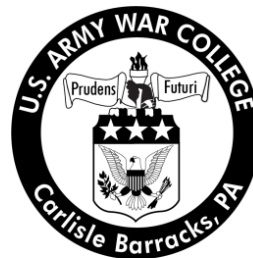


Civilian Research Project USAWC Fellow

Suicide Prevention in the Army National Guard: Modeling Effective Strategies

by

Lieutenant Colonel Thomas G. Rynders
United States Army National Guard



United States Army War College
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A plethora of the suicide prevention programs in the Army National Guard mirror those of the active Army and yet, the military service obligations of traditional Army National Guard Soldiers stress them in ways unlike their active duty counterparts. Compounding this problem are looming budget cuts through 2020 that will no doubt compel the Army National Guard to shift resources from health and welfare programs to other readiness priorities. States are now faced with the formidable task of reducing an alarming suicide rate with dwindling resources. However, a few states have indeed developed suicide prevention programs that target the unique stressors of traditional ARNG service members and are remarkably cost-effective to sustain and their models merit attention. This paper will scope the problem of suicides in the Army National Guard, illustrate the efforts of states that have developed effective programs, and recommend suicide prevention programs for implementation across the Army National Guard.

Suicide Prevention in the Army National Guard: Modeling Effective Strategies

“The Army is committed to providing the best resources for suicide awareness, intervention, prevention, and follow-up care – all of which are critical in helping Soldiers and family members prevent unnecessary loss of life.”¹

GEN George W. Casey, Chief of Staff, Army, October 2008

“The Army National Guard recognizes that each Soldier and family is part of a support structure and a network that helps them cope – even thrive – in the face of life’s challenges. The success of our Soldiers and families in remaining resilient has much to do with the individual efforts of the states, territories, and communities.”²

MG Ray Carpenter, Acting Director, Army National Guard, 2010

These quotes by the two senior leaders in the Army and the Army National Guard frame the problem of suicides on two fronts; every suicide is an unnecessary loss of life and, effective suicide prevention in the Army National Guard lies within its states, territories and communities as much as in the military. Since September 11, 2001, the traditional Army National Guard Soldier has been stressed on an unprecedented level with multiple deployments to combat zones, peacekeeping operations, and large-scale domestic emergencies of hurricanes, wildfires, southwest border operations and even national inaugural events. The breadth, scope, and frequency of these obligations combined with a recovering economy have exacted an extraordinary commitment from citizen Soldiers.

Significantly compounding the high operational tempo, the Army National Guard is also struggling with a troubling suicide problem that, in some years, has exceeded the rate of any other reserve or active component and national civilian rates. The joint efforts of the DoD, Veterans Administration, the Army and the National Guard Bureau to address the dilemma are problematic to quantify in terms of human and financial

resources. However, a cursory examination of the various suicide prevention initiatives of the Army and Army National Guard reveals little distinction in the programs designed for active duty Soldiers and those designed for Soldiers in the National Guard. This is surprising given the unique service obligations and stressors experienced by National Guard Soldiers. After nearly ten years of formally tracking and researching the problem and the innumerable programs and resources to prevent them, suicides continue to confound leaders, devastate families, and stun communities, leaving many to question, what else can be done?

Does the answer to the problem of suicides in the ARNG depend upon more money, more training, or even more awareness? Or, are more specific, targeted approaches the way ahead? A small number of states have taken Major General Carpenter's statement to heart and have developed suicide prevention programs that target and mitigate the unique stressors and disadvantages of the traditional Army National Guard Soldier.

The intent of this paper is to examine the scope of the suicide problem in the Army National Guard, the programs the DoD, the Army, and the National Guard Bureau have initiated to address the problem, and the disadvantages of the traditional Guard Soldier regarding those programs. This paper will further identify unique stressors experienced by ARNG Soldiers compared to their active-duty counterparts and the characteristics of effective state suicide prevention programs that target those disadvantages and unique service-related stressors. Finally, this paper will recommend state-specific suicide prevention programs for implementation across every state and territory in the Army National Guard.

Scoping the Problem of Suicides in the ARNG

In 2004, the rate of suicides in the Army was 9.6 per 100,000 Soldiers, much lower than 17.3 per 100,000 suicides in the U.S. civilian population. However, by 2009, the rate of Army suicides rose to 21.9 per 100,000 Soldiers, surpassing the civilian rate which remained relatively unchanged at 18.6 suicides per 100,000. By 2012, suicide rates in the Army soared to 29.5 per 100,000, the highest since tracking began in 2001.³

Regrettably, The Army National Guard is faring no better than the active component. The ARNG began formally tracking and monitoring suicide trends in 2004 when its rate was approximately 7 per 100,000. But, by 2010, 114 suicides in the ARNG exceeded both the active Army and the U.S. civilian rates, equating to 31 per 100,000.⁴ In 2011 and 2012, the ARNG experienced 99 and 113 suicides respectively, an indication that the problem may be worsening.⁵

The comparison of average suicide rates per 100,000 between the ARNG and other reserve components from 2004-2010 is stark. For example, the ARNG average suicide rate during that seven year period was 18.4 with a peak rate of 31 per 100,000 in 2010. For the same years, the Army Reserve average rate was 12 per 100,000 with a peak rate of 23 in 2010⁶ and the Air National Guard suicide rate was 12.7, peaking at 18 in 2010.⁷ The total number suicides in the U.S. Navy Reserves from 2004-2010 was 39, with an average rate of approximately 9 per 100,000.⁸

Although no demographic group in the ARNG is without suicides, analysis reflects the predominant population at risk are young, white males, ages 18-24, as high as 80% of all ARNG suicides from 2007-09.⁹ Additionally, suicides occurred more often in traditional guard service members (part-time, not full-time), with no prior military

service who are unmarried. Finally, suicides occurred most often while these service members were not on military duty (drill weekends) and the most frequent methods are by gunshot and hangings.¹⁰

A popular conclusion is that combat related stress is chief among the reasons for suicides. In fact, military-related indicators accounted for a surprisingly small percentage of suicides compared to demographic categories that accounted for more than 50% from 2007-2010.¹¹ Since 2009, the predominant attributes for suicides are relationships, employment problems, and financial issues among ARNG members who have never deployed or deployed only once.¹² Of course, discounting the emotional strain of multiple deployments on Guard members is naïve, as it no doubt is often a corresponding factor if not a causal one. As such, the Army National Guard is grappling with suicide as a confounding and dreadful problem plaguing its ranks.

Efforts to Address the Problem

As medical professionals in the military behavioral health community focus on the root-causes of the high suicide rates in the ARNG, civilian and military leaders from the federal level to the National Guard Bureau have unleashed a flood of resources aimed at suicide prevention.

Section 703 of the 2012 *National Defense Authorization Act* (NDAA), titled “Behavioral Health Support for Members of the Reserve Component of the Armed Forces” authorizes the Secretary of Defense to provide access to and referrals from licensed mental health professionals for members of the reserve component during scheduled inactive duty training.¹³

Subsequent to section 703 NDAA is Section Two of *The Embedded Mental Health Providers for Reserves Act of 2010* (EMHPRA), directing the service secretaries to provide every member of a reserve component performing scheduled inactive duty or annual training access to a licensed mental health counselor. These counselors are to be available on the installation or premise of the training reserve unit and at no cost to the service member. Section Three of the 2010 EMHPRA provides reserve component members on scheduled inactive duty or annual training access to Behavioral Health Support Programs, suicide prevention and post-suicide response programs, psychological health programs, and other programs deemed appropriate by state or federal military behavioral health professionals.¹⁴

In February of 2012, the Acting Under-Secretary of Defense for Personnel and Readiness issued Department of Defense Instruction (DoDI) 6490.09 outlining a “uniform psychological health leadership structure for the Reserve Component that parallels the Active Component structure, to ensure that the psychological health needs of Reservists and National Guard members and their families are met.”¹⁵ The DoDI establishes the requirement to resource and defines the responsibilities of a Director of Psychological Health (DPH) and appoint a DPH at the Department of Defense, each military department, the National Guard Bureau and every state Joint Force Headquarters.¹⁶ For the National Guard, this policy funds a full-time DPH at each state’s Joint Force Headquarters to develop strategic psychological health plans, monitor the effectiveness of the state’s ARNG mental health services, ensure communication to Directors of Psychological Health at the National Guard Bureau, and

establishes the NGB DPH as a voting member of the Department of Defense Psychological Health Council.¹⁷

In advance of the 2012 NDAA and the Acting Under Secretary's Instruction 6490.09, the Army, in 2010, published the *Health Promotion Risk Reduction Suicide Prevention Report*¹⁸ (HP-RRSP) summarizing the scope of the suicide problem within its ranks. At the direction of then Vice Chief of Staff General Peter Chiarelli, the report is remarkably comprehensive and highlights 67 conclusions and recommendations of resiliency and suicide prevention measures for the Army.

Formalizing the HP-RRSP, the Army issued a Rapid Action Revision (RAR) of DA Pamphlet 600-24, *Health Promotion, Risk Reduction, and Suicide Prevention*, in September, 2010, outlining the Army's Suicide Prevention Program (ASPP) and strategies. The ASPP is a commander-centric suicide prevention program centered on three overarching tenants; Prevention, Intervention, and Postvention.¹⁹

Although the ASPP leverages the responsibilities of installation commanders, chaplains, and even law enforcement officials, it clearly places ownership of suicide prevention in the hands of unit commanders, primarily at the battalion and brigade level. Beyond establishing suicide prevention policies and training, the ASPP directs commanders to personally manage Soldiers displaying at risk behaviors and refer Soldiers with personal or emotional issues to appropriate outlets for help. Commanders are also charged to maintain updates of the Soldiers' care and establish a command climate that avoids ridiculing of Soldiers who seek behavioral health treatment.²⁰

Commanders are not alone, of course, in the Army's strategy to prevent suicide. Active and Reserve installations and National Guard Joint Force Headquarters' have

established Suicide Prevention Task Forces (SPTF) under the Community Health Promotion Council (CHPC) to assist commanders in implementing the ASPP to include Risk Reduction Teams, Installation Prevention Teams, and Case Review Committees.²¹

Similar to the Army's suicide prevention strategy, the Army National Guard's suicide prevention programs have evolved in an attempt to understand and address the growing crisis. The ARNG's Resilience, Risk-Reduction and Suicide Prevention Campaign (R3SP) is an extension of the Army's ASPP with additional programs and personnel designed to target the traditional guard Soldier's unique service obligations.²²

The following is an illustration of some of the more prominent ARNG programs to add context to their efforts. The purpose of this cursory review is intended to highlight some of the suicide prevention initiatives at the DoD, Army, and National Guard command levels. An elaboration of all the suicide prevention programs and strategies goes beyond the scope of this research and the breadth of programs in the Army alone may also be an indicator as to why measuring the effectiveness of suicide mitigation programs is frustrating leaders.²³

Director of Psychological Health. After funding approval, the National Guard Bureau (NGB) began staffing every state and territory's Joint Force Headquarters (JFHQ) with a Director of Psychological Health (DPH) in January, 2009. DPHs are licensed, clinical mental health professionals with an overarching, dual purpose. First, the DPH provides confidential behavioral health services to traditional and full-time Guard members within the protections for the release of medical information per the Health Insurance Portability and Accountability Act (HIPAA). However, they are, in fact, constrained from providing treatment to service members beyond a medical emergency.

Second, DPHs serve as behavioral health advisors to state leadership and can serve on various family program and resiliency related staffs and action teams.²⁴

Master Resiliency Trainer (MRT). The Master Resiliency Trainer course is a 10-day program of instruction at Fort McCoy, Wisconsin, to train first-line leaders as primary resiliency trainers and mentors at the battalion level. MRT's train resiliency skills to Soldiers, advise commanders on unit-level resiliency issues, and can recommend or refer Soldiers in need to other behavioral health services. In essence, MRT's are on point for battalion leaders to train, assess, and continually develop the unit's resiliency programs. By 2012, more than 1000 Soldiers have been certified as Master Resilience Trainers.²⁵

Applied Suicide Intervention Skills Training (ASIST) and Train for Trainers (T4T). AR 600-63, Army Health Promotion, directs all gatekeepers to receive suicide intervention training and ALARACT 079-212 defines intervention training for gatekeepers as ASIST and ASIST T4T.²⁶ ASIST and ASIST T4T are suicide intervention training programs of two and five days respectively, for primary and secondary gatekeepers in the Army. Gatekeepers are characterized as personnel with inherent responsibilities as counselors or crisis intervention skills such as chaplains, medical professionals, military police, or family advocacy programmers.²⁷ By January, 2013, the ARNG had more than 450 personnel certified in ASIST T4T and 6761 ASIST certified gatekeepers with a goal of 10% of its total force, or approximately 35,000, ASIST certified.²⁸

ARNG service members are not limited solely to Guard suicide mitigation and resiliency programs for help. For instance, all members of the seven reserve

components can access Vets4Warriors, a 24-hour a day toll-free peer-to-peer hotline, live-chat or email service staffed with veterans from all military branches. In addition to counseling Soldiers in need, the Vets4Warriors staff has immediate access to military health care providers or mental health clinicians in case of an emergency.²⁹ Military One Source (MOS) is another example of a program that is available to all members of the military. MOS is a web-based service that offers on-line, face-to-face, or telephonic counseling sessions (up to 12 for reserve component service members) across a broad spectrum of topics beyond behavioral health to include financial, employment and education related challenges for service members and families.³⁰

To further illustrate factors compounding the suicide problem in the ARNG, a look at the unique and wholly non-traditional service dynamics of the Guard Soldier is necessary.

Disadvantages for the Traditional Guard

Although suicide rates in the active Army reflect a continuing crisis, Soldiers on active duty have a number of favorable circumstances compared to their ARNG peers when it comes to resiliency programs and behavioral health treatment. Tricare, daily interaction between peers, more training time, and commanders who are authorized to direct behavioral health assessments are simply byproducts for the active duty Soldier, yet, these can indeed be inhibitors for the traditional ARNG soldier.

In comparison to their active duty counterparts, traditional ARNG commanders are constrained by two significant factors. First, their authority to direct a Soldier to a behavioral health evaluation can only be exercised while on duty such as drill weekends, annual training, or while mobilized. Second, a traditional ARNG Soldier who,

on his or her own volition, seeks help for mental health from a civilian provider while not on duty is under no obligation to report such activity to their ARNG leadership. This means an ARNG Soldier can indeed have severe behavioral health issues, even suicidal ideations while under the care of a civilian provider without ever informing his or her chain of command.

Limited interaction between traditional Soldiers and leaders will continue to confound suicide prevention efforts. Although NCO's, officers and Soldiers have received substantial suicide prevention awareness and training, personal interaction between Soldiers and leaders is usually no more than two days per month. Peer programs designed to encourage Soldiers to help a buddy may be suitable for active duty Soldiers in daily contact but are logically less effective for ARNG Soldiers who are only together for a monthly drill weekend. And, suicide prevention and resiliency programs compete with demanding drill-weekend training schedules and leave little room for leaders and peers to observe and detect at risk behaviors or for Soldiers to seek face-to-face counseling, even though counselors may be available.

Finally and perhaps most importantly, is the fact that ARNG Soldiers are not entitled to comprehensive behavioral health providers and treatments under the various Tricare programs as are active-duty service members. Unless mobilized, reserve component members are only eligible for Tricare Reserve Select (TRS), but are required to pay monthly premiums of nearly \$200 and annual outpatient deductibles approaching \$300, per family.³¹ When accounting for the fact that the highest risk demographic of suicides in the ARNG are males ages 18-24 coupled with a national unemployment rate of 17% for the same age group,³² Tricare Reserve Select is not

always an affordable option. And, whether an ARNG Soldier enrolls in TRS or has private health insurance, their distance from a military treatment facility may result in having a civilian behavioral health provider lacking experience in treating common stressors of military service members.³³

Unique Stressors of Traditional Guard Members

Disadvantages for ARNG members regarding suicide and resiliency programs are indeed troubling, but compounding those circumstances are stressors unique to the ARNG service and lifecycle.

The impact of multiple deployments causing the traditional Soldier to leave the workplace, deploy to a combat zone, and return home to resume civilian employment are challenges their active counterparts do not experience. Employment and financial related issues rank among the top stressors leading to suicides of ARNG service members from 2009-2012.³⁴ This is made evident by the fact that “the unemployment rates of Reserve and National Guardsmen, who often leave behind civilian jobs when they deploy, have more than quadrupled since 2007.”³⁵

Of course, the Army and the National Guard are under no obligation to obtain civilian employment for its citizen Soldiers. In fact, there are agencies and programs designed to assist traditional Soldiers with employment issues such as the Employer Support of the Guard and Reserve (ESGR). But until the national unemployment rate of over 17% for 18-24 year olds³⁶ (the highest risk age group for suicides) improves, employment will no doubt continue to compound the suicide problem of ARNG Soldiers.

In preparation for mobilization and deployment, Guard Soldiers must notify their civilian employer of the impending mobilization, which can be a precarious event, while

contemplating a potential loss in income. Although there are federal laws protecting reemployment rights, returning to civilian jobs after a year's absence, and often on the heels of experiences in a combat zone, is a challenging circumstance for many Soldiers. For ARNG members who are also business owners, deployments can bring extraordinarily difficult decisions regarding how to sustain the company in their absence, especially if they have employees relying on them for employment. Self Employed Soldiers such as electricians, truck drivers, or landscapers have the additional worry of losing clientele while deployed.

For family members of Guard Soldiers, deployments bring more than just the separation and absence of their loved one. Spouses and children are compelled to make several adjustments such as changes in income and a cumbersome and often confusing transition to military medical programs. Furthermore, unlike active-duty units comprised of garrison military communities with robust, experienced family readiness support groups (FRG's), many traditional Guard families live in communities where they are the only military family and have to rely on monthly or quarterly FRG meetings or social media venues for information.

Also, unlike their active counterparts, ARNG soldiers are rapidly demobilized and placed back into the surroundings of civilian life, often within days after redeployment from a combat zone. No longer surrounded by battle buddies and a military community supportive of Soldiers' needs, recently demobilized ARNG Soldiers often feel isolated, struggling to reintegrate with their families and communities.

Federal mobilizations and deployments are not the only obligations requiring citizen Soldiers to leave their jobs, families, and communities. ARNG service members

also have a commitment to respond to domestic emergencies at the order of a governor while their active duty counterparts do not. From 2001-2010 the Army and Air Guard experienced 3187 separate call-ups for domestic emergencies or operations totaling more than 9,130,357 man-days of duty.³⁷ Domestic emergencies and operations are not limited to hurricanes and wildfires. During this ten-year period, ARNG service members augmented patrol agents on the southwest border, assisted federal responders for the Deep Water Horizon crisis in the Gulf of Mexico, and provided security for the 2009 presidential inauguration in Washington, D.C. In August of 2005 alone the Army National Guard mobilized more than 45,000 Soldiers on title 32 status in response to hurricane Katrina while Operations Iraqi and Enduring Freedom were in full swing.³⁸

In contrast to federal mobilizations and deployments to war zones whereby Soldiers are often afforded several months' notice to prepare, traditional ARNG Soldiers are often called to support domestic emergencies with only a few days' notice and often with no fixed return date, exacerbating employment, family, or educational situations.

Characteristics of Effective Suicide Prevention Models

Unfortunately, empirical data measuring the effectiveness of specific suicide prevention programs remains problematic. For example, just because suicide rates are unchanged or regrettably increase does not mean a program is altogether ineffective. Conversely, a decrease in suicide rates is not necessarily an indicator of an effective suicide prevention program. Arguably, suicide prevention efforts in the Army are more prevalent than ever and yet, Soldiers continue taking their lives at an alarming rate.

In the ARNG, characteristics that make suicide prevention programs effective are those that target unique stressors and disadvantages experienced by traditional ARNG

service members. Specifically, effective programs mitigate the barriers experienced by traditional ARNG service. Thus they, (1) give ARNG Soldiers emergency access to licensed providers; (2) are at no cost to the Soldier to use and sustainable for the state to resource within its operational or training budget; (3) reach Soldiers regardless of their geographic dispersion; (4) educate civilian providers of military-related stressors, and (5) collaborate with community agencies and local resources.

The following are illustrations of states' efforts that have developed suicide prevention and postvention programs targeted specifically at the stressors experienced by traditional ARNG service members. These efforts are not 'best practices,' a term hardly appropriate when considering they are methods to prevent Soldiers from taking their own lives. Rather, the following are examples of deliberate, well planned and resourced strategies by states that have taken ownership of suicide prevention beyond mandates by the National Guard Bureau, the Army, and the Department of Defense.

New Hampshire. From 2007 to 2010, the civilian suicide rate for the state of New Hampshire was 13.4 per 100,000, above the national average of 11.9 per 100,000 for the same period. The last time the New Hampshire suicide rate was below the U.S. national rate was in 2004. Interestingly, over a six year period from 2007-2012, the New Hampshire Army National Guard experienced only two suicides within its population of more than 2700, meaning the state suffered no suicides in four out of six years the ARNG suicide rates were at their highest.³⁹ One attribute to this accomplishment may lie in the ownership with which the state's guard leadership has assumed in suicide prevention and the distinctive programs they have implemented to better understand suicides and how to reach Soldiers at risk.

In 2009, the New Hampshire National Guard entered into an enduring memorandum of agreement (MOA) with several state agencies including the Department of Health and Human Services (DHHS), the Office of the Chief Medical Examiner (OCME), crisis centers, law enforcement, two major hospitals and ten clinics. The most significant result of these memoranda is the fusing of state mental health professionals with ARNG leaders and behavioral health teams by way of liaisons and integrated councils for resiliency and suicide prevention programs. Under the agreements, emergency service providers in New Hampshire now ask patients seeking mental health treatment if they are military veterans during assessments, an important measure because the state has no military treatment facilities. The memoranda also permit emergency service personnel to provide ARNG leaders with non-personal information of a suicide event of a guard member, usually within 48 hours, allowing a more rapid response mechanism to hasten suicide postvention efforts with family members.

In 2009, with the benefit of an initial \$3.2 million earmark, the NH ARNG launched the Deployment Cycle Support Program (DSCP), a collaborative effort with the Department of Health and Human Services and the Easter Seals. With a network of approximately 100 licensed clinicians state-wide, deploying units are provided with embedded counselors 12 months prior to mobilization through 12 months after demobilization. Services are at no expense to the Soldier, can take place during drill weekends or arranged confidentially, and extend to family members, especially significant during deployments.⁴⁰

Thinking outside of the box: in 2012, the New Hampshire ARNG resiliency coordinator, the Director of Psychological Health and counselors from the Veterans Administration traveled to six Veteran of Foreign War posts across the state to brief suicide awareness and prevention to post members. Plans to deliver the same message to the state's 15,000 American Legion post members are scheduled in 2013. Clearly, the NH ARNG has leveraged suicide prevention resources from the highest levels of state government and has developed and embraced a community approach to get ARNG soldiers the help they deserve.

North Carolina. The “*Integrated Behavioral Health System*” or, IBHS, in North Carolina is arguably the most comprehensive suicide prevention model at the state-level. Launched in 2010, the system is staffed full-time by geographically assigned state-licensed clinicians and case-managers available 24 hours a day via toll-free telephonic service. However, the system's staff is not just for service members with a behavioral or emotional crisis. Providers are also available for ARNG unit leaders and commanders for consultation on handling behavioral health issues within their units. Indeed, from its inception in 2010 the system has logged more than 1800 calls with more than 700 from buddies, leaders, and unit commanders for help assisting other service members in need.⁴¹

Another important feature of the IBHS is the effective bridging of resources for Soldiers through dedicated case managers, whose sole responsibility is referring Soldiers to the appropriate military, state, or civilian resource for follow-on care. For instance, when a Soldier with suicidal ideations or a behavioral health crisis calls the system, they are first connected with a state-licensed provider to assess his or her

situation and get them the immediate help they need. When necessary, a case is initiated and the Soldier is assigned a case manager who personally “bridges the gap” between the Soldier and the appropriate resource such as the Veterans Administration, Department of Health and Human Services, or a Soldier’s private medical provider. Case managers personally follow-up with Soldiers within 48 hours of receiving an assessment from an IBHS provider and within 24 hours after scheduled clinical or non-clinical appointments.

Tennessee. A look at the suicide rates for the Tennessee Guard (TN ARNG) begs the question: why are they exemplified as a model program? Indeed, from 2007-2011, the TN ARNG experienced 13 suicides. Alarming, the state suffered 9 suicides in 2012, the highest of any state in the National Guard.⁴² Yet, the state has resourced and implemented a program giving Soldiers with suicidal ideations or an emotional health crisis an immediate telephonic connection to a licensed counselor 24 hours a day, 7 days a week, called **“Guard Your Buddy.”**

A joint effort of the Tennessee Guard, the Jason Foundation, and E4 Health, **“Guard Your Buddy”** is a comprehensive emotional health and resiliency resource for Soldiers and their families. However, its most distinctive feature is an application Soldiers can download to their personal cell phones that, when activated, connects them directly to a licensed mental health counselor specifically trained and resourced for the program. In time of an emotional crisis or suicidal ideations, Soldiers are no longer burdened with speculating who or from where they can get emergency help or, more importantly, how to pay for it.

The “**Guard Your Buddy**” program is no secret among the Tennessee service members, fortunately. From December 2011 through January 2013, the “**Guard Your Buddy**” application has been downloaded nearly 4000 times to personal cellular phones and has been activated for assistance more than 30 times. The Tennessee guard funded the approximately \$36,000 to initiate the program and the licensed providers are volunteers, making the “**Guard Your Buddy**” program remarkably inexpensive to resource and sustain.⁴³

California. “Studies show that military veterans with mental health problems trust peer counselors to help them more than traditional medical staff.”⁴⁴ California can be credited with perhaps the first deliberate, well-resourced and professionally trained peer support program in the Army National Guard targeted at suicide prevention. The state’s “**Peer to Peer Program**” (P-T-P) was conceived and launched in 2005 when the state experienced a record number of guard members deployed in support of Operation Iraqi Freedom and Operation Enduring Freedom and the state’s sole resource for resiliency and suicide prevention was its Chaplain Corps. The state chaplain, who coincidentally was the Sacramento Police Department Chaplain, proposed a program to the California Adjutant General that ultimately evolved into the “**Peer To Peer Program**”.

Because of its relative early date of origin of its prevention program, California struggled to find existing, reputable peer support programs with which to model. Fortunately, the program developers instinctively reached out to state law enforcement and emergency management agencies for guidance and developed a program ultimately recommended by the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury in 2011 as a “Best Practice Peer to Peer Support Program.”⁴⁵

Specifically, the program was based on collaboration and the blending of efforts and practices of the California Guard, the Sacramento Police Department, and area firefighting agencies.

Many states have peer support programs, yet California's P-T-P has two distinctive characteristics; the selection criteria and training of Peer-Support-Personnel (PSP) and, the unique obligations of PSP. Soldiers selected as a Peer-Support-Person are not just volunteers with time available or who can fit the training into their personal schedule. Candidates must first be screened and recommended by their unit's leadership who then submit an application to a selection board usually consisting of their chain-of-command and representatives of the Peer Support Program, for approval. After selection, candidates attend a three day course certifying them in assessment, problem solving, grief management, suicide intervention, substance abuse and ethics among other relevant areas. Upon completion of the course, PSP are committed to be available 24 hours a day, seven days a week as immediate responders to Soldiers experiencing an emotional crisis, not just during drill weekends or annual training. Since its inception in 2005, the state has trained more than 900 Soldiers with plans to maintain or increase the number of PSP in 2013 and beyond. The program is remarkably inexpensive and funding is drawn completely from the state training budget with each three day session costing approximately \$4000-\$5000, permitting up to five California Guard trainers to travel to a unit location to deliver the training.

Indiana. Although ARNG service members may have medical insurance that provides mental health care, their geographic displacement from a military treatment facility may compel them to seek care from a civilian provider. However, civilian

behavioral health care providers simply may not be trained or experienced in providing quality care to current or former military service members with military-service related stressors.⁴⁶

Realizing the need for a referral-based system of civilian behavioral health providers to treat service members experiencing military-related stressors, the Indiana National Guard developed the “***Star Behavioral Health Program***” (SBHP). Launched in 2011, the program solicits volunteers from across the state to join a network of mental health providers to better serve current and former military service members. Volunteer providers attend workshops of one to three days hosted by the state Director of Psychological Health. The curriculum educates mental health providers on the more prominent stressors experienced by military service members and families such as combat stress, separation anxiety, employment and relationship issues and substance abuse. Workshops incorporate cognitive processing therapy, prolonged exposure therapy, and suicidality.

Since its inception, the state has trained over 200 mental health providers across more than 40 counties and 111 zip codes in Indiana. Service members can access the SBHP website registry to locate a SBHP trained provider. Because all of the providers volunteer their time for training and various state institutions host the training events, the cost of the program is nominal and not dependant on the state’s Guard budget.

Oregon. The Oregon Army National Guard has certainly not been spared in terms of Soldier suicides, experiencing 12 from 2008-2012, one of the highest rates in the entire Army National Guard and exceeded only by nine other states.⁴⁷ Perhaps that

fact combined with the absence of active-duty military bases in the state precipitated the state's leadership to develop the "***Joint Transition Assistance Program***" (JTAP).

JTAP was developed in October of 2011, from a legacy of Oregon's family assistance programs since 2003, and is a comprehensive resource for service members of any branch and component residing within Oregon. Although the program targets service members transitioning from military service to civilian life, as its name suggests, it nonetheless serves guard and reserve component members and their families at any point in his or her service lifecycle. However, the program's effect on suicide prevention efforts in the state deserves notice.

The essence of JTAP is its staffing of 17 contracted and ASIST trained program coordinators in geographically dispersed locations throughout the state for the purpose of providing immediate, professional and local assistance to service members, especially those residing in remote communities. The program coordinators are full-time, are military veterans, and are trained to link service members with myriad of state and federal services and programs for veterans. Beyond suicide prevention, coordinators link service members to agencies for education, employment, personal finance, and the Veterans Administration, among others.⁴⁸

Because JTAP is a full-time responsibility, coordinators are available by phone 24 hours a day, 7 days a week, for immediate assistance or referral, a critical factor for Soldiers with a mental health crisis. Since its inception in October 2011 through April of 2012, JTAP program coordinators responded to at least 80 calls from service members experiencing thoughts of suicide, more than 300 calls for various mental health issues, and over 800 calls requesting health and welfare checks of service members.⁴⁹

JTAP is not solely a military effort. Program coordinators connect service members to dozens of state and private organizations for assistance such as the state Department of Labor, the Easter Seals Foundation, Select Oregon Employer Partners, the Oregon Reintegration Program and the American Legion, among others, who have signed on as part of the JTAP Reintegration Team. Considering the various factors causing suicides of ARNG Soldiers such as employment, family problems, isolation, and substance abuse, Oregon's Joint Transition Assistance Program clearly targets the right population with effective methods.

JTAP was initially funded in 2011 from a congressional earmark of \$1.6 million, primarily for the 17 program coordinators. The state has appropriated funding for the program through FY '13 however, projected DoD budget cuts and sequestration may compel the state to shift resources to other readiness priorities.

Recommendations: Modeling Effective Strategies

Across the 54 states and territories of the Army National Guard there are dozens of distinct suicide prevention "Best Practices" incorporating hotlines, web pages, peer programs, task forces and crisis teams.⁵⁰ These practices are in addition to the mandated suicide prevention programs of the National Guard Bureau and the Department of the Army such as ASIST, Directors of Psychological Health, and Master Resiliency Trainers.

Every one of the 54 states and territories of the Army National Guard are different. No two have identical structure, demographic make-up, deployment history, or economic circumstances. Therefore, many of the suicide prevention programs cannot be modeled nationally across the various ARNG communities. However, most, if not all,

of the disadvantages and unique stressors experienced by traditional ARNG Soldiers are consistent across the entire formation regardless of the organization or state to which they belong. Additionally, no state is exempt of Soldiers with insufficient medical insurance, intermittent contact with peers, or units and Soldiers geographically dislocated from military communities, although most do vary in degree.

To that end, the following state-level suicide prevention, post-vention, and resiliency programs are recommended for implementation across the Army National Guard.

The “**Guard Your Buddy**” program in Tennessee targets the ARNG population, most of whom have insufficient medical insurance or are geographically isolated from military communities. The “**Guard Your Buddy**” program, specifically the downloadable telephonic application, connects users instantly to a professional counselor in a crisis situation anytime and anywhere. The Tennessee guard funded the start-up cost of approximately \$36,000 and the application costs users \$.38 cents a month. Additionally, all of the behavioral health providers are volunteers making the program remarkably inexpensive and suitable as a prevention program in every state and territory, regardless of the scope of the suicide problem.

The “**Star Behavioral Health Program**”, developed by the Indiana ARNG, is a model for the entire Army National Guard for several reasons. First, it educates volunteer civilian mental health providers across the state, effectively collaborating military and community resources. Second, because all of the providers are volunteers, the program is virtually cost-free beyond the nominal expense of administering the website registry. Finally, with over 200 trained providers covering more than 40

counties, the program mitigates the disadvantage of the lack of military bases with medical communities experienced in serving members with military-related stressors. The “**Star Behavioral Health Program**” is poised to be an efficient, low-cost, suicide prevention program in any state or territory.

There is no shortage of peer to peer programs in the ARNG to promote resiliency. To a degree, Master Resiliency Trainers (MRT) and Applied Suicide Intervention Trainers (ASIST) are peer programs because they train suicide prevention to Soldiers at the Battalion and Company levels. But, it is no accident that the “**Peer-to-Peer Support Program**” of the California National Guard received national recognition as a model suicide prevention program. The program creatively incorporates peer support concepts of local fire and law enforcement agencies and is very selective of peer support candidates who are recommended by unit commanders and screened for qualification into the program. After a 3-day training course on problem solving, substance abuse, and suicide awareness, peer support candidates obligate their time for support 24 hours a day, 7 days a week, to fellow Soldiers.

Funding for the program is predominately for training peer support candidates, stemming generally from travel costs of the trainers, approximately \$4000-\$5000 per session that is taken from the state’s training budget. There are no operating costs of the program because all of the peer support personnel are volunteers. The program is highly regarded and was recommended as a “Peer Support Best Practice” by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury in 2011.⁵¹ The program is feasible, leverages community resources, and provides willing

and knowledgeable peer support to Soldiers in need anytime, anywhere, and should be modeled across the Army National Guard.

The “**Community Collaboration Model**” (CCM) constructed by the state of New Hampshire and the New Hampshire Guard is a superb example of civilian and military entities joining efforts to prevent suicides. This model merges the NH Guard’s Community Health Promotion Council with the state of New Hampshire’s Suicide Prevention Council, effectively eliminating redundancy but more importantly, promoting collaboration between state and National Guard health experts. The CCM is enduring, officially chartered and incorporates MOA’s between the NH ARNG and several state health and emergency entities to expand and expedite suicide prevention and post-vention efforts. Subcommittees of the joint council meet monthly to address issues of services to military veterans and families, suicide analysis, reporting, and training, and methods to improve resiliency in civilian and military communities.

Because the model blends existing state and National Guard personnel and resources, it does not require an operating budget. Furthermore, the state agencies comprising the councils and MOAs (Health and Human Services, Chief Medical Examiner, Fire and Law Enforcement) are part of every state’s emergency service agencies, making New Hampshire’s suicide prevention model suitable and feasible across the entire Army National Guard.

Finally, two distinct programs that are dependent on external resources for administration yet are nonetheless superb examples of state-level suicide prevention programs that, with some modification, may prove effective and sustainable. First, the “**Integrated Behavioral Health System**” of the North Carolina Guard. The IBHS

provides licensed clinicians free of charge, 24 hours a day not just to service members with an emotional crisis but also to Soldiers and leaders with behavioral health care concerns for others. Case managers assume ownership of Soldiers in need and connect them to appropriate resources. The system inherently tracks data and statistics to provide leaders and the medical community with critical mental health information. And, the “**Joint Transition Assistance Program**” or, JTAP, in Oregon. JTAP contracts 17 Program Coordinators who are prior service personnel and trains them extensively in suicide prevention, resiliency and other military service-related issues. These coordinators are then stationed strategically across the entire state to locally serve military-affiliated populations 24 hours a day.

JTAP mitigates the problem of guard members geographically dispersed from units or military installations because Oregon has no active military bases. Also, guard members know when they are in need of emotional support or are experiencing suicidal ideations, they can rely on a single, locally trusted veteran whose sole responsibility is their well-being. Program coordinators are also responsible for suicide post-vention follow-up to ensure service members receive appropriate care from the various medical and veteran communities.

Funding is the achilles heel for JTAP and the IBHS as program coordinators and case managers are compensated as full-time employees of the state but require external funding from federal entities.⁵² However, many states are not burdened with both being large geographically and lacking an active military installation, and therefore, can modify their programs accordingly. Small states or states with military communities may indeed require fewer program coordinators because covering 100% of the state is

unnecessary. Regardless, the expertise, trust, and availability of JTAP program coordinators and IBHS case managers are exactly what traditional guard service members want and need in time of an emotional crisis.

Final Recommendation. The Department of Defense, Veterans Administration, the Department of the Army and the National Guard Bureau may never fully appreciate or understand the scope of the suicide problem in the Army National Guard until traditional ARNG service members receive identical behavioral health care entitlements that active-duty service members receive. The Total Force deserves a total and equitable provision required resources for service-connected identified needs. Their commitments, sacrifices, and stressors as citizen-Soldiers are as compelling as their active-duty counterparts and their emotional health justifies at least as much consideration and resources.

Second, in conjunction with full-time behavioral health care, ARNG Commanders should have the authority to command-direct Soldiers to service-connected behavioral health assessments any time, not just on drill weekends, during annual training or upon mobilization. Peer-to-peer programs, hotlines, and resiliency efforts are not simply “one-weekend-a-month” suicide prevention programs, so why should ARNG commanders be constrained to direct mental health evaluations only while on duty? The authority to command-direct a service-connected mental health evaluation regardless of duty status will offer ARNG leaders significantly more leverage in preventing suicides within their ranks and improves a commander’s judgment of the overall mental health of their units anytime, especially important on the eve of a mobilization.

The statutory and budgetary barriers preventing these two measures are not insurmountable. Both require only the resolve of senior military and political leaders to help Soldiers from unnecessarily taking their own lives.

Conclusion

Framing suicides for the ARNG exclusively within the context of an era of recent persistent conflict is short-sided. Regardless of the spectrum or nature of a war, suicides in all services and components of the U.S. military are always a preventable and tragic loss of our most treasured resource: a Soldier's life. And, although parallels can clearly be drawn of the military experiences of active duty and National Guard Soldiers, the dynamic service obligations and stressors of traditional National Guard Soldiers are wholly unique and demand suicide prevention programs equally dynamic. Current sequestration, proposed budget cuts for the Army through 2020, and diminishing congressional earmarks will only further constrain the financial resources of the ARNG at the very time that the requirements are greatest for suicide prevention programs that are sustainable within the state's existing operational and training accounts.

Three overarching measures must be implemented to mitigate the confluences of these factors: Soldiers with suicidal ideations must have immediate, unambiguous access to a licensed professional to assess their situation, assist them through the crisis, and direct them to the appropriate level of care and follow-up. And, like the health care entitlements of their active duty counterparts, this access must be at no cost to the Soldier. Second, states that have few or no military installations must geographically network with civilian mental health providers to offer and encourage training in the

unique behavioral health stressors of military service members, especially those in the National Guard. Additionally, collaboration with community and state emergency, medical, occupational and veteran's agencies will leverage suicide prevention expertise not readily available or organic to National Guard entities. Several states have already formally joined efforts with these agencies, clearly demonstrating a willingness and desire to partner with National Guard service members. And third, state-level suicide prevention programs must be flexible and enduring to meet the unpredictable and uncertain future operational requirements for traditional Army National Guard Soldiers.

Endnotes

¹ Quote from General George Casey, Army Chief of Staff, Headquarters, Department of the Army, Washington, D.C., DA PAM 600-24, Health Promotion, Risk Reduction, and Suicide Prevention Rapid Action Review, 7 September 2010

² Quote from Major General Raymond Carpenter, Acting Director, Army National Guard. *The Army National Guard's Path to Greater Resilience*, Association of the United States Army, Voice for the Army – Support for the Soldier, December, 2010

³ Colonel George Glaze, Chief, Health Promotion Risk Reduction, "Army Suicide Prevention Suicide Trend Analysis" briefing slides, HQDA G1, the Pentagon, September 28, 2012.

⁴ James Griffith, PhD, "Suicide in the Army National Guard: An Empirical Inquiry," *Suicide and Life Threatening Behavior* 42, no. 1 (February 2012): 104-119.

⁵ Army National Guard Family Support Division, briefing slides, Army National Guard G1, Soldier and Family Support Division, Arlington, VA. January 8, 2013.

⁶ James Griffith, PhD, "Army Suicides: Known's and an Interpretive Framework for Future Directions," *Military Psychology* 24, no. 5 (September 10, 2012): 488-512.

⁷ Air National Guard, briefing slides, Air National Guard Calendar Year Number/Rate of Suicides – 1992-2011. National Guard Bureau J1, Arlington, VA.

⁸ Department of Defense, "Suicide Prevention and Risk Reduction Committee," briefing slides, October 9, 2012.

⁹ Army National Guard, “Year to Date Suicides-Cumulative: 2007-2012,” briefing slides, Army National Guard Soldier and Family Support Division, Arlington, VA October 3, 2012.

¹⁰ Griffith, “Army Suicides,” 491.

¹¹ Griffith, “Suicide in the Army National Guard,” 104-119.

¹² Army Suicide Prevention Program, “Reserve Component Trend Analysis,” briefing slides, Health Promotion, Risk Reduction Division HQDA G1, the Pentagon, October 9, 2012.

¹³ *National Defense Authorization Act of 2012*, Public Law 112-81, Section 703, 112th Congress., (December 31, 2012).

¹⁴ *Embedded Mental Health Providers for Reserves Act of 2010*, 111th Congress, 2nd Session., (April 28, 2010).

¹⁵ Department of Defense Instruction 6490.09, Directors of Psychological Health, Under Secretary of Defense for Personnel and Readiness, Washington, D.C., February 27, 2012, p. 1.

¹⁶ IBID, p. 5.

¹⁷ IBID, p. 9.

¹⁸ U.S. Department of the Army, *Health Promotion Risk Reduction Suicide Prevention Report 2010*, (Washington, D.C., U.S. Department of the Army, July 29, 2010).

¹⁹ U.S. Department of the Army, *Health Promotion, Risk Reduction, and Suicide Prevention Rapid Action Review*, DA PAM 600-24 (Washington, D.C: U.S. Department of the Army , September 7, 2010), p. 1.

²⁰ IBID, p. 3.

²¹ U.S. Department of the Army, *Army Health Promotion*, Army Regulation 600-63, September 7, 2010, (Washington, DC: U.S. Department of the Army).

²² Departments of the Army and Air Force, National Guard Bureau, Arlington, Virginia. *Army National Guard Resilience, Risk Reduction and Suicide Prevention Campaign Plan*, November 23, 2010.

²³ Army National Guard Health Promotion, Risk Reduction and Suicide Prevention, briefing slides, Army National Guard G1, Arlington, VA., p. 85.

²⁴ Craig Apperson MS., *Behavioral Health Needs in the National Guard: A Preliminary Overview*, National Guard Psychological Health Program, Western Region, April, 2010, p. 3.

²⁵ Army National Guard Suicide Mitigation Programs Information Paper, Soldier and Family Support Division, Arlington, VA., March 21, 2012

²⁶ U.S. Department of the Army, All Army Action Message 079/12, *Army Suicide Prevention Program*, March 27, 2012 (Washington, DC: U.S. Department of the Army).

²⁷ U.S. Department of the Army, *Army Health Promotion*, Army Regulation 600-63, September 7, 2010, and All Army Action Message 079/12, *Army Suicide Prevention Program*, March 27, 2012 (Washington, DC: U.S. Department of the Army).

²⁸ Marshall Bradshaw, Army National Guard G1, Soldier and Family Support Division, email message to author, January 24, 2013.

²⁹ LTC Maureen Weigl, Army National Guard G1, Chief, Family Programs Division, *Vets4Warriors National Peer Support Outreach Program*, Information Paper, September 28, 2012.

³⁰ Military One Source, March 12, 2013. <http://www.militaryonesource.mil/> (accessed February 8, 2013).

³¹ U.S. Department of Defense, Tricare Management, January 4, 2013. <http://www.tricare.mil/Welcome/Plans.aspx> (accessed February 22, 2013).

³² U.S. Department of Labor, U.S. Bureau of Labor Statistics, Employment and Unemployment Youth Summary, August 12, 2012.

³³ Defense Centers of Excellence for Psychological Health & Traumatic Brain Injury, *A Review of National Guard and Reserve Psychological Health and Traumatic Brain Injury Reintegration Needs*, December 29, 2011. P.9.

³⁴ Army Suicide Prevention Program, "Reserve Component Trend Analysis," briefing slides, Health Promotion, Risk Reduction Division HQDA G1, the Pentagon, October 9, 2012, p. 2.

³⁵ Army National Guard Health Promotion, Risk Reduction and Suicide Prevention, briefing slides, Army National Guard G1, Arlington, VA., p. 65.

³⁶ U.S. Department of Labor, U.S. Bureau of Labor Statistics, Employment and Unemployment Youth Summary, August 12, 2012, <http://www.bls.gov/news.release/youth.nr0.htm> (accessed February 8, 2013).

³⁷ United States Army and Air National Guard FY10 Domestic Response Report, briefing slides, February 23, 2011. National Guard Bureau J3, Arlington, Virginia.

³⁸ Department of Defense, *Defense Science Board Task Force on Deployment of Members of the National Guard and Reserve in the Global War on Terrorism*, September 2007, Office of the Under Secretary of Defense for Acquisition, Technology and Logistics. Washington, D.C., p. 17.

³⁹ National Alliance on Mental Illness - New Hampshire State Suicide Prevention Assembly. *New Hampshire's 2011 Suicide Prevention Annual Report, Suicide Across Lifespan*. P. 22.

⁴⁰ New Hampshire National Guard Joint Force Headquarters, New Hampshire National Guard 2011 Community Collaboration Model, briefing slides. Concord, New Hampshire.

⁴¹ North Carolina National Guard Joint Force Headquarters, NGNC Integrated Behavioral Health System, System Inception Data Report, January 10, 2013, Raleigh, North Carolina, p. 1.

⁴² Army National Guard, "Year to Date Suicides-Cumulative: 2007-2012," briefing slides, Army National Guard Soldier and Family Support Division, Arlington, VA October 3, 2012, p.5.

⁴³ Elizabeth Nielsen, Tennessee Army National Guard Suicide Prevention Program Manager, email message to author, February 19, 2013.

⁴⁴ Army National Guard Health Promotion, Risk Reduction and Suicide Prevention, briefing slides, Army National Guard G1, Arlington, VA., p. 153.

⁴⁵ Defense Center of Excellence for Psychological Health and Traumatic Brain Injury. *White Paper, Best Practices Identified for Peer Support Programs*. Arlington, Virginia, January 2011. P. 7.

⁴⁶ Army National Guard Health Promotion, Risk Reduction and Suicide Prevention, briefing slides, Army National Guard G1, Arlington, VA., p. 62.

⁴⁷ Army National Guard, "Year to Date Suicides-Cumulative: 2007-2012," briefing slides, Army National Guard Soldier and Family Support Division, Arlington, VA October 3, 2012, p.6

⁴⁸ Oregon National Guard, White Paper, "*The Role of the Joint Transition Assistance Program in the Oregon National Guard's Suicide Prevention Efforts*," Oregon National Guard J9 Directorate, Salem, Oregon. March 13, 2012.

⁴⁹ Phillip Jacques, "Joint Transition Assistance Program Overview Brief," briefing slides, Oregon National Guard J9 Directorate, Salem, Oregon, February 20, 2013.

⁵⁰ Army National Guard, Soldier and Family Support Division, “ARNG State-level Resilience, Risk Reduction and Suicide Prevention Programs and Best Practices.” Army National Guard, Arlington, VA. September, 2012.

⁵¹ Defense Center of Excellence for Psychological Health and Traumatic Brain Injury. *White Paper*, p. 7.

⁵² Timothy Merrit, Oregon Army National Guard Service Member and Family Support, J1 Directorate, email message to author, January 31, 2013.

