

AU/ACSC/2016

AIR COMMAND AND STAFF COLLEGE
DISTANCE LEARNING
AIR UNIVERSITY

SUICIDE IN THE GUARD AND RESERVE: VARIABLES
IN MENTAL HEALTH ACCESS AND SUPPORT

by

Dorrie E. Staal, Major, USANG

A Research Report Submitted to the Faculty

In Partial Fulfillment of the Graduation Requirements

Proposal Advisor: Dr. Paul Moscarelli

Project Advisor: Dr. Andrew Niesiobedzki

Maxwell Air Force Base, Alabama

June 2016

DISTRIBUTION A. Approved for public release: distribution unlimited.

Disclaimer

The views expressed in this academic research paper are those of the author and do not reflect the official policy or position of the US government or the Department of Defense. In accordance with Air Force Instruction 51-303, it is not copyrighted, but is the property of the United States government.



Table of Contents

	Page
Disclaimer.....	ii
Table of Contents	iii
List of Tables	vii
Table of Appendices.....	vii
Appendix A: Acronyms and Definitions	
Acknowledgements.....	ix
Preface.....	x
Abstract	xi
INTRODUCTION	1
Overview of the Study	1
The Nature of the Problem.....	1
Purpose of the Study	3
The Research Question	4
The Anticipated Significance of the Study	4
Research Methodology.....	4
EVALUATION OF CURRENT RESEARCH.....	6
EVALUATION OF STATISTICS, DEMOGRAPHICS, KEY ISSUES AND FACTORS..	10
Military Suicide Statistics.....	10
Demographics Among Suicide Victims.....	13
Factors Unique to Guard and Reserve Members.....	15
Mental Health Access for Guard and Reserve Members	17
Mental Health Access for Active Duty.....	19
EVALUATION OF CURRENT PREVENTION PROGRAMS	20
Air Force Suicide Prevention Program.....	20
Army Suicide Prevention Program	21
Marine Suicide Prevention Program.....	23
Navy Suicide Prevention Program.....	23
RESULTS AND ANALYSIS	24
Five Evaluation Criteria.....	24
Analysis of Suicide Rates and Demographics.....	25

Analysis of Key Issues and Unique Factors Affecting National Guard and Reserve Members	25
Analysis of Mental Health Access	26
Analysis of Mental Health Programs	27
CONCLUSIONS AND RECOMMENDATIONS	27
Conclusions	27
Recommendations	28
Endnotes	30
Bibliography	34
Appendix A: Acronyms and Abbreviations	36



Preface

This paper is an attempt to increase awareness of the suicide rates among military members. I hope to bring to light the past disproportionately higher rate of suicide in the National Guard and Reserve compared to the suicide rate in Active Duty members, as well as bring to light the new trend emerging in the 2015 quarterly data showing evidence of another increase in Guard and Reserve suicide rates. All branches of service including Active Duty, Reserve and National Guard have suicide prevention protocols, regulations, instructions, and prevention training programs in place. These programs are mandated by their respective branch's regulations. However, the Guard and Reserve suicide rates remain high. There must be additional factors unique to the Guard and Reserve that contribute to the high suicide rate. This topic is extremely important to me because I've witnessed first-hand what a serious problem suicide is in the National Guard. I've served for almost ten years in the Air National Guard. My career has consisted of serving in two states, both as a traditional Guardsman working with Army and Air Force.

During my time in service, I've personally known service members (Airmen and Soldiers) who have taken their own lives. I suspect I knew more Airmen and Soldiers who took their own lives, but their deaths were ruled accidental due to overdose or car accident. I believe we, as health care providers in the military need more information to help us identify these individuals at high risk, and to help us identify the areas lacking to advocate for and provide necessary access and support. Those identified at high risk could then be offered extra support and quicker access to mental health care or appropriate support programs.

Abstract

Suicide rates for the U.S. military reached a crisis level in 2006 and continued to rise. There were many theories as to why the suicide rates had reached such high levels and the Department of Defense (DoD) among several other entities began to study this problem. In 2012 the DoD began to report the components separately and provided the first data related to suicide rates for Active Duty vs. Guard and Reserve. The rates overall were shocking for this time period; however, the rates for the Guard and Reserve were disproportionately high. Suicide rates did begin to fall by 2014 after much direction from the Department of Defense to military installations around the world regarding suicide prevention and mental health support. However, rates are again on the rise according to Quarter 3 of 2015 DoD Suicide Event Report data. This data is the most recently published statistics from the Department of Defense. Considering these statistics, there must be factors and or variables that are unique to the Guard and Reserve forces and therefore, require unique interventions. This research evaluation explores the factors and variables unique to Guard and Reserve members and whether there are gaps in mental health support that may attribute to the past disproportionate suicide rates and the rates that appear to be climbing again based on 2015 preliminary data. This study also recommends demographics relevant to Guard and Reserve members not currently reported and suggests areas for future research, as well as interventions that may impact the support programs for Guard and Reserve members.

Tables

Table 1.1	11
Table 1.2	12



INTRODUCTION

“Regardless of whether the [suicide] rate is going up or down, so long as a single soldier takes his or her own life we owe it to the soldiers we serve with to focus on how to prevent and reduce suicides within our ranks.”

Lt Gen. Timothy J. Kadavy, Director of the Army National Guard¹

Overview of Study

This study uses an evaluation framework to analyze the problem of past disproportionately high suicide rates in the National Guard and Reserve forces compared to Active Duty and the new emerging evidence of yet another rise in Guard and Reserve rates. The problem was identified by evaluation of Department of Defense (DoD) suicide statistics. This study will analyze suicide statistics in further depth. It will also analyze key demographics and unique factors affecting National Guard and Reserve forces, and will analyze constructs of suicide prevention programs currently mandated in each branch of service. This study also analyzes suicide prevention program website content to determine current state of web based suicide prevention programs, and how these program mandates fit with the Guard and Reserve versus Active Duty.

The purpose of this study is to determine whether there are unique factors or variables in support and mental health access for the National Guard and Reserve forces versus Active Duty. This study will provide data to determine whether there are unique factors and key issues or variables that may disproportionately affect the National Guard and Reserve suicide rates. This study will also evaluate needs for further research and/or interventions necessary to positively impact Guard and Reserve forces high suicide rates.

Nature of the Problem

Suicide within the U.S. military has been on the rise since 2006; and has been at a crisis level since 2011. As of 2012, there were more suicide related deaths than combat related deaths.² In 2012, the DoD began tracking suicide related deaths by component instead of strictly by branch of service.

The Active Duty suicide rate for 2013 actually showed a promising decline from 2012.³ However, it became quickly apparent the National Guard and Reserve suicide rates had reached a catastrophic high in 2013. The rates for 2014 were lower overall compared to 2013, but still remained disproportionately higher for the Reserve forces compared to Active Duty.⁴ The National Guard rates showed a marked decline but still remained above the National average for the same age and demographics compared to Center for Disease Control (CDC) statistics.⁵ It is not difficult to reason that there are many unique stressors for the National Guard and Reserve forces including potential employment issues, geographic isolation from easily accessible mental health care, and the stress of balancing two careers. Not to mention in recent years, the National Guard and Reserve forces have often faced multiple deployments, which can easily take a toll on family stability and civilian careers.

In response to these predicted stressors, the DoD implemented numerous programs in recent years and created new positions on military installations to give Guard and Reserve members more support. Specifically, the National Defense Authorization Act (NDAA) authorized the Secretary of Defense to provide access to and provide referrals from licensed mental health professionals for reserve component members during inactive duty training. The NDAA also provided every reserve component access to mental health counselors at no charge.⁶ There was also an initiative to increase education and strengthen suicide prevention education at all Guard and Reserve installations. Efforts were made to provide better mental health access to geographically dispersed members, and to communicate and better educate civilian mental health providers regarding the unique stressors military members face.⁷

Despite all these interventions and initiatives, the problem is the rates are still high. In fact, the rates remain higher for the National Guard and Reserve than for the civilian population of the same age and demographics. As of 2014, the Reserve component suicide rate was higher than the Active Duty component.⁸

The 2015 DOD Annual Suicide Event Report is yet to be released. However, 2015 Quarter 3 preliminary data shows an increase in all branches of the Reserve forces and a marked increase in the Army National Guard and Army Reserve suicide rates compared to Quarter 3 of 2014.⁹ The Active Duty also showed a slight increase compared to Quarter 3 of 2014, but not near the increase the Guard and Reserve component show.¹⁰ This is a troubling trend considering all the interventions invested in the Guard and Reserve suicide prevention programs in recent years.

Purpose of the Study

The purpose of this study is to identify key issues and factors to determine whether unique variables or gaps exist in support programs and mental health access for Guard and Reserve forces, which may affect suicide rates. Identification of unique variables may be key to understanding the past high suicide rates for the Guard and Reserve compared to Active Duty and to understand the current trend of increasing suicide rates for the Guard and Reserve. Identification of factors unique to the Guard and Reserve should also be explored to determine whether those factors directly impact the availability of support and mental health access. The identified variables and factors may directly impact the suicide rates for National Guard and Reserve forces. If these factors or variables can be isolated or identified, this study could pave the way for future research to determine interventions to further reduce suicide rates for National Guard and Reserve members.

Research Question

There is an obvious history of disproportion in the number of suicides in the National Guard and Reserves compared to Active Duty. Suicide prevention and awareness programs have certainly increased in number in recent years, and the 2014 suicide rates compared to 2013 have declined overall, yet the higher trends still remain between the National Guard and Reserve components compared to Active Duty. Not to mention the preliminary data for 2015

shows rates again on the rise. Therefore, the research question of this study is: Are there unique factors that lead to variables or gaps in mental health access and support programs available to the National Guard and Reserve forces compared to their Active Duty counterparts?

The Anticipated Significance of the Study

The suicide rates for National Guard and Reserve members increased by 9.2% in 2013 while Active Duty suicide rates showed an 8% decline from 2012 rates.¹¹ In 2014, there appeared to be a marked improvement overall with Active Duty and Guard and Reserve showing a promising decline. However, current (2015) quarterly data shows evidence that Guard and Reserve rates are again on the rise.¹² Therefore, there must be unique factors, variables and/or gaps directly contributing to the disproportionate suicide rates. Identification of these factors, variables and/or gaps in support programs and mental health access for Guard and Reserve forces may be key to understanding the disproportionate suicide rates of the Guard and Reserve forces compared to Active Duty. The research and resulting conclusions will lay groundwork for future research that will identify specific interventions necessary to close the gaps and provide adequate support for National Guard and Reserve forces.

Research Methodology

This author will use an evaluation framework to explore the research question. The Evaluation framework provides the ability to analyze statistical data regarding the differences in the suicide rates of Guard and Reserve compared to Active Duty, as well as statistical data regarding particular risk factors that may contribute to these rates. The statistical data proves the question is relevant, and also helps to identify factors contributing to the high rates unique to Guard and Reserve. Identifying contributing factors in common for Guard and Reserve compared to Active Duty are extremely valuable to answering the question of whether or not

there are gaps in mental health access and support. In order to identify gaps, one must first know what is needed compared to what programs or accessibility currently exist. This will necessitate gathering data regarding support program guidelines for suicide prevention and an evaluation of program content.

This author will examine unique factors identified, as well as variables in mental health access and support that may negatively affect the Guard and Reserve forces. The research will be accomplished through statistical analysis and review of other research regarding mental health access, support and other unique factors identified. The research will answer the question of whether or not there are gaps or unique variables in mental health access and support programs for Guard and Reserve compared to Active Duty. This will also allow the author to evaluate current support/prevention program criteria versus actual program content across the Armed forces to identify gaps in programs compared to directives.

In conclusion, the evaluation framework will use the following criteria to evaluate the question of whether there are variables or gaps in mental health access and other support programs available to the National Guard and Reserve forces compared to their Active Duty counterparts?

1. National Guard and Reserve suicide rates and demographics compared to Active Duty.
2. Key issues affecting National Guard and Reserve members.
3. Unique factors affecting National Guard and Reserve members.
4. Mental health access for National Guard and Reserve compared to Active Duty.
5. Mental health programs and support programs for National Guard and Reserve compared to Active Duty.

This framework will provide the ability to compare and integrate data findings with perspectives of subject matter experts. The evaluation approach and the resulting data findings can then be presented to prompt future research opportunities. The findings may also prompt recommendations for Guard and Reserve units to further modify or tailor support programs and or mental health access for the National Guard and Reserve forces.

EVALUATION OF CURRENT RESEARCH

Suicide among veterans and military personnel has been widely studied due to the suicide epidemic that has plagued the U.S. Military in recent years. The Department of Defense (DoD) reports suicide rates annually for U.S. Military personnel via the DoD Suicide Event Report (DoDSER). The information is available on the DoD website.¹³ The DoDSER report is often used as a platform for research studies surrounding suicide in the military. This author will highlight data from reports spanning from 2012 to the most recent available data in 2015 for this study. The data includes suicide rates, methods, demographics (including Active, Guard or Reserve component), mental health history and whether or not the individual accessed mental health services in the 90 days prior to death.¹⁴

RAND Research on Suicide Research Strategy

The RAND Corporation recently completed a study to develop a strategy for researching suicide prevention within the DoD.¹⁵ Recommendations from this study encourage the DoD to “create a unified, strategic, and comprehensive DoD plan for research in military suicide prevention. A comprehensive plan ensures that DoD’s military suicide prevention research portfolio is thoughtfully planned to cover topics in prevention, intervention, and postvention.”¹⁶ Data from this study will be used in this author’s research, and will also be used in conjunction with this study’s recommendation for future research.

RAND Research on Improving Remote Access for Military Members

RAND Corporation published a study in 2015 titled *Improving Access to Behavioral Health Care for Remote Service Members and Their Families*. This study was related to improving mental healthcare access for service members in remote locations.¹⁷ Recommendations from this study included establishing policies to foster an increase in behavioral health care among service members and families.¹⁸ The study further recommended to “take steps to improve remote behavioral healthcare.”¹⁹ According to this study, remote access to healthcare is a relevant factor in suicide prevention. Data from this study will also be included in this author’s research to quantify statistics related to mental health care access and unique factors related to Guard and Reserve.²⁰ Data in this research study will be instrumental in answering the research question because it addresses possible gaps in mental health support and accessibility for National Guard and Reserve members. It specifically addresses the effects of remote geographic location on mental health accessibility. The study also provides data related to what gaps exist in current policy and practice for improving access to mental health care for National Guard and Reserve service members who live in remote areas because of the likelihood those members have less access to mental health care.

RAND Research on Suicide Prevention in the Military

RAND Corporation also conducted research published in 2011. The study was named *The War Within: Preventing Suicide in the US Military*. This study was related to prevention of suicide in the U.S. Military.²¹ This study provides data that will be used for a comparison of suicide prevention programs across the Armed Forces to their existing suicide prevention policies. It will also define important information related to prevention programs.²² This data is relevant in identifying factors related to suicide prevention programs.

Army STARRS Research on Risk and Resilience for Army members

The Army Study to Assess Risk and Resilience in Service members (Army STARRS) released a three-part publication in 2014 related to a study outlining various strategies regarding evaluation of suicide risk and recognition of potential protective factors.²³ This study contains data related to risk factors to Army service members.²⁴ The study also identifies possible protective factors and recommendations regarding existing prevention programs.²⁵ This data will be evaluated in this research study because identification of risk factors may lead to identification of unique variables for Guard and Reserve members that must be considered in suicide prevention of Guard and Reserve forces.

Policies and Instructions for Suicide Prevention Across the Armed Forces

AFI 90-505 Air Force Suicide Prevention Program will be utilized to establish guidelines mandated for the Air Force suicide prevention program.²⁶

The data in this AFI will be valuable to establish mandated program content for suicide prevention and mental health support. The data can then be compared to website content outlining actual suicide prevention services on various Air Force installations.

Army Regulation 600-63, Army Health Promotion outlines regulations and requirements for suicide prevention programs for the Army Active Duty, Guard, Reserve and Civilian forces.²⁷ The data in this regulation will be valuable to establish mandated program content for suicide prevention and mental health support. The data can then be compared to website content outlining actual suicide prevention programs and services offered on various Army installations.

The *Marine Corps Order (MCO) 1720.2, Marine Corps Suicide Prevention Program* document provides Marine regulation on suicide prevention programs for the Active Duty, Reserve and Civilian forces.²⁸ This document outlines the requirements for suicide prevention programs in the Marine Corps. This data will be valuable to establish mandated program content for suicide prevention and mental health support. The data can then be compared to

website content outlining actual suicide prevention programs and services offered on various Marine installations.



Website Information for Suicide Prevention

The Defense Suicide Prevention Office website contains links to all suicide prevention program links for each branch of service including National Guard, Reserve and VA sources. This is an official DoD website.²⁹ This website content will be instrumental in evaluating suicide prevention programs across the Armed Forces and its components. This website content will allow this author to compare and contrast the content of suicide prevention programs to determine similarities and differences among the suicide prevention programs. This author will then be able to compare those similarities and differences with the suicide rates and look for correlations in increased suicide rates when one or more key elements of a mental health support program are missing.

Content review from this website will allow this author to evaluate whether there are gaps in the recommended programs. Once this is determined, this author can explore and compare a sample of actual suicide prevention support programs to identify gaps.

The research and primary data sources outlined in the above paragraphs contain the necessary content to answer the research question of whether there are variable or gaps in support and mental health access for Guard and Reserve forces compared to Active Duty. Answering this question will address the problem of disproportionate suicide rates for Guard and Reserve forces compared to Active Duty.

EVALUATION OF STATISTICS, KEY ISSUES AND FACTORS

Evaluation of Military Suicide Statistics

Prior to 2012, the annual suicide rates released by the Department of Defense Suicide Event Report (DoDSER) were only grouped by branch of service, which made it difficult to discern whether there were differences between the Active and Reserve/Guard components. In 2012, the DoD began to separate suicide statistics by component.³⁰ This means not only the branch of service is specified in the report, but also whether the service member was

Active Duty, Guard or Reserve. This is extremely valuable information considering the Guard and Reserve components are in many ways significantly different from Active Duty. The differences include distance from a member's assigned military installation, access to health care (on base vs. off base), intervention programs, military cultural differences, and deployment variances as just a few among a multitude of other differences. Several of these differences will be explored in later chapters of this research paper. The statistics identified are key to identification of differences in the National Guard and Reserve suicide statistics compared to Active Duty. These may be key in identification of unique factors or variables that may affect the effectiveness of support and prevention programs for National Guard and Reserve members.

In 2006, the DoD began to report elevated suicide rates among military members.³¹ The number of deaths continued to rise and prompted the DoD to take a closer look at those statistics. This included, as mentioned earlier, the breakdown of not only branch, but also component. In 2012, the updated suicide rates were released. There were no real surprises for the Active Duty components. However, the Army Guard and Reserve statistics are outlined below and were shocking at best.

The rate of suicide, per 100,000 Service members, in each of the aforementioned components was as follows: Active component – 22.7, Reserve – 19.3, and National Guard – 28.1. The suicide rates for the Active component of the four Services, per 100,000 Service members, were as follows: Air Force – 15.0, Army – 29.7, Marine Corps – 24.3, Navy – 17.8. The number of suicides for the Reserve components for each Service was too small ($n < 20$) for the calculation of rates, with the exception of the Air National Guard (19.1 per 100,000 Service members), Army Reserve (24.7 per 100,000 Service members), and the Army National Guard (30.8 per 100,000 Service members)³².

The new reporting method of these statistics raised awareness of the serious problem facing the National Guard and Reserve components, especially the Army National Guard. The Guard and Reserve suicide rates prompted multiple intervention programs across these components in attempt to lower the high suicide rates. In 2013, the numbers had not improved and in fact were even higher for the Reserve and Guard compared to 2012.³³

The rate of suicide (per 100,000 SMs) for Active Component SMs was 18.7. The rates for the Reserve and National Guard Components of the SELRES were 23.4 and 28.9, respectively. The suicide rates for the Active Components of the four Services were as follows: Air Force – 14.4, Army – 23.0, Marine Corps – 23.1, Navy – 13.4. The number of suicides in the SELRES for each Service was too small to calculate stable unadjusted rates with the exception of the Army Reserve and Army National Guard Components of the SELRES with rates of 30.1 and 33.4, respectively.³⁴

		2012	2013	2014
	Component	Rate ¹	Rate ¹	Rate ¹
All Services	Active	22.7	18.7	19.9
	Reserve ²	19.3	23.4	21.9
	National Guard ²	28.1	28.9	19.4
Air Force	Active	15.0	14.4	18.5
	Reserve ²	--	--	--
	National Guard ²	19.1	--	--
Army	Active	29.7	23.0	23.8
	Reserve ²	24.7	30.1	21.4
	National Guard ²	30.8	33.4	21.5
Marine Corps	Active	24.3	23.1	17.9
	Reserve ²	--	--	--
Navy	Active	17.8	13.4	16.3
	Reserve ²	--	--	--

¹Rates per 100,000 Service Members

²Includes SMs irrespective of duty status.

Table 1.1 Suicide rates for Active, Reserve, and National Guard Component suicides, all Services, 2012 - 2014³⁵

Again, data shows the Guard and Reserve components were significantly higher than the Active Duty. Specifically, the Army Reserve and Army National Guard are significantly higher than the other components or Active Duty. Furthermore, the CDC reports suicide per 100,000 as 13.0 for 2013.³⁶ When one compares the military suicide rates to the civilian population, it puts in perspective the problem facing the DoD. The most recent complete DoD data set currently available is data from 2015, and is as follows:

The rate of suicide for the Active Component, all Services, was 19.9 per 100,000 Service members. This list shows the rates of suicide for the Active Component of each Service: Air Force: 18.5 per 100,000 Service members.

Army: 23.8 per 100,000 Service members. Marine Corps: 17.9 per 100,000 Service members. Navy: 16.3 per 100,000 Service members. The rate of suicide for the Reserve Component of the Selected Reserve (SELRES; irrespective of duty status) was 21.9 per 100,000 Service members. The rate of suicide within the National Guard (irrespective of duty status) was 19.4 per 100,000 Service members.³⁷

DOD Service and Component	2013 Q3	2014 Q3	2015 Q3
Active Component	69	57	72
Air Force	15	19	16
Army	33	35	32
Marine	13	8	13
Navy	8	11	11
Reserve Component	53	48	70
Reserve	23	20	38
Air Force Reserve	5	3	3
Army Reserve	15	15	22
Marine Corps Reserve	2	1	8
Navy Reserve	1	1	5
National Guard	30	28	32
Air National Guard	6	4	5
Army National Guard	24	24	27

Note: These figures are subject to change as updated information is released.

Table 1.2 Suicide Rates for Active, Reserve, and National Guard Component suicides, all Services, Quarter 3 2013 – 2015. ³⁸

Also, the Army National Guard suicide rate is 21.5 per 100,000, which continues to show a disproportionately high rate compared to overall Active Duty rates.³⁹ Reviewing the statistics on the diagram below, it appears the suicide rates are falling at a steady rate. However, the Guard and Reserve rates remain above the national average by comparing civilians with the same age range and demographics.⁴⁰ The most concerning, however, is that when one reviews the quarterly suicide statistics for Q3 2015 compared to 2014, it is apparent the rates are actually on the rise once again. Reserve component suicides for Q3 are

higher than any quarter since 2012.⁴¹ See Table 2 below for details. This table compares data for the same quarter (Quarter 3) for 2013 through 2015.⁴² Quarter 3 is the latest information available from the DoD.

Evaluation of Demographics Among Suicide Victims

When evaluating suicide by service component and evaluating the rates of suicide and their increase or decline; it is also necessary to evaluate the demographics attached to the men and women who commit suicide in the Guard and Reserve Component compared to Active Duty. This will enable the author to determine trends in demographics and whether or not any of the trends are unique to Guard and Reserve forces. Reviewing the DoDSER for 2012 through 2014, and reviewing RAND studies related to suicide in the military can identify the following key demographics for military members who committed suicide.

2012 Statistics evaluated suicides committed by members on Title 10 orders (Active Duty status) and studied demographics including race, age, marital status, education and rank.⁴³ Overall, the most common age range for a service member to commit suicide is between 17 and 24 years old. Not surprising, the suicide rate for military members decreased as their age increased.⁴⁴ The highest rate of suicide per race was Caucasian, and the rate of suicide by sex was more than twice as high for males than females.⁴⁵ Educational level of service members committing suicide at the highest rate was either alternative high school education or regular high school education. Further, it was also observed the rate of suicide decreased as the educational level increased.⁴⁶

The most prevalent marital status among the victims was listed as never married, although married service members were second.⁴⁷

It is important to note that in 2012, the DoD began to report suicide statistics for the Reserve and National Guard separate from the Active Duty components for the first time. However, even though the data was available, the report did not separate the demographics

by Active Duty and Reserve or National Guard. The lack of separation definitely created a gap in tracking and trending demographics for the National Guard and Reserve.

In 2013 and moving forward, the demographics are reported out in order to consistently track demographics and other data across the services and components.

In 2013, the demographics were extremely similar for both Guard and Reserve and Active Duty with white males (Caucasian) under 30 years of age, junior enlisted, never married and educated through high school equivalent being the most common demographic characteristics of all service members committing suicide.⁴⁸ One interesting difference noted in comparison, Active Duty has the highest rate of suicide in the age range of 25 to 29 and for the Reserve Component it is 20 to 24 years of age. However, the rate for E1 to E4 remains the same for both Active and Reserve components.⁴⁹ This author recommends further analysis to determine average age for achieving E1 to E4 for both components to determine whether there is a difference in average time frame to achieve rank, and whether or not it correlates with the age differences within the components. The National Guard on the other hand, had an almost equal mix of the age range 20 to 24 and 25 to 29 years of age.⁵⁰ The 2014 suicide demographics are not significantly different from 2012 or 2013.⁵¹ However, the data may prove to be significant as the research on suicide prevention progresses and other data are analyzed and compared. The method of reporting for 2014 was far more detailed than previous years and did a thorough job of outlining all demographics by service and component. This report outlines statistics, demographics and factors for 2012 through 2014, and will be utilized by this author to analyze, outline and compare future data for all three years and all branches of service and components for this research.

The demographics outlined in the above paragraphs are fairly common data points used for tracking data in statistical analysis. This author found it interesting that neither religion nor religious practice were included in the demographics. This may be a

demographic that can be easily tracked. Service members are asked to disclose this information to the DoD on deployment forms, as well as on the record of emergency data. A person's religious preference, beliefs or the lack of religious beliefs may have a significant impact on a person's outlook on death and suicide.

Evaluation of Key Issues and Factors Unique to Guard and Reserve Members

Many factors were reported in the 2014 DoDSER in relation to suicide rates among military members in both the Active Duty components and the Reserve components. However, the report failed to separate the factors by Guard and Reserve. Some of the factors pertinent to Guard and Reserve members tend to be unique or have unique aspects compared to Active Duty. These include, but are not limited to employment status, deployments, domestic duty, relationship problems, and mental health care.⁵² These unique factors may be key to identification of reasons for the historically higher suicide rate for the Guard and Reserve forces, and may also be key to preventing these rates from continuing to rise again.

One factor particularly unique to the National Guard and Reserve forces compared to Active Duty is employment or in many instances, the lack of employment. In Active Duty, the military member has a full time assignment in the military and only has to worry about their performance on that job. Whereas, the majority of the time, traditional National Guard and Reserve forces are juggling their part time military career with a full time job, and must worry about their performance in both jobs. This is a unique situation compared to Active Duty and brings unique stressors simply because of the member periodically missing work for additional military duty, the challenge of balancing the commitment and requirements to two employers, and fewer days off each month related to the one weekend per month requirement for Unit Training Assemblies (UTAs). This lifestyle also requires more time away from family members, which can take a toll on personal relationships.

Another employment factor unique to the Guard and Reserve is that Guard and Reserve members are not guaranteed full time employment. Therefore, they are more likely to have stress related to unemployment or underemployment in their civilian jobs. Employment is an important factor for a Guard or Reserve member. Unfortunately, it is not a data element currently reported from the DoD SER statistics. This is definitely a gap in recognizing this as a possible factor contributing to emotional stress for a Guard or Reserve member. Guard and Reserve members often struggle with employment after returning from deployment. The Uniformed Services Employment and Reemployment Rights Act (USERRA) passed in 1994 protects these members from being fired or demoted due to military service obligations. However, with the deployment tempo of recent years, many find it hard to establish stable careers in the first place, or they may find it difficult to reintegrate after returning from deployment. Also, Guard and Reserve members who own businesses may suffer major losses of income when they deploy.⁵³

National Guard members are even more unique than Reserve members because they can also be activated for state service. In addition to a high deployment tempo, they must also respond to Domestic Operations including hurricanes, wildfires, floods, border crises and any other domestic need or disaster that may arise. These additional duty requirements require more time off work and more time away from loved ones, which in turn may cause even more financial and emotional stress for the member. These duties are in addition to their normal deployment tempo and their regular training requirements throughout the year. The DoD SER reports that consistently across the services including Guard and Reserve, around 42% of victims reported relationship problems prior to their committing suicide.⁵⁴

Relationship problems may be caused or at least further aggravated by frequent deployments or activations and the stresses these events may bring. While deployment and relationship problems are not necessarily unique, there are unique aspects to this problem for

Guard and Reserve members. In general, separation during deployments is most certainly a contributing factor to stresses in personal relationships. However, sometimes the reintegration to civilian life for Guard and Reserve members can be just as difficult. Active Duty military redeploy back to their home base and are surrounded by other members who shared similar experiences. They are surrounded by a support system that is familiar with the deployment and all the challenges that reintegration may bring. The Guard or Reserve member on the other hand, returns to civilian life often within days of leaving a war zone. These members are then expected to immediately return to their previous life and responsibilities.⁵⁵

One additional factor that cannot go unreported in this study is the fact there is research recently published and still underway that is exploring the mental health factor for Army members. Mental health is an important risk factor for suicide. According to the three part STARRS study on resilience in the Army using a comparable healthy civilian sample, 53% of Army members have a lifetime history of some form of mental illness. However, 91% had this mental health issue prior to joining the military.⁵⁶ This report provides information for consideration on current screening factors and supportive factors for these individuals moving forward.

Civilian employers may be pressing the returning service member for a date to return to work and loved ones expect the member to return to the previous responsibilities and routines. Many times the trauma of war makes this reintegration extremely difficult for the member. This may cause feelings of isolation if that person is not in close proximity to other members who shared the same experiences. DoDSER 2014 statistics show that roughly 50% of military members who committed suicide in 2014 had deployed.⁵⁷ This is a factor worthy of additional research regarding whether current interventions are effective and what more can be done for members and families returning from deployment.

Evaluation of Mental Health Access for Guard and Reserve Members

Another unique factor that may cause additional stress to Guard and Reserve members is their access to mental health care. While Active Duty members enjoy access to mental health care on base and without additional cost, roughly half of National Guard and Reserve forces live in rural areas where access to mental health care is not as easily accessible, not to mention civilian providers may not be familiar with treating military members who may have issues a civilian provider is not experienced with. According to a RAND study published in 2015, remoteness affects as many as 50% of Guard and Reserve forces live in rural areas. This equates to approximately 260,000 National Guard and Reserve members who live more than 30 minutes away from behavioral health care. In contrast, only 10% of Active Duty are living remotely⁵⁸ There may also be a challenge for the Guard or Reserve member to afford mental health care because Tricare Reserve Select (TRS) is an additional cost that can be as much as \$210.83 per month for a member and family. In addition, Tricare TRS does not cover 100% of mental health care services. The cost share to the member for outpatient mental health services is 15% in network and 20% out of network.⁵⁹ This would be for each session with a mental health professional, which means the out of pocket cost for a course of treatment could add up quickly.

There have been recent interventions in attempt to reach remote members via Internet Telemental Health Care (TMH) at no cost to the member. This is a great concept for members living in rural areas where there are few providers. It also protects a member's privacy; therefore, the member may be more likely to seek mental health care. For example, in some rural communities there may only be one mental health provider. The military member may perceive that everyone in town will know his or her problems if he seeks mental health care in that rural community. Even though at present, many of these remote members may not have reliable broadband Internet available at home, it is still a step in the right

direction and should be further evaluated for the need to expand these types of TMH services.⁶⁰ The RAND study referenced in this research recommends establishing guidelines for using this service by establishing a maximum perimeter of 30 miles to drive for mental health care. However, this author recommends making TMH available to all service members because it protects the member's privacy and may increase the likelihood of the member seeking mental health care.

Another concern regarding mental health and the National Guard and Reserve is the fact that Commanders have little authority to direct mental health care to a member when they are not on duty status. This means that the member may not be following through with their mental health care when not on duty status and there is little a commander can do to enforce compliance. This is extremely concerning, considering a commander sees a member in the Guard and Reserve an average of two days per month.⁶¹

EVALUATION OF CURRENT PREVENTION PROGRAMS AND PRACTICES

Evaluation of Mental Health Access for Active Duty Members

In contrast to the unique factors affecting mental health access for Guard and Reserve members, Tricare Prime provides access to mental health for Active Duty members. This requires the member to have a referral prior to receiving services but those services will not cost the member, and there is no premium or out of pocket charges. However, to access the TMH, as long as it is one of the first eight mental health visits, the member will not need a referral to schedule an appointment.⁶² Also, according to 2015 RAND statistics, 90% of Active Duty live within close proximity to mental health care.⁶³ This is a definite advantage over Guard and Reserve because the longer the distance a military member is required to drive to seek mental health care services, the less likely they are to continue to utilize those services.⁶⁴ Also, rural health services are often considered underserved medically, which means those areas may not have a mental health provider at all or may have a provider that is

not properly trained to handle the unique stresses encountered by military members. Only 10% of Active Duty members face this type of dilemma compared to 50% of Guard and Reserve members.⁶⁵

Both Active Duty and the Guard and Reserve component members all face the same fears when accessing mental health care. Many fear the loss of their security clearance if diagnosed unfit for duty. They also fear being labeled by colleagues and supervisors if they seek mental health services due to the stigma attached to seeking mental health care as a military member. However, it is apparent that National Guard and Reserve forces may face serious financial and logistical challenges when seeking mental health services related to living in remote areas and due to the costs of accessing mental health care as a Guard or Reserve member. Further research should be conducted related to accessibility of services and feasibility of offering free or reduced cost mental health care. Efforts should be continued and increased to reduce the fear and stigma attached to seeking help. Further research and intervention in these areas may directly impact the suicide rates for Guard and Reserve members.

Evaluation of Military Suicide Prevention Programs

All branches of the military have regulations or instruction related to suicide prevention. The regulations are published for each branch of service and must be followed by all service members. However, how these regulations are interpreted and implemented for individual Wing or Base programs around the Nation depends entirely on the leadership and interpretation of those regulations. These programs are expansive and detailed to fit the needs of that Wing or Base. Many go above the minimum requirements for mandated regulations. The ability for wings and bases to expand on these regulations is promising. National Guard and Reserve bases can then tailor those programs to best suit the unique needs of the Guard and Reserve. However, due to the expansive nature of these programs, this paper cannot

focus on that level of detail due to scope limitations of this research. Therefore, the suicide programs will be evaluated for each branch of service as they relate to the Active Duty, Guard, Reserve and their civilian personnel.

The Air Force Suicide Prevention Program is outlined in *Air Force Instruction (AFI) 90-505*. This AFI was updated in October 2014 and describes a comprehensive program designed to prevent suicides throughout the Air Force. This AFI applies to the Active duty, Guard, Reserve, and Civilian Employees of the Air Force.⁶⁶ This program focuses on leadership involvement, guidelines for Commanders related to the use of mental health services, investigations and education and training.⁶⁷ The training outlined in this AFI focuses on self awareness and awareness of a Wingman's mental health state. This means that Airmen are responsible to recognize when the people they work with are experiencing mental health issues, this may also be referred to as buddy care. This concept is significantly more challenging for the Guard and Reserve Airman, because on average, that Airman only sees his or her fellow Airmen or Wingmen two days per month. This may present challenges in realizing that a fellow Wingman is at high risk for suicide. The AFI contains specific guidance regarding the Air Reserve Component (ARC) as follows:

ARC Airmen will recognize the unique challenges of being a Citizen Airman and practice healthy behaviors to maintain readiness at a moment's notice. When not with the unit, will recognize it takes even more initiative and integrity to practice active self and buddy care.⁶⁸

Active buddy care as described by the AFI as taking care of one's buddy, fellow Airmen, co-workers by knowing the risk factors for suicide and notifying their chain of command of Airmen identified at risk.⁶⁹ This requires building relationships with fellow Guardsmen or Reservists outside of the military. This may be extremely challenging considering the busy civilian life of the majority of ARC personnel. Most have civilian careers, families and other numerous responsibilities outside the military. An Airman's ability to keep close watch on a

fellow Wingman may prove difficult at best. Also, according to the American Foundation for Suicide Prevention, people at risk for suicide may be withdrawn from activities and may isolate themselves from friends and family, which may make it even more difficult to connect outside of required military duty.⁷⁰ Unfortunately, as mentioned previously, there is also limited scope of what a Commander can do outside of duty status to direct mental health care of an Airman.⁷¹ This makes it even more difficult to intervene from a military perspective to protect the at risk individual from committing suicide.

In contrast, Active Duty members receive the same direction regarding buddy care. However, they are with their fellow Wingmen nearly every day. These men and women work together, train together, work out together and most socialize together in off duty time. The full time status of Active Duty Airmen provides much more opportunity for Wingmen to recognize risk factors in their buddies and to report concerns through the chain of Command. Active Duty Airmen are therefore, more likely to recognize a buddy in crisis and interventions are therefore more likely to occur for Active Duty Airmen in crisis than Airmen in the Guard and Reserves.

The Air Force does offer online tools to help Airmen; one in particular is the Wingman Toolkit. This toolkit provides outreach materials, personal stories, resilience training, numerous articles and videos for self-help and a list of resources for Airmen to utilize for self help and referral for fellow Wingmen in crisis.⁷² This toolkit is even available in the form of a mobile application. Web based programs make are more easily accessible to members of the Air Force regardless of component.

For Army National Guard the suicide prevention program is outlined in Army Regulation 600-63, last updated April 14, 2015. Similar to the Air Force Instruction, the Army Suicide Prevention Program outlined in this regulation also relies heavily upon fellow Soldiers recognizing and reporting fellow members who appear to be at risk for suicidal

behavior.⁷³ Again, this is obviously easier for Active Duty members to recognize than for National Guard or Reserve due to the limited time Soldiers spend with each other in the National Guard or Reserves. There may be an excellent prevention and surveillance program in place that equips Soldiers with all the right tools to spot those at risk for suicide. However, if the member is not present to observe a fellow Soldier, it proves difficult to recognize those at high risk and implement the proper interventions to prevent self-harm. The suicide prevention program also relies heavily upon urging Commanders to create a climate of “help-seeking behavior.”⁷⁴ Part of this concept is to eliminate the barriers and stigma previously associated with, and many would argue they currently plague the Armed Forces when it comes to members seeking psychological help. The Army’s program also seeks to educate Family members of Soldiers related to warning signs, risk, coping skills and resources available to help the Family member or their Soldier in times of crisis.⁷⁵ This part of the program is excellent for Guard and Reserve members because it equips family with tools to support and monitor their Soldier at home.

The Defense Suicide Prevention Office has a website with links to each of the Services’ online suicide prevention programs.⁷⁶ Unfortunately, this author attempted on multiple occasions over several days to access the Army’s program link on the DSPO website but was continuously routed to a dead link. The suicide prevention link on the Army’s “Stand To!” page was also not working.⁷⁷ This is extremely disappointing considering how many people may be searching for resources or seeking online help.

Marine Corps Order 1720.2 is defined as the Marine Corps Suicide Prevention Program (MCSPP). This program is similar to the Air Force and Army programs defined above. It focuses heavily on creating a culture within the Marine Corps of responsibility and duty to fellow Marines who are in crisis. The Marine Corps claims its “strategy is aligned with the Marine Corps larger, holistic prevention approach to behavioral health that seeks to

develop coping skills, increase resilience, and increase access to and engagement of behavioral healthcare services.”⁷⁸ These are all methods repeated throughout the various services’ suicide prevention programs. Again, the Reservists may be at a disadvantage due to the limited time those Marines are together each month.

The Navy OPNAV Instruction 1720.4A outlines its suicide prevention program. This program also defines prevention as “everyone’s duty” and focuses on education regarding risk factors, signs and symptoms and protocols for handling a crisis event involving a Seaman at risk for suicide.⁷⁹ This instruction also contains some detailed instruction for Commanders related to creation of a climate that minimizes stress on members. There is very little instruction or guidance in this instruction related to Reserve personnel.

The Navy and Marines have a link on the DSPO website that outlines again the risk factors, warning signs, protective factors, various support services, education, videos, other resource links, as well as a large number of contacts. This website is comprehensive and contains not only the education needed to obtain self-help or help for someone else, the website also posts the number for the military crisis hotline and provides a variety of other resources and information.⁸⁰

RESULTS AND ANALYSIS

Evaluation Results and Analysis

The evaluation criteria for this study included the following areas: Evaluation of suicide rates and demographics of the National Guard and Reserve compared to Active Duty, key issues and unique factors affecting National Guard and Reserve members compared to Active Duty, mental health access for National Guard and Reserve compared to Active Duty and Mental Health programs and support programs for National Guard and Reserve compared to Active Duty. These criteria were chosen because review of current research shows there is a difference in the suicide rates for National Guard and Reserve related to

Active Duty. However, to date, there has been little research comparing the Active Duty and Reserve components. Much of the research evaluates these criteria for one component or the other but rarely both. Military suicide rates have shown a decline overall. However, the suicide rates appear to be again on the rise and especially for the Reserve component.

National Guard and Reserve suicide rates and demographics

As stated above, suicide statistics for National Guard and Reserve certainly showed a history of disproportionately high rates but have declined in recent years. However, according to the 2015 Q3 data, they are again on the rise along with Active Duty rates.⁸¹ Most of the demographics were not unique comparing the Active Duty to the National Guard and Reserve. As stated earlier, one interesting difference noted in comparison, Active Duty has the highest rate of suicide in the age range of 25 to 29 and for the Reserve Component it is 20 to 24 years of age. However, the rate for E1 to E4 rank remains the same for both Active and Reserve components.⁸² This author recommends further analysis to determine average age for achieving E1 to E4 for both components to determine whether there is a difference in average time frame to achieve rank, and whether or not it correlates with the age differences within the components. The National Guard on the other hand, had an almost equal mix of the age range 20 to 24 and 25 to 29 years of age.⁸³ The 2014 suicide demographics are not significantly different from 2012 or 2013.⁸⁴ However, the data may prove to be significant as the research on suicide prevention progresses and other data are analyzed and compared.

This author did note the absence of capturing religious practice in the analysis. This demographic may affect overall suicide rates but was not captured. Religious practice or the lack of could be easily tracked and captured. This is something that is asked on a member's record of emergency data questions and most likely multiple other places, especially when

preparing to deploy. It would be interesting to see if rates differ for those who report religious beliefs versus those who do not.

Key issues and Unique Factors affecting National Guard and Reserve members

Numerous unique factors and key issues were identified for the National Guard and Reserve members in contrast to Active Duty, the largest factor involving employment. Employment may be a challenge for members returning from deployment. Many times members have given up their jobs or have a really hard time reintegrating to their previous job after deployment. Even for non-deploying members employment can be very stressful due to juggling two careers and the struggle to balance a civilian career with a military career. Another employment related stressor related to the National Guard in particular is the risk of also being called domestically to serve, which results in additional absences from work. With the recent years of high deployment tempos and readiness training required for the National Guard and Reserve forces, it could be financially devastating for a business owner. In contrast, Active Duty members do not have this stress. They have one career to focus on and always have a job upon return from deployment. There is definitely more financial stability for the Active Duty member. Employment is a unique factor and a significant source of stress for a lot of Guard and Reserve members, yet it is not tracked in the DODSER.

Relationship problems are not unique to any family dynamic. However, with Guard and Reserve members may experience additional stress on intimate relationships due to the increased deployment tempo of recent years. They may also experience more stress in the fact that all Guard and Reserve members give up one weekend a month with their family every month they serve, plus the additional training requirements they must accomplish in addition to their regular full time jobs.

The other major issue found in this study that is unique to Guard and Reserve is the reintegration process returning from deployment. In Active Duty, there is a support system

present that understands the stresses of returning from a war zone. For the Guard and Reserve members, they are expected to reintegrate to their previous routines and life just days after leaving a war zone. Very often members are widely dispersed throughout the state or region they serve. This makes it extremely challenging for those members to reach out to battle buddies for support and many feel they cannot talk to loved ones about their feelings.

Mental health access for National Guard and Reserve

There are definitely unique circumstances surrounding mental health access for Guard and Reserve members. Many members are living more than thirty minutes from a Military Treatment Facility (MTF). Due to their remote location, access can be a major problem for members seeking help. In addition, members living in small towns may be afraid to seek mental health care because of the fear that confidentiality may be an issue. Another factor affecting access is the fact that Tricare Reserve Select is not free to its members plus there are copays and deductibles involved for mental health care. This may be an extreme challenge for some members to afford. An effective strategy identified is the use of TMH programs for some remote members provided they have Internet capability.

Mental health programs and support programs for National Guard and Reserve

The guidelines mandated for suicide prevention programs and mental health support programs are for Active Duty as well as Guard and Reserve members. There is very little differentiation in the guidance. However, all of these programs stress buddy care and support for fellow members. The guidelines also rely heavily on reporting up the chain of command when a member feels another member may be in crisis. However, with the unique UTA structure of the National Guard and Reserve, members only see each other on average two days the entire month. This creates an extreme challenge to carrying out effective buddy care.

Some effective strategies identified include the family member education programs and the web based self-help tools and resources. These strategies are more likely effective for both Reserve and Active components.

CONCLUSIONS AND RECOMMENDATIONS

Conclusion

In conclusion, while there are a few unexplained differences in statistics for different branches and components mostly involving age and rank, there were not significant differences in the demographics for the suicide rates of Guard and Reserve members in comparison to Active Duty. However, there are a lot of unique issues and factors affecting the Guard and Reserve forces. These factors include employment challenges, unique relationship stressors, reintegration challenges when returning from deployment. In addition, challenges with seeking mental health treatment include access issues when remotely located, financial issues due to insurance premium and copay requirements and fear of lack of confidentiality when seeking mental health care in a rural area. Guidelines for mental health support and suicide prevention rely heavily on buddy care, yet the Guard and Reserve member may only see other military members two days per month and Command directed mental health care is somewhat limited when a member is not on Active status. Online support programs provide a multitude of education and resources for support. However, this author found that all links to the Army site were down.

Recommendations

Recommendations related to this study include recommending the DODSER report more demographics including religious preference or practice and report more employment status details. This author also recommends more research into the age differences between the Reserve component and Active Duty to determine the significance, if any, of this difference. In addition, it is recommended that DODSER further report out the Reserve and

National Guard data in every category of the demographics categories. More detailed reporting by component will certainly clarify areas requiring more resources and intervention.

This author also recommends updating existing guidance on suicide prevention programs to include more focused guidelines on the unique structure of the Reserve component and base prevention training on those unique factors that include remote living and separation from other members throughout the month. Guidelines should recommend assignment of buddy system, especially for those members identified at high risk. Members should be checking on those at risk individuals throughout the month and Commander should have additional guidelines mandated for follow up care and ensuring ongoing contact with that member. In addition, all branches of service should focus on family involvement and education for its Guard and/or Reserve members. This may be the most effective support strategy the military can provide a remotely located Guard or Reserve member. It is also recommended that the Army ensure the link located on the DSPO website is repaired and that site is up and running for those members seeking online help. The Army suicide rates for both Active and Reserve components are currently the highest in the military. This author also recommends remote mental health care is made available to all Guard and Reserve members regardless of their distance from an MTF. Members are less likely to seek mental health care in rural areas for fear of being seen by people they know. In fact, this author recommends this as an option for all service members if they choose. This author also recommends mental healthcare be free to members seeking help. Tricare should cover this service 100%, especially if the member is seeking help based on stresses caused by military service. The RAND study regarding recommended priorities for future research identified access, psychological interventions and help seeking as the highest rank areas for recommended future research.⁸⁵ This directly aligns with this author's findings and

recommendations and this author further recommends the DoD follow the recommendations contained in the RAND study on research priorities. Furthermore, considering the Army STARRS findings related to pre-existing mental health issues in its members, more research is recommended to evaluate why so many members have pre-existing mental health issues and what the Army can do to reduce this vulnerability to its members.⁸⁶ This could potentially benefit all branches with members who have behavioral health issues.

Endnotes

¹ Rebecca Autrey, "Suicide: One is Too Many," NGAUS: The National Guard Association of the United States, October 9, 2015. <http://www.ngaus.org/blog/15/10/suicide-one-too-many>. Accessed 7 May 2016.

² Gregg Zoroya, "Suicide Surpassed War As The Military's Leading Cause of Death," USA Today, 31 October 2014. <http://www.usatoday.com/story/nation/2014/10/31/suicide-deaths-us-military-war-study/18261185/>.

³ Patricia Kime, "DOD: Military Suicide Rate Declining," *Military Times*, 16 January 2015. <http://www.militarytimes.com/story/military/pentagon/2015/01/16/defense-department-suic>

⁴ Ben Watson. "Reserve, Guard Soldiers Committing Suicide at Higher Rates," *Defense One*, 25 April 2014. <http://www.defenseone.com/news/2014/04/reserve-guard-soldiers-committing-suicide-higher-rates/83239/>. [ides-2013-report/21865977/](http://www.defenseone.com/news/2014/04/reserve-guard-soldiers-committing-suicide-higher-rates/83239/).

⁵ "Injury Prevention & Control: Division of Violence Prevention," CDC Centers for Disease Control and Prevention, Last updated 28 March 2016. <http://www.cdc.gov/violenceprevention/suicide/statistics/index.html>. Accessed 16 May 2016.

⁶ Lt Col Thomas G. Rynders, *Suicide Prevention in the Army National Guard: Modeling Effective Strategies*, United States Army War College, April 2013, www.dtic.mil/cgi-bin/GetTRDoc?AD=ADA592978, 5.

⁷ Ibid, 11.

⁸ Department of Defense, *Department of Defense Suicide Event Report: Calendar Year 2014 Annual Report*, 13 Jan 2015, <https://dodser.t2.health.mil/>. Accessed on 9 May 2016, 19.

⁹ Keita Franklin, Ph.D., *Department of Defense Quarterly Suicide Report Calendar Year 2015 3rd Quarter*, Defense Suicide Prevention Office, www.dspo.mil/Portals/.../DoD-Quarterly-Suicide-Report-CY2015-Q3.pdf, 4.

¹⁰ Ibid.

¹¹ Department of Defense, *Department of Defense Suicide Event Report: Calendar Year 2014 Annual Report*, 19.

¹² Keita Franklin, Ph.D., *Department of Defense Quarterly Suicide Report Calendar Year 2015 3rd Quarter*, 4.

¹³ Department of Defense, "Department of Defense Suicide Event Report." <http://www.dspo.mil/Directorates/PlansPolicy/GuidesandReports.aspx>.

¹⁴ Keita Franklin, Ph.D., *Department of Defense Quarterly Suicide Report Calendar Year 2015 3rd Quarter*.

¹⁵ Rajeev Ramchand, et al., *Developing a Research Strategy for Suicide Prevention in the Department of Defense: Status of Current Research, Prioritizing Areas of Need, and Recommendations for Moving Forward*, Rand Report RR559, RAND Corporation. 2014. http://www.rand.org/pubs/research_reports/RR559.html, 94.

-
- ¹⁶ Ibid.
- ¹⁷ Ryan Andrew Brown, et al., *Improving Access to Behavioral Health Care for Remote Service Members and Their Families*, Santa Monica, Calif.: Rand Corporation, RR578z1, 2015, 1.
- ¹⁸ Ibid.
- ¹⁹ Ibid, 8.
- ²⁰ Ibid.
- ²¹ Rajeev Ramchand, et al., *The War Within: Preventing Suicide in the US Military*, (Santa Monica, Calif.: RAND Corporation, MG953, 2011), 1.
- ²² Ibid.
- ²³ Nock MK, et al., *Prevalence and Correlates of Suicidal Behavior Among Soldiers: Results from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS)*. JAMA Psychiatry, March 5, 2014.
- ²⁴ M Schoenbaum, et al., *Predictors of suicide and accident death in the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS)*. JAMA Psychiatry, March 3, 2014.
- ²⁵ *Prevalence and Correlates of suicidal behavior among soldiers: Results from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS)*.
- ²⁶ Air Force Instruction (AFI) 90-505. *Suicide Prevention*. 6 October 2014.
- ²⁷ Army Regulation 600-63. *Army Health Promotion*. 14 April 2015.
- ²⁸ OPNAV Instruction 1720.4a. *Suicide Prevention Program*. 4 August 2009.
- ²⁹ Defense Suicide Prevention Office. "Suicide Prevention Program Links."
<http://www.dspo.mil/SuicideData/DoDSEAnnualReports.aspx>.
- ³⁰ DoDSE Department of Defense Suicide Event Report: Calendar Year 2012 Annual Report. 20 Dec 2013. <https://dodser.t2.health.mil/>.
- ³¹ Rajeev Ramchand, Joie Acosta, Rachel M. Burns, Lisa H. Jaycox, Christopher G. Pernin. *The War Within: Preventing Suicide in the US Military*, Santa Monica, Calif.: RAND Corporation, MG953, 2011, xv.
- ³² DoDSE Department of Defense Suicide Event Report: Calendar Year 2012 Annual Report. 20 Dec 2013. <https://dodser.t2.health.mil/>. Accessed on 9 May 2016, 2.
- ³³ DoDSE Department of Defense Suicide Event Report: Calendar Year 2013 Annual Report. 24 July 2014. <https://dodser.t2.health.mil/>. Accessed on 9 May 2016, 2.
- ³⁴ Ibid.
- ³⁵ DoDSE Department of Defense Suicide Event Report: Calendar Year 2014, 19.
- ³⁶ Injury Prevention & Control: Division of Violence Prevention. CDC Centers for Disease Control and Prevention. Last updated 28 March 2016.
<http://www.cdc.gov/violenceprevention/suicide/statistics/index.html>. Accessed 16 May 2016.
- ³⁷ DoDSE Department of Defense Suicide Event Report: Calendar Year 2014, 17.
- ³⁸ Keita Franklin, Ph.D., Department of Defense Quarterly Suicide Report Calendar Year 2015 3rd Quarter. Defense Suicide Prevention Office. Quarter 3, 2015, 4.
- ³⁹ Ibid.
- ⁴⁰ Ibid.
- ⁴¹ Ibid.
- ⁴² Ibid.
- ⁴³ DoDSE Department of Defense Suicide Event Report: Calendar Year 2012 Annual Report. 20 Dec 2013. <https://dodser.t2.health.mil/>. Accessed on 9 May 2016, ix-x.
- ⁴⁴ Ibid, 2.
- ⁴⁵ Ibid, 58.
- ⁴⁶ Ibid, 59.
- ⁴⁷ Ibid, 59.

-
- ⁴⁸ DoDSER Department of Defense Suicide Event Report: Calendar Year 2013 Annual Report. 24 July 2014. <https://dodser.t2.health.mil/>. Accessed on 9 May 2016.
- ⁴⁹ Ibid, 23-26.
- ⁵⁰ Ibid, 23-26.
- ⁵¹ DoDSER Department of Defense Suicide Event Report: Calendar Year 2014, vii.
- ⁵² Ibid.
- ⁵³ Lt Col Thomas G. Rynders, Suicide Prevention in the Army National Guard, 12.
- ⁵⁴ DoDSER Department of Defense Suicide Event Report: Calendar Year 2014, 49.
- ⁵⁵ Lt Col Thomas G. Rynders, Suicide Prevention in the Army National Guard, 12.
- ⁵⁶ Lisa J. Colpe, PhD, MPH, *Army Study to Assess Risk and Resilience in Service Members* (Army STARRS), National Institute of Mental Health, http://www.dcoe.mil/content/Navigation/Documents/SPC2012/2012SPC-Colpe-Army_Study_to_Assess_Risk_and_Resilience_in_Service_members.pdf, 22.
- ⁵⁷ DoDSER Department of Defense Suicide Event Report: Calendar Year 2014, 49.
- ⁵⁸ Ryan Andrew Brown, et al., *Improving Access to Behavioral Health Care for Remote Service Members and Their Families*, Santa Monica, Calif.: Rand Corporation, RR578z1, 2015, 4.
- ⁵⁹ Tricare, "Tricare Reserve Select Monthly Premiums." <http://www.tricare.mil/Plans/Enroll/TRS/Premiums>. Last updated 8 January 2016.
- ⁶⁰ Ryan Andrew Brown, et al., *Improving Access to Behavioral Health Care for Remote Service Members and Their Families*, Santa Monica, Calif.: Rand Corporation, RR578z1, 2015, http://www.rand.org/pubs/research_reports/RR578z1.html, 7.
- ⁶¹ Lt Col Thomas G. Rynders, Suicide Prevention in the Army National Guard, 9.
- ⁶² Tricare Prime Costs. Tricare. <http://www.tricare.mil/Costs/HealthPlanCosts/PrimeOptions>. Last updated 2 March 2016.
- ⁶³ Ryan Andrew Brown, et al., *Improving Access to Behavioral Health Care for Remote Service Members and Their Families*, Santa Monica, Calif.: Rand Corporation, RR578z1, 2015, 3.
- ⁶⁴ Ibid.
- ⁶⁵ Ibid.
- ⁶⁶ Air Force Instruction (AFI) 90-505. *Suicide Prevention*. 6 October 2014.
- ⁶⁷ Ibid.
- ⁶⁸ Ibid, 16.
- ⁶⁹ Ibid, 4.
- ⁷⁰ American Foundation for Suicide Prevention. "Risk Factors and Warning Signs." 2016. <https://afsp.org/about-suicide/risk-factors-and-warning-signs/>. (Accessed 6 June 2016).
- ⁷¹ Lt Col Thomas G. Rynders, Suicide Prevention in the Army National Guard, 9.
- ⁷² Wingman Toolkit: Resilience Tools to Maintain a Balanced Lifestyle. <http://www.wingmantoolkit.org/about-the-toolkit/>. (Accessed 7 June 2016).
- ⁷³ Army Regulation 600-63. *Army Health Promotion*. 14 April 2015.
- ⁷⁴ Ibid, 18.
- ⁷⁵ Ibid, 18.
- ⁷⁶ Defense Suicide Prevention Office. "Suicide Prevention Program Links." <http://www.dspo.mil/SuicideData/DoDSERAnnualReports.aspx>. (Accessed 7 June 2016).
- ⁷⁷ U.S. Army. "Stand-To!: The Official Focus of the U.S. Army." 3 September 2013. https://www.army.mil/standto/archive_2013-09-03/. (Accessed 8-10 June 2016).
- ⁷⁸ Marine Corps Order (MCO) 1720.2. *Marine Corps Suicide Prevention Program*. 10 April 2012.
- ⁷⁹ OPNAV Instruction 1720.4a. *Suicide Prevention Program*. 4 August 2009.

⁸⁰ Navy and Marine Corps Public Health Center. Prevention and Protection Start Here. <http://www.med.navy.mil/sites/nmcphc/health-promotion/psychological-emotional-wellbeing/Pages/suicide-prevention.aspx>. (Accessed 7 June 2016).

⁸¹ Keita Franklin, Ph.D., Department of Defense Quarterly Suicide Report Calendar Year 2015 3rd Quarter, 4.

⁸² Ibid.

⁸³ Ibid.

⁸⁴ DoDSER Department of Defense Suicide Event Report: Calendar Year 2014, vii.

⁸⁵ Ramchand, Rajeev, et al., *Developing a Research Strategy for Suicide Prevention in the Department of Defense: Status of Current Research, Prioritizing Areas of Need, and Recommendations for Moving Forward*, Rand Report RR559, RAND Corporation. 2014. http://www.rand.org/pubs/research_reports/RR559.html, 92.

⁸⁶ Lisa J. Colpe, PhD, MPH, *Army Study to Assess Risk and Resilience in Service Members (Army STARRS)*, 22.



Bibliography

Air Force Instruction (AFI) 90-505. *Suicide Prevention*. 6 October 2014.

Army Regulation 600-63. *Army Health Promotion*. 14 April 2015.

Autrey, Rebecca. "Suicide: One is Too Many," NGAUS: The National Guard Association of the United States, October 9, 2015. <http://www.ngaus.org/blog/15/10/suicide-one-too-many>.

Brown, Ryan Andrew, Grant N. Marshall, Joshua Breslau, Coreen Farris, Karen Chan Osilla, Harold Alan Pincus, Teague Ruder, et al. *Improving Access to Behavioral Health Care for Remote Service Members and Their Families*, Santa Monica, Calif.: Rand Corporation, RR578z1, 2015.
http://www.rand.org/pubs/research_reports/RR578z1.html.

CDC Centers for Disease Control and Prevention, "Injury Prevention & Control: Division of Violence Prevention," Last updated 28 March 2016.
<http://www.cdc.gov/violenceprevention/suicide/statistics/index.html>. Accessed 30 May 2016.

Colpe, Lisa J. PhD, MPH, "Army Study to Assess Risk and Resilience in Service Members (Army STARRS)", National Institute of Mental Health. Powerpoint.
http://www.dcoe.mil/content/Navigation/Documents/SPC2012/2012SPC-Colpe-Army_Study_to_Assess_Risk_and_Resilience_in_Service_members.pdf.

Defense Suicide Prevention Office (DSPO). "Suicide Prevention Program Links."
<http://www.dspo.mil/SuicideData/DoDSERAnnualReports.aspx>. Accessed 6 June 2016.

Department of Defense (DoD), "Department of Defense Suicide Event Report."
<http://www.dspo.mil/Directorates/PlansPolicy/GuidesandReports.aspx>.

Department of Defense Suicide Event Report (DoDSER), *Department of Defense Suicide Event Report: Calendar Year 2012 Annual Report*. 20 Dec 2013.
<https://dodser.t2.health.mil/>.

Department of Defense Suicide Event Report (DoDSER), *Department of Defense Suicide Event Report: Calendar Year 2013 Annual Report*. 24 July 2014.
<https://dodser.t2.health.mil/>.

Department of Defense Suicide Event Report (DoDSER), *Department of Defense Suicide Event Report: Calendar Year 2014 Annual Report*. 13 Jan 2015.
<https://dodser.t2.health.mil/>.

Franklin, Keita (Ph.D.), Defense Suicide Prevention Office (DSPO). *Department of Defense Quarterly Suicide Report Calendar Year 2015 3rd Quarter*.
www.dspo.mil/Portals/.../DoD-Quarterly-Suicide-Report-CY2015-Q3.pdf

Kime, Patricia. "DOD: Military Suicide Rate Declining," *Military Times*, 16 January 2015. <http://www.militarytimes.com/story/military/pentagon/2015/01/16/defense-department-suic>

Marine Corps Order (MCO) 1720.2. *Marine Corps Suicide Prevention Program*. 10 April 2012.

Navy and Marine Corps Public Health Center. Prevention and Protection Start Here. <http://www.med.navy.mil/sites/nmcphc/health-promotion/psychological-emotional-wellbeing/Pages/suicide-prevention.aspx>.

Nock MK, Stein MB, Heeringa SG, Ursano RJ, Colpe LJ, Fullerton CS, Hwang I, Naifeh JA, Sampson NA, Schoenbaum M, Zaslavsky AM, Kessler RC, *Prevalence and Correlates of Suicidal Behavior Among Soldiers: Results from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS)*. JAMA Psychiatry, March 5, 2014.

OPNAV Instruction 1720.4a. *Suicide Prevention Program*. 4 August 2009.

Rynders, Thomas G. (Lt Col). *Suicide Prevention in the Army National Guard: Modeling Effective Strategies*, United States Army War College, April 2013, www.dtic.mil/cgi-bin/GetTRDoc?AD=ADA592978.

Ramchand, Rajeev., Nicole K. Eberhart, Christopher Guo, Eric Pedersen, Terrance Dean Savitsky, Terri Tanielian, Phoenix Voorhies. *Developing a Research Strategy for Suicide Prevention in the Department of Defense: Status of Current Research, Prioritizing Areas of Need, and Recommendations for Moving Forward*, Rand Report RR559, RAND Corporation. 2014. http://www.rand.org/pubs/research_reports/RR559.html.

Ramchand, Rajeev., Joie Acosta, Rachel M. Burns, Lisa H. Jaycox, Christopher G. Pernin. *The War Within: Preventing Suicide in the US Military*, (Santa Monica, Calif.: RAND Corporation, MG953, 2011).

Risk Factors and Warning Signs. American Foundation for Suicide Prevention. 2016. <https://afsp.org/about-suicide/risk-factors-and-warning-signs/>.

Schoenbaum, M., RC Kessler, SE Gilman, LJ Colpe, SG Heeringa, MB Stein, RJ Ursano, KL Cox, *Predictors of suicide and accident death in the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS)*. JAMA Psychiatry, March 3, 2014.

Tricare, "Tricare Reserve Select Monthly Premiums." <http://www.tricare.mil/Plans/Enroll/TRS/Premiums>. Last updated 8 January 2016.

Watson, Ben. "Reserve, Guard Soldiers Committing Suicide at Higher Rates," *Defense One*, 25 April 2014. <http://www.defenseone.com/news/2014/04/reserve-guard-soldiers-committing-suicide-higher-rates/83239/>. ides-2013-report/21865977/.

Zoroya, Gregg. "Suicide Surpassed War As The Military's Leading Cause of Death," USA Today, 31 October 2014. <http://www.usatoday.com/story/nation/2014/10/31/suicide-deaths-us-military-war-study/18261185/>.

Appendix A

Acronyms and Abbreviations

AFI- Air Force Instruction

Airman- Member of Air Force (Active, Guard or Reserve)

ARC- Air Reserve Component

CDC- Center for Disease Control

DoD- Department of Defense

DoDSER- Department of Defense Suicide Event Report

DSPO- Defense Suicide Prevention Office

MCSSP- Marine Corps Suicide Prevention Program

MTF- Military Treatment Facility

NDAA- National Defense Authorization Act

RAND-

Soldier- Member of the Army (Active, Guard or Reserve)

STARRS- The Army Study to Assess Risk and Resilience in Service Members

TMH- Telemental Healthcare

VA- Veterans Affairs

Wingman- A fellow Air Force member; also known as buddy or fellow Airman. May be enlisted or an officer in Active, Reserve or National Guard.