that the military takes care of its own, that they have programs to address suicide prevention among soldiers and vets," says Molly McCoy Brack, professional director of Agora: UNM Crisis Center in Albuquerque, N.M.

It's true that military and veteran programs to address suicide are in place. Yet their depth, scope and reach vary along with veteran participation levels – with many veterans choosing to seek help from non-VA-affiliated resources. ■

THE COUNSELOR

Michael Henry McBurmette, 50

"A helicopter pilot in the Vietnam War, his helicopter was hit by enemy fire and crashed. Mike was the only survivor. All 13 of his buddies were killed. He suffered from survivor guilt and depression for years. He also battled addictions to alcohol and nicotine and food. He was divorced twice. Mike had two daughters.... He was a substance abuse counselor for over ten years. Mike touched many lives in his 50 years...Mike helped to get 12-Step meetings for Vietnam vets (who were) incarcerated for their crimes to support their addictions."

Sally Frederick Brown on her mentor and friend. An Air Force sergeant, McBurmette took his life by carbon monoxide poisoning in 1995. He had just become divorced a few months before his death.

THE PARENT

Randall Lee Jones, 43

"I know he suffered greatly from the war and didn't like to talk about it. He left a suicide note stating 'my past is catching up with me.' I believe that is a direct reference to Vietnam. I know that he suffered great spells of depression. He committed suicide at the time the Gulf War started. I was told he began watching war movies over and over at that time. He was a great father, and I wish I could have helped him."

Troy Jones on his father who took his life with a gun shot to the head in 1991.

Tough Struggle

The military experience, particularly of those who serve in combat, can leave its mark – including these challenges that soldiers and vets may face. These can combine with other predisposing factors to create risk for suicide:

A “**dependency culture**” in the military that can make reintegration into civilian life difficult.

A culture of heavy alcohol use. In a survey conducted in fall 2002 and just released in March of this year, military members categorized as heavy drinkers (having five or more drinks on a single occasion at least once a week) rose to 18.1 percent from 15.4 percent in the previous survey from 1998.

Exposure to Lariam, an anti-malaria drug linked to mental problems. The U.S. Food and Drug Administration warns that Lariam (also called mefloquine), invented by the Army and administered to troops in Iraq and Afghanistan, can cause panic attacks, thoughts of suicide, depression, anxiety, paranoia, delusions and psychosis that can occur long after taking the drug. In February 2004 the Pentagon reversed its stance on Lariam – once asserting it could not be a factor in causing suicides. Assistant Secretary of Defense for Health Affairs William Winkenwerder, Jr., M.D., told a House Armed Services Committee he would launch a study into the side effects of Lariam, “to include suicide and neuropsychiatric outcomes.” Pentagon health officials also said they would no longer use Lariam in Iraq because the malaria risk does not warrant it.

Stigma regarding post-traumatic stress disorder (PTSD) and mental illness that is still present in the military despite noteworthy programs to dissipate that stigma (see February 2004 “Preventing Suicide” for U.S. Air Force program). PTSD is the most prevalent psychiatric disorder arising from

combat. Many in the military won’t report its symptoms because they fear it will interfere with their mission, disrupt morale of their colleagues, and possibly curtail their military career. Yet studies show that if not treated in the short term, PTSD can last a lifetime. A new military policy now requires troops returning from combat to be screened for PTSD and other mental problems. This policy was put in place after four military wives of special forces soldiers returning from Afghanistan were killed by their husbands at Fort Bragg, N.C., in 2002. Two of these soldiers also took their own lives. Some had apparently taken Lariam, according to a March 2004 story by United Press International.

Lack of employment support – A recent comprehensive evaluation of VA work-therapy programs found that less than 1 percent of the 82,000 veterans with schizophrenia, who were in their prime working years and were employable given appropriate supports, participated in VA rehabilitation programs that emphasize work therapy to assist veterans in recovery. Legislation introduced last November in the U.S. Congress (Veterans Mental Health and Back-to-Work Act, H.R. 3442) would enable VA to provide supported employment services to veterans with mental illnesses as “recovery-focused services.” Meanwhile, some employers in the civilian sector are making extra efforts to hire veterans – including the “Hire the Heroes” program recently launched by automobile dealers and manufacturers through their consortium Automotive Retailing Today. The initiative hopes to place qualified recent military veterans in auto repair technician jobs to help counter shortages of some 35,000 service-technician positions that go unfilled each year. For more information on “Hire the Heroes” visit <http://www.autoretailing.org/military>. ■

Learning More

To locate the nearest VA facilities in your area, visit the Facilities Directory at the Department of Veterans Affairs at www.appc1.va.gov/directory/guide/allstate.asp.

Every state has VA facilities including:

- VA medical centers in major urban areas
- VA community-based outpatient clinics
- Vet centers
- Central offices

Also, the following cities serve as key headquarters for 21 regional Veterans Integrated Service Networks, or VISNs, overseeing multi-state areas: Albany, N.Y.; Ann Arbor, Mich.; Arlington (Dallas), Texas; Bay Pines (St. Petersburg), Fla.; Bedford, Mass.; Bronx, N.Y.; Cincinnati, Ohio; Duluth (Atlanta), Ga.; Durham, N.C.; Glendale (Denver), Colo.; Hines (Chicago), Ill.; Jackson, Miss.; Kansas City, Mo.; Linthicum (Baltimore), Md.; Long Beach, Calif.; Mare Island (San Francisco), Calif.; Mesa (Phoenix), Ariz.; Minneapolis, Minn.; Nashville, Tenn.; Portland, Ore.; Pittsburgh, Penn.

Other sources of information for people in the military service and veterans:

Homecoming After Deployment

www.ncptsd.org/war/homecoming.html

Tips for military service personnel, spouses and families on dealing with changes and expectations, tips for reunion and more.

How Terrorist Acts May Affect Veterans

www.ncptsd.org/facts/disasters/fs_veterans_disaster.html

What might veterans experience as a result of terrorist acts on U.S. soil, how veterans can take care of themselves when current events cause distress.

War-Zone-Related Stress Reactions: What Families Need to Know

www.ncptsd.org/war/war_families.html

How traumatic stress reactions can affect families, the important role of families in recovery, what happens in treatment for PTSD, self-care suggestions for families.

Mason, P. (1990). *Recovering from the War: A Woman's Guide to Helping Your Vietnam Vet, Your Family, and Yourself*. High Springs, FL: Patience Press.

Matsakis, A. (1996). *Vietnam Wives: Facing the Challenges of Life with Veterans Suffering Posttraumatic Stress*. Baltimore, MD: Sidran Press.

The Damage Done: A Photo Essay

www.motherjones.com/news/feature/2004/03/03_100.html

Moving stories of vets who recently returned from Iraq and Afghanistan after having lost limbs, vision and boyhood innocence.

SAMHSA Office of Applied Studies: Veterans

www.samhsa.gov/oas.veterans.htm

Alcohol and drug use among veterans, treatment. ■



Frontline

Unnoticed Statistics: Homeless Suicides

By R. Courtney, TaskForce Fore Ending Homelessness, Inc., Fort Lauderdale
and Lorraine D. Wilby, M.A., Broward Partnership for the Homeless, Inc., Fort Lauderdale, Fla.

Most of us consider suicide a personal tragedy. It is a personal tragedy for survivors – for people who loved the individual, who worked with him or her, for friends and others who had personal contact. Suicide is a personal tragedy for the people who cared, who know the person is dead.

But are all suicides indeed personal tragedies? If you take your life, and few others know you exist, is that suicide still a personal tragedy? If a homeless person completes suicide – one homeless person among a vast landscape of the homeless – and no one cares to listen, is it a personal tragedy? Is it a matter of public concern?

On a recent evening in Fort Lauderdale, a chronic homeless man street-named Cowboy was taken to a local hospital by the Homeless Outreach Team for a psychiatric evaluation. The Outreach Team is a program jointly supported by the Fort Lauderdale Police Department and a non-profit agency, the TaskForce Fore Ending Homelessness, Inc.

The team, made up of one civilian and one police officer, reached out to Cowboy. They had him admitted into the hospital under the mental health Baker Act, a state law to protect him from himself. Cowboy was known to the team as someone who was drinking himself to death and would act upon suicidal behaviors.

Unbeknownst to the Outreach Team, Cowboy was released from the hospital nine hours later. He probably sobered up. The headline of a newspaper article the next day read, “Man Dies in Fall off City Garage: Police consider Lauderdale death a suicide.”

Unfortunately the Homeless Outreach Team could not use Florida’s Marchman Act to protect Cowboy. This state law pertains to substance abusers, and until Jan. 1, 2004, Broward County did not have a Marchman Act facility for adults. As of January 2004, the TaskForce Fore Ending Homelessness has access to Marchman Act beds in a local private hospital through a program funded by the Department of Children and Families, Division of Alcohol, Drugs and Mental Health.

Yet more tragic headlines in local newspapers continue to report homeless suicides:

Homeless man drowns in Intracoastal: Witnesses say he leaped from seawall

Burned woman dies from her injuries: Troubled drifter may have burned herself, police say

Since January 2000 the medical examiner of Broward County has been working closely with the Homeless Outreach Team to identify homeless people who have died. Each year there is a steady rise in these statistics. One possible reason is that the Outreach Team is becoming more familiar with its “clients.” Another is the increased interest and sensitivity by the Medical Examiner’s Office.

In 2000 17 people who died were reported as homeless by the medical examiner. In 2001 there were 26, and in 2002 44 people who died were identified as homeless.

The tragedy within these statistics is that more than 40 percent of all deaths among homeless people in 2002 were by suicide.

We two authors – one a suicidologist and one an outreach worker – have different perspectives when hearing news of death by suicide among homeless people:

Suicidologist: “Did they call the suicide hotline?”

Outreach Worker: “Did they choose to spend the 35 cents on a hamburger instead?”

Suicidologist: “Why didn’t the doctors, the mental health or the substance abuse professionals see the classic warning signs for suicide?”

Outreach Worker: “Who would see them, who would know them well enough to pay attention?”

What kind of system provides continuity of care for chronic homeless individuals? Those living on the street are a community we recognize does exist. They are the difficult to reach, but we know who they are because we try to reach them. At present attempts to intervene with the suicidal chronic homeless population are inadequate perhaps because we, the homeless professionals, focus on the issues we believe are most pertinent to homelessness.

We look at and work on the substance abuse problems, the mental health issues, the lack of financial resources, even the key issue – the lack of affordable housing. But in the process we need to specifically address the prevention of suicide for a population that does not have access to traditional avenues of service delivery.

For starters, we can:

- Publicize and disseminate the 1-800-SUICIDE Hopeline number directly to the homeless.
- Provide suicide intervention and prevention training that teaches practical application techniques and strategies to clinicians and case managers working within the homeless arena.
- Encourage researchers to focus on the suicidal homeless population – this large cohort of people that is impacting the statistics in a way no other “occupation” of people have done.

If we professionals have more information regarding the homeless population and suicidal ideation, we will be better equipped to deal with this very serious public health problem – this very serious *personal tragedy*. ■

R. Courtney is the chief executive officer and president of the TaskForce Fore Ending Homelessness, Inc., in Fort Lauderdale, Fla. He is the civilian partner on the Homeless Outreach Team, a program of the Fort Lauderdale Police Department. A U.S. military veteran and formerly homeless person, Courtney is an ardent advocate for the homeless. courtneytfeh@bellsouth.net

Lorraine D. Wilby, M.A., is director of Housing for the Broward Partnership for the Homeless, Inc., Fort Lauderdale, Fla. Wilby is former director of CrisisLine at The Center for Information & Crisis Services in Palm Beach County, Fla. ldwilby@bellsouth.net

Antidepressant use in preschoolers soars

The number of preschool children using antidepressant drugs increased by almost 50 percent from 1998 to 2002, according to the April issue of "Psychiatric Services." Also the number of antidepressant prescriptions for children and adolescents is rising at a rate of about 10 percent each year.

The U.S. Food and Drug Administration (FDA) alerted physicians in March about a potential link between some medications and childhood suicide rates, indicating that selective serotonin reuptake inhibitors (SSRIs) and other antidepressants may cause increased suicidal tendencies in some patients. While some applaud the FDA warning, others argue the action could discourage use of these medications in youth.

With depression affecting approximately one in 33 children and one in eight adolescents (according to the National Mental Health Association), proponents of antidepressant use in youth populations argue that they may be vital to controlling depressive disorders, which, if left untreated, can be life-threatening.

'Care managers' may help depressed elderly reduce suicidal thoughts

Quality treatment of depression in primary care can be a prevention strategy to reduce the risk for suicide in late life, according to a study funded by the National Institute of Mental Health (NIMH) and appearing in the March 3, 2004, "Journal of the American Medical Association." The study showed that staffing doctors' offices with depression care managers helps depressed elderly patients reduce suicidal thoughts.

Researchers set out to demonstrate that by educating physicians and improving treatment up to guideline standards, a "depression care manager," i.e. a social worker, nurse or masters-level psychologist, can significantly improve clinical outcomes. These include suicidal thinking that is resolved more quickly in patients who received the intervention.

Older Americans comprise 13 percent of the population but account for 18 percent of all suicides. The major risk factor for suicide in late life is major depression.

Appeal for addition to Vietnam Veterans Memorial sparks controversy

Debate about how the toll of the Vietnam War should be measured is under way, sparked in part by appeals from relatives of a veteran who took his life four months after he returned home in 1973. The Washington Post reported that the family of Air Force Capt. Edward Alan Brudno has received authorization from the Defense Department to add his name to the Vietnam Veterans Memorial in Washington, D.C. Brudno endured more than seven years as a prisoner of war after his F-4 was shot down over North Vietnam in 1965, and was the first released POW from Vietnam to die. Yet some argue that adding Brudno's name to the memorial sets a precedent that could open the door to thousands of others who may expect similar recognition for veterans who died by their own hand. The Vietnam Veterans Memorial Fund plans to add a plaque to the memorial that will honor all those whose premature deaths were a result of their service in Vietnam but who are not eligible for name recognition on the wall, reported the Post.

Students witness classmate taking his life in school

An eighth-grader shot himself to death in March while

sitting in a mobile classroom during a social studies/language class at Crescent Elementary School in Joyce, Wash. About 20 other students were present when 13-year-old Joe Rogers took his life, reports the Seattle Post-Intelligencer. He had concealed a .22-caliber rifle inside a guitar case.

State legislatures adopting bullying laws

Anti-bullying laws spurred in part by the 1999 shootings at Colorado's Columbine High School have been adopted in nearly 20 states, according to Stateline.org. And interest continues as 16 state legislatures consider such legislation – among them Iowa, Georgia, Kentucky, Maryland and Missouri. Those states adopting the most comprehensive laws to date are New Jersey, Rhode Island and Connecticut; a 2002 Connecticut law not only requires schools to adopt anti-bullying policies, but also mandates that schools record incidents of bullying and make them available to the public upon request. The U.S. Department of Health and Human Services recently established a multi-million-dollar awareness campaign called "Stop Bullying Now!" It is targeted at children ages 9-13.

Depression stigma in workplace alive and well

A disconnect between company perception and employee reality appears to be in place when it comes to depression in the workplace. This is according to a recent study by the University of Michigan Depression Center.

While private companies believe they are effectively addressing depression in the workplace, less than half of employees feel they can acknowledge depression in their lives without risking detriment to their careers. According to the study, 89 percent of employees report having some mental health coverage, yet three out of four delay seeking help and just over a third obtain only partial treatment.

College credit for suicide prevention courses

A unique online suicide prevention training program has been launched by the School of Social Work and Human Services at Eastern Washington University. Two one-credit prevention courses are available, addressing suicide risk assessment and management.

The first course covers suicide triage for first responders and professionals who *assess* or *refer* potentially suicidal persons. These professionals include teachers, school counselors, hospice workers, corrections personnel and residential staff.

The second course covers suicide risk assessment for professionals who *evaluate* and *treat* potentially suicidal persons. These include psychologists, psychiatrists, social workers, health care providers, therapists and substance treatment providers.

Because the courses are available online they can reach a national and global audience of students and practicing professionals. The EWU program is offered in partnership with the QPR Institute. To register online or for more information visit <http://suicideprevention.ewu.edu> or call (509) 359-7380 or (800) 331-9959.

Depression and diabetes guide released

Magellan Health Services has developed an informational guide on the connection between diabetes and depression to address what it estimates are 6 million diabetics in the United States who also suffer from depression. For more information visit www.magellanhealth.com or call Kristin Brunnworth at (410) 953-2423. ♦

SPAN USA sets date for 2004 awareness event

Mark your calendars for the 2004 SPAN USA National Awareness Event Sept. 19-21 in Washington, D.C. This ninth annual event will include advocacy training, a memorial event,

and a visit to Capitol Hill to educate Congress about the tragedy of suicide. It attracts grassroots advocates from states across the country. For more information email Karin at kschild@spanusa.org or visit www.spanusa.org/nae.html. ■

investigator

Federal Investigator



Senate promotes youth suicide prevention

Sen. Gordon Smith (R-Ore.), who lost his 21-year-old son Garrett to suicide in September 2003, made a heartfelt public plea in March to a U.S. Senate subcommittee on suicide among young people.

Days later, a bill was introduced by Sen. Christopher Dodd (D-Conn.) and Sen. Mike DeWine (R-Ohio), chairman of the Senate Health and Education subcommittee on substance abuse and mental health services. The legislation is S. 2175, the Youth Suicide Early Intervention and Prevention Expansion Act of 2004. After its introduction March 8, the bill was referred to the Senate Health, Education, Labor and Pensions (HELP) Committee.

This new bipartisan proposal in the U.S. Senate would allocate \$90 million over three years to help states create and enhance suicide intervention programs for youth. The bill would provide federal funding for statewide prevention and intervention strategies and for programs to treat the mental health issues that can cause suicidal behavior in children and young adults.

These will help ensure that services reach youth and their families in settings that include school, the juvenile justice system, substance-abuse and mental health programs, foster care systems and other child-serving entities.

This legislation “promotes accountability from those awarded grants by requiring an evaluation of and reporting on the effectiveness and efficacy of the suicide prevention and early intervention activities,” notes the National Alliance for the Mentally Ill, or NAMI. “Those awarded grants must also develop community awareness campaigns on risk factors associated with youth suicide and the care available from early intervention and prevention services.”

To contact your elected officials to support S.2175, visit the SPAN USA Legislative Action Center at www.spanusa.org.

Deadline set to apply for National Training and Technical Assistance Center for Child Adolescent Mental Health

SAMHSA is accepting applications to support a national resource and training center for children with, or at risk for, serious emotional disturbances. Nearly \$3.5 million in grant monies is anticipated to fund one award in 2004. Applications for a fiscal year 2004 cooperative agreement are due by May 21, 2004. This national resource and training center would promote coordinated care for at-risk youths, including those with co-occurring substance abuse and mental disorders. It would advocate keeping children within home and community-based settings. To obtain an application for SM-04-002 (National Training and Technical Assistance Center for Child and Adolescent Mental Health), call the SAMHSA clearinghouse at (800) 729-6686, or visit www.samhsa.gov and click on “grant opportunities.” For questions on program issues contact Michele Herman at (301) 443-1333 or mherman@samhsa.gov

May 28 deadline for SAMHSA grants for drug/alcohol and mental health treatment for homeless

To help communities expand and strengthen treatment services for homeless individuals with substance abuse disorders, mental illness or both as co-occurring disorders SAMHSA announced in late March that grants are available. About \$13.9 million is available and up to 35 awards will be made, with maximum funding of \$400,000 per year for up to five years. The application deadline is May 28, 2004. To obtain an application for No. TI 04-001, call the SAMHSA clearinghouse at (800) 729-6686 or visit www.samhsa.gov and click on “grant opportunities.” For questions on program issues contact Joanne Gampel at (301) 443-7945 or jgampel@samhsa.gov; or Gigi Belanger at (301) 443-1391 or gbelange@samhsa.gov.

NAMI calls for smarter investment in federal research on mental illness

NAMI is advocating for stronger, smarter investment in scientific research on the most severe mental illnesses with the recent release of its Roadmap to Recovery and Cure. The 40-page report was released earlier this year by the NAMI Policy Research Institute’s Task Force on Serious Mental Illness Research. It is available at www.nami.org/sciencetaskforce.

The NAMI report calls for:

- A \$1 billion increase in funds for the National Institute of Mental Health (NIMH) over five years.
- A single authority within the federal government to coordinate psychiatric research and services investment, to overcome currently fragmented efforts, which often do not reflect evidence-based practices.
- A congressional directive for NIMH to prioritize severe mental illness research, with increases to its research portfolio for basic, clinical and health care research relevant to the most severe illnesses – and traditionally underserved populations.

The report also calls for better integration of research and service systems to provide “effective treatment in the real world.”

“Scientific research by the federal government has moved closer to unlocking the secret of severe mental illnesses, but whether scientists ‘solve the case’ depends on President Bush’s and Congress’s willingness to increase investment to pursue promising new opportunities,” notes a NAMI news release. ■