# PARITY for PATRIOTS

The mental health needs of military personnel, veterans and their families

NAMI
National Alliance on Mental Illness

June 2012


National Alliance on Mental Illness

*Find Help. Find Hope.*



NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research and is steadfast in its commitment to raising awareness and building a community of hope for all of those in need.

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## Introduction

The long wars are winding down and the troops are coming home, but thousands of military service members, veterans and their families must tend to the psychological wounds of battle for years to come. Mental health disorders, signature injuries of the wars in Iraq and Afghanistan, affect one in five active duty service members and are the most common cause of hospitalization.[1]

Spouses and children, particularly among the National Guard and Reserves, develop mental health conditions at about the same rate as service members yet many have scant health care coverage and scarce access to military-informed care.[1,3]

Too often, once a war is over, the mental health needs of those who have served are forgotten. They struggle with stigmatizing attitudes that surround mental health care and must navigate as many as four disjointed health care systems.

> "He just said he thinks he should walk out into traffic on Interstate 5 and end it all. That life is not worth living."
>
> - 911 Call Center Counselor[4]

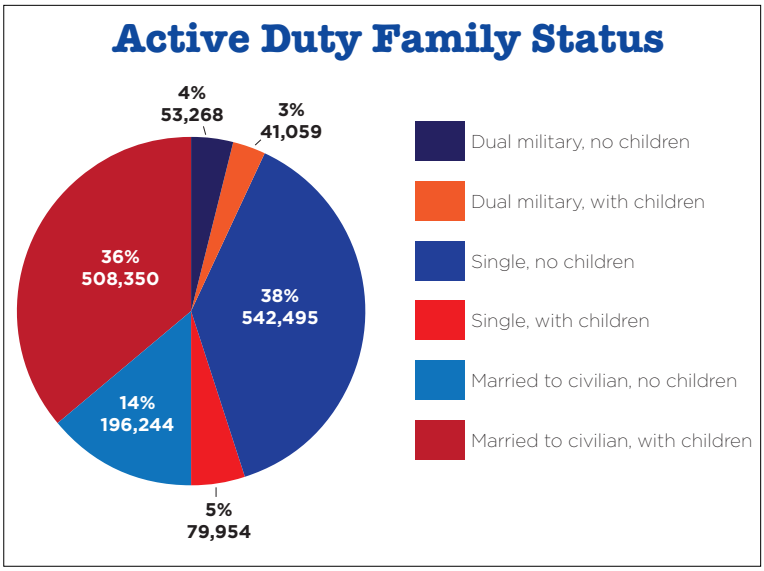
As a nation, we can learn from the past. Investment in the mental health of the active duty military, veterans and their families is integral to the cost of war. Early identification and military-informed care, specifically tailored to war experiences, can successfully return those who have served to full civilian life—and prevent escalating long-term costs of untreated mental disorders. Federal and state leaders need to ensure mental health parity for warriors and their families so they can access services when and where they are needed.

## Our Armed Forces

The active duty military is about 2.2 million at any one time[5] with the National Guard, at 800,000 strong, representing over one-third of the force. Twenty-three thousand troops will come home by the end of August, of the 91,000 troops deployed in Afghanistan as of April, 2012. The 68,000 who remain will gradually return through December, 2014.[6]

## Military Families

While resilience and self-sufficiency are woven through military culture, the weight of repeated deployments has fallen heavily on the estimated three million spouses and children who support Iraq and Afghanistan veterans. Today's service members are more likely to have families than veterans from previous eras. Over half (56 percent) of today's active duty military are married, 17 percent are women and 44 percent have children.[7] Care for children is an especially critical concern for 76,000 service members who are active duty single parents and 41,000 who are dual military parents.[8]




## Hidden Wounds

The current wars have required longer and more frequent deployments than at any other time since the military became an all-volunteer force in 1973.

- One in five (20 percent) active duty service members experienced symptoms of posttraumatic stress (PTS),[9] depression and other mental health problems.[10,11,12]
- Rates of PTS in veterans of the Iraq and Afghanistan wars range from five to 37 percent, while rates of depression were found to be as high as 27 percent.[13,14] The Veterans' Administration has treated more than 400,000 post 9/11 veterans for a mental health problems.[15]
- About one in five active duty service members engage in chronic heavy drinking.[16]
- Drug abuse, including prescription drugs, increased from five percent in 2005 to 12 percent in 2008.[17] Drug or alcohol abuse was involved in one-third of the Army suicide deaths from 2003 to 2009.
- Military suicide is a national crisis with one active duty soldier taking his or her own life every 36 hours and one veteran every 80 minutes.[18]
- Suicide has increased within the National Guard and Reserve, even among those who have never been officially "activated" and are not eligible for care through the Veterans' Administration.[19]

Veterans returning home often live in remote areas or do not have the transportation necessary to get to appointments. Many experiencing mental health issues simply do not have the energy or resources to travel several hours each way to have "face-to-face" visits with mental health professionals and are not approved to seek local care on a fee-basis from the Department of Veterans' Affairs (VA), Veterans Health Administration (VHA). The VHA has increased telehealth capacity for mental health treatment,[20] but many veterans have little access to the technology that a distance delivery system can offer.

On the home front, spouses and children have been left to manage the fallout from intensified deployment cycles. In fact, mental health conditions such as depression and PTS are as prevalent in families as in service members.[21] A study of over 250,000 military spouses showed that more than one-third (37 percent) were diagnosed with at least one mental disorder, most frequently anxiety, depression or sleep disorders. Rates of depression rose dramatically with deployments longer than 11 months.[22] More than a third (34 percent) of Michigan National Guard spouses met criteria for mental health problems such as PTS and depression, according to a 2011 study.[23]

PTS can combine with financial and interpersonal stress to make home life difficult. Service members and veterans living with PTS, especially if co-occurring with other mental or substance abuse conditions, are at extremely high risk for domestic violence—up to 58 percent. Military spouses are often isolated from their extended family and may not report abuse for fear of retaliation or inadequate protection by authorities.[24] Divorce, which had been lower in the military than in the general public, has climbed steadily since 1999.[25]

Although most of the 776,000 children with active duty parents adapt and thrive despite the challenges of parental deployment,[26] one-third of children with at least one deployed parent have had psychological challenges such as acute stress reaction, depression, anxiety and behavioral disorders,[27] which intensified with longer deployments.[28] Older children and teens can be at greater risk for behavioral issues and are more likely to have difficulty reconnecting with parents after long deployments.[29]

**National Suicide Prevention Hotline**

Includes Military and Veterans

**1-(800)-273-TALK (8255)**

The National Suicide Prevention hotline is a confidential lifeline for all callers, including active duty military personnel, National Guard members and veterans.

Anyone who is feeling distressed or hopeless, thinking about death or wanting to die—or is concerned about someone else who may be suicidal—is encouraged to call the lifeline at 1-(800)-273-TALK (8255) anytime, day or night.

Callers will be immediately connected to one of over 150 local crisis centers nationwide or to the national Military and Veterans Crisis Lines. For more information, please visit www.suicdepreventionlifeline.org or www.veteranscrisisline.net. Calls are kept confidential.

## Service System

To get help, service members, veterans and their families must navigate the rocky terrain between four health care systems:

- *Department of Defense (DoD), In Theater*: During deployment chaplains provide supportive counseling. Embedded mental health specialists engage service members in treatment for intensive psychological wounds.
- *Department of Defense, Stateside*: Community-based and hospital mental health care are available at military installations. Online counseling, information and referral can be accessed at any time through resources such as Military OneSource. TRICARE, the military health insurance program, contracts with a network of mental health providers in communities nationwide.
- *Veterans Health Administration (VA)*: The VHA provides inpatient and outpatient care through a network of health facilities and community clinics. Individual, marital, group and grief counseling are available through community based vets centers.
- *Civilian health system*: Those who do not qualify, or do not wish to access care, through the DoD and VHA systems, rely on employer sponsored health coverage and public community mental health systems.

**Military/Veteran Health Systems[1]**

| System | Services Offered Through (or By) | Population |
|---|---|---|
| Department of Defense, In Theater | • Embedded mental health providers<br>• Chaplains: supportive counseling<br>• Treatment facilities in theater | • Active duty forces in theater |
| Department of Defense, Stateside | • Embedded mental health providers<br>• Chaplains: supportive counseling<br>• Military Treatment Facility (TRICARE)<br>• Military OneSource<br>• Community providers in TRICARE network | • Active duty<br>• Guard/ Reserve[a]<br>• Retired military<br>• Dependents of active duty, military retirees and Guard/Reserve |
| Veterans Health Administration | • VHA health facilities and clinics<br>• VHA polytrauma centers[b]<br>• Vet Centers | • Combat veterans<br>• Individuals with service-connected disability[c] |
| Community | • Private physicians or clinics | • Veterans with non service-connected mental health needs<br>• Guard/Reserve and their dependents, based on duty status |

[1]Tanielian, T., & Jaycox, L.H. (2008) Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery. Retrieved from www.rand.org/pubs/monographs/2008/RAND_MG720.pdf
[a]Based on duty status and TRICARE eligibility
[b]Active-duty service members with multiple combat-related injuries may receive initial care through the VA polytrauma centers and may transfer back to DoD upon recovery.
[c]Access is based on priority rating system and enrollment; for those without rating, depends on time since separation from service.

## Parity Barriers: Policies

Despite sustained effort to improve screening, assessment and treatment capacity, the DoD and VA have a long way to go. Recovery for service members, veterans and their families is complicated by onerous eligibility requirements for services and benefits, lack of continuity between health care systems, inadequate private health care coverage and too few practitioners qualified to provide military-informed treatment. The need is particularly critical for returned National Guard and Reserve members and their families who have endured the same stresses of multiple deployments as the regular armed forces, yet often live in remote areas away from military bases with far less access to effective care.

Veterans who seek mental health care can find the VA medical system hard to penetrate. More than 1.3 million working-age veterans have no health insurance with those under age 35 least likely to be covered.[30] While veterans with service-connected conditions officially qualify for up to five years of free care through the VA, delayed onset of PTS and depression complicates eligibility. A recent study by the VA Inspector General found that more than one-half of the veterans seeking mental health care for the first time waited 50 days for an assessment. The VA had a backlog of over 897,000 claims for disability benefits with two-thirds pending more than 125 days.[31]

> "Getting our veterans timely mental health care can quite frankly often be the difference between life and death...What's particularly disappointing is that...the VA is failing many of those who have been brave enough to seek care...Once a veteran takes the step to reach out for help we need to knock down every potential barrier to care."
>
> - U.S. Sen. Patty Murray (Washington)[32]

In 2008, President George Bush signed into law the landmark Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. This mental health parity law requires employer-sponsored group health insurance plans to cover mental illness and substance use disorders on the same terms and conditions as other medical disorders, *i.e.* at "parity." Since then, discriminatory limits on mental health benefits such as higher deductibles, higher co-payments as well as shorter limits on the length of hospital stays and the number of outpatient visits have become a thing of the past. At the same time, more subtle forms of insurance discrimination, such as increased prior authorization restrictions for specific mental health benefits, exclusion of entire categories of services and more aggressive restrictive management of benefits, have kept the law from achieving its full, intended potential.

The parity law affects veterans and their families, as well as other Americans. It is a major component for ensuring that those veterans who do not rely on the VA system, but are in the nation's work force, get the help they need when they need it for mental health conditions. Ending discrimination in insurance coverage is also a means of changing the broader culture of stigma and discrimination that traditionally has surrounded mental illness—and for too long has created barriers of silence and discouraged veterans and others from seeking help in the first place.

On the plus side, the Obama Administration issued an "interim final regulation" to implement the parity law in 2010. However, "publication" of the final regulation has not yet occurred. This technical, seemingly obscure bureaucratic process has immense legal significance. Until the final regulation is in place, limits on restrictive management of benefits and "scope of services" will not be legally binding on insurance plans. Until action occurs, veterans and their families, as well as others, will find that equitable coverage of mental health care falls short—at a time when, in the aftermath of war, it is greatly needed.

## Parity Barriers: Attitudes

Active duty service members tend to be reluctant to seek mental health treatment because they live in a warrior culture of "toughing it out." Although trends are improving, service members resist seeking professional help believing it will delay their return home or will limit career advancement. Military leaders have been instructed to encourage those under their command to get help at the earliest opportunity, yet too many remain mired in the perspective that asking for mental health care is a sign of weakness.

> "Our post-deployment mental health screening took place with the entire unit sitting down with the chaplain, and the chaplain asking if we had any problems, and the commanding officer saying that no one had any problems."
>
> - Dan West retired, noncommissioned Army officer[33]

The Department of Defense has invested significant resources in mental health treatment and suicide prevention programs for troops. However, it is hard to imagine that these efforts will succeed until attitudes and environmental barriers that too often discourage soldiers from seeking help when they most need it are overcome. A recent statement by Major General Dana Pittard at Ft. Bliss is an example of these attitudes:

"I have now come to the conclusion that suicide is an absolutely selfish act. I am personally fed up with soldiers who are choosing to take their own lives so that others can clean up their mess. Be an adult, act like an adult and deal with your real-life problems like the rest of us."[34]

Families also resist seeking care for themselves for fear of embarrassment within tight-knit military communities and out of concern for the professional prospects of the service member. Although the military and veterans' health systems are promoting help seeking as a sign of strength, change is slow.

> "Spouses tell me all the time that they want to get mental health assistance. As incorrect as this is, they really do believe if they seek help it will have a negative impact on their spouse's military career."
>
> - Deborah Mullen, wife of Admiral Mike Mullen, former chairman, Joint Chiefs of Staff[35]

## Call to Action

The **U.S. Department of Defense** must move more forcibly to end discrimination associated with invisible wounds of war. Reducing the stigma of mental illness will enhance opportunities to deliver prompt, effective treatment to military service members and families who live with PTS, depression and other mental health conditions. Examples of immediate steps that can be taken to eliminate stigma and barriers to seeking help include:

- *Military leader accountability for stigma and suicide*: Military leaders throughout the chain of command should be required to focus on preventable psychological injuries and deaths, which should be part of their efficiency reporting process. Suicides are preventable just as are the heat and cold injuries of service members for which leaders are routinely relieved of command.

- *Purple Heart for psychological wounds*: Posttraumatic stress and other mental health injuries, that are the result of hostile action, including terrorism, should be eligible for award of the Purple Heart with the same level of appreciation and recognition as those awarded to warriors with visible wounds.

The **Veterans Health Administration** must increase service capacity by expanding provider networks to include community mental health agencies and private practitioners. The VHA should monitor the degree to which contract providers accept veterans and families as clients and should adjust networks to make care available when and where it is needed. Ongoing training in military-informed mental health treatment should be a basic requirement for contract providers. Improved distance delivery through technology should be implemented to remove the travel burden from veterans and improve the use of professional care giver time.

The **U.S. Department of Health and Human Services** must move immediately to fully implement and enforce the federal parity law enacted four years ago.

The **American people** must reach out, listen and care. We must support those who have shouldered the burden of our longest war. Simple things will make the difference. Neighbors, friends, family and employers can relieve emotional pressure or make it possible to get to treatment by watching the  children, providing a ride or granting time off work. We can applaud the strength it takes to recognize a problem and seek help. We can support veterans and military families as they reach back to help others heal. Most importantly, we must seek them out, because military families will not generally come to us. Saying "call me if you have a problem" is not enough. We must nurture the bond and maintain communication.

> "In every community, every day, we can find concrete ways to show our military families the respect and gratitude the each of us holds for them in our hearts. They deserve our support long after welcome home ceremonies are over...Every American can do something."
>
> - First Lady Michelle Obama and Dr. Jill Biden[36]

## Conclusion

Just as warriors do not forsake wounded comrades in battle, our nation must leave no service member, veteran or their families behind.

NAMI calls upon the Department of Defense, the Department of Veterans' Affairs and the Department of Health and Human Services to eradicate barriers to mental health care and increase service capacity through use of technology and local care. Our country must do what it takes to encourage service members, veterans and their families to get help when and where it is needed. As citizens—neighbors, employers and friends—we must reach out, listen and care.

Because military culture is about service and heroism, service members, veterans and their families have much to teach us. Once they have the tools necessary to heal from the hidden wounds of war, they can reach back to help others and, in the process, will help strengthen our nation.

# Appendix I

| Military/Veteran Population by State | | | | | |
|---|---|---|---|---|---|
| State | Regular Armed Forces | National Guard/ Reserve | Veterans | State Totals | % of National Total |
| California | 117,806 | 57,792 | 1,594,873 | 1,770,471 | 9.09% |
| Texas | 131,548 | 56,367 | 1,290,655 | 1,478,570 | 7.59% |
| Florida | 42,642 | 34,653 | 1,310,403 | 1,387,698 | 7.13% |
| New York | 29,553 | 30,362 | 784,310 | 844,225 | 4.34% |
| Pennsylvania | 5,215 | 32,297 | 781,136 | 818,648 | 4.20% |
| Ohio | 8,261 | 28,523 | 704,861 | 741,645 | 3.81% |
| North Carolina | 116,073 | 22,542 | 575,069 | 713,684 | 3.66% |
| Virginia | 63,160 | 25,109 | 608,919 | 697,188 | 3.58% |
| Georgia | 73,988 | 29,358 | 565,955 | 669,301 | 3.44% |
| Illinois | 10,111 | 25,084 | 625,532 | 660,727 | 3.39% |
| Michigan | 2,858 | 17,618 | 561,364 | 581,840 | 2.99% |
| Washington | 46,161 | 19,470 | 482,031 | 547,662 | 2.81% |
| Arizona | 21,343 | 13,728 | 427,264 | 462,335 | 2.37% |
| Missouri | 17,925 | 23,769 | 392,387 | 434,081 | 2.23% |
| Tennessee | 3,511 | 20,606 | 379,172 | 403,289 | 2.07% |
| Indiana | 3,108 | 21,073 | 376,510 | 400,691 | 2.06% |
| New Jersey | 6,673 | 17,312 | 373,749 | 397,734 | 2.04% |
| Maryland | 29,160 | 16,000 | 352,466 | 397,626 | 2.04% |
| Colorado | 35,404 | 12,491 | 321,623 | 369,518 | 1.90% |
| South Carolina | 32,518 | 19,102 | 306,758 | 358,378 | 1.84% |
| Alabama | 11,896 | 22,099 | 310,808 | 344,803 | 1.77% |
| Massachusetts | 3,205 | 15,335 | 326,004 | 344,544 | 1.77% |
| Wisconsin | 2,046 | 15,833 | 325,371 | 343,250 | 1.76% |
| Minnesota | 1,897 | 19,256 | 301,562 | 322,715 | 1.66% |
| Kentucky | 43,138 | 13,126 | 257,910 | 314,174 | 1.61% |
| Oklahoma | 21,673 | 15,640 | 258,475 | 295,788 | 1.52% |
| Louisiana | 17,398 | 18,011 | 246,743 | 282,152 | 1.45% |
| Oregon | 1,615 | 10,470 | 262,662 | 274,747 | 1.41% |
| Kansas | 25,482 | 11,479 | 179,415 | 216,376 | 1.11% |
| Arkansas | 6,717 | 13,051 | 195,182 | 214,950 | 1.10% |
| Iowa | 1,296 | 12,390 | 190,761 | 204,447 | 1.05% |
| Nevada | 10,034 | 6,087 | 180,970 | 197,091 | 1.01% |
| Connecticut | 1,914 | 6,369 | 186,934 | 195,217 | 1.01% |

Continued...

# Appendix I (continued)

| Military/Veteran Population by State | | | | | |
|---|---|---|---|---|---|
| State | Regular Armed Forces | National Guard/ Reserve | Veterans | State Totals | % of National Total |
| Mississippi | 9,895 | 17,332 | 162,506 | 189,733 | 0.97% |
| New Mexico | 11,038 | 5,199 | 134,528 | 150,765 | 0.77% |
| West Virginia | 1,199 | 9,303 | 132,943 | 143,445 | 0.74% |
| Hawaii | 40,874 | 9,276 | 88,661 | 138,811 | 0.71% |
| Utah | 6,237 | 11,999 | 120,415 | 138,651 | 0.71% |
| Nebraska | 6,845 | 7,498 | 117,530 | 131,873 | 0.68% |
| Idaho | 4,967 | 5,892 | 104,933 | 115,792 | 0.59% |
| Maine | 730 | 4,153 | 105,586 | 110,469 | 0.57% |
| New Hampshire | 675 | 4,251 | 95,906 | 100,832 | 0.52% |
| Montana | 3,623 | 4,748 | 78,610 | 86,981 | 0.45% |
| Alaska | 23,178 | 4,747 | 55,548 | 83,473 | 0.43% |
| Delaware | 3,870 | 4,881 | 59,124 | 67,875 | 0.35% |
| South Dakota | 3,910 | 4,982 | 56,487 | 65,379 | 0.34% |
| Rhode Island | 1,490 | 4,438 | 59,320 | 65,248 | 0.34% |
| North Dakota | 7,209 | 4,669 | 44,018 | 55,896 | 0.29% |
| Wyoming | 3,407 | 3,218 | 43,307 | 49,932 | 0.26% |
| D.C. | 13,424 | 6,378 | 28,794 | 48,596 | 0.25% |
| Vermont | 565 | 3,952 | 39,825 | 44,342 | 0.23% |
| US Total | 1,088,465 | 819,318 | 17,565,876 | 19,473,659 | 100.01% |

Source: Department of Defense. (2010) Demographics 2010: Profile of the military community. Retrieved from www.militaryhomefront.dod.mil/12038/Project%20Documents/MilitaryHOMEFRONT/Reports/2010_Demographics_Report.pdf

# Appendix II

| Military Families by State | | | Military Families by State<br>Ranked highest to lowest | | |
|---|---|---|---|---|---|
| State | Dependents at Installations | % All States | State | Dependents at Installations | % All States |
| Alabama | 16,541 | 0.98% | Virginia | 193,479 | 11.41% |
| Alaska | 30,553 | 1.80% | Texas | 183,166 | 10.80% |
| Arizona | 29,669 | 1.75% | California | 174,617 | 10.30% |
| Arkansas | 7,702 | 0.45% | North Carolina | 153,036 | 9.03% |
| California | 174,617 | 10.30% | Georgia | 109,662 | 6.47% |
| Colorado | 61,654 | 3.64% | Washington | 86,274 | 5.09% |
| Connecticut | 7,462 | 0.44% | Florida | 75,713 | 4.47% |
| Delaware | 4,699 | 0.28% | Kentucky | 72,780 | 4.29% |
| D.C. | 21,901 | 1.29% | Hawaii | 66,963 | 3.95% |
| Florida | 75,713 | 4.47% | Colorado | 61,654 | 3.64% |
| Georgia | 109,662 | 6.47% | Kansas | 43,265 | 2.55% |
| Hawaii | 66,963 | 3.95% | South Carolina | 40,162 | 2.37% |
| Idaho | 5,141 | 0.30% | Maryland | 38,667 | 2.28% |
| Illinois | 20,172 | 1.19% | New York | 37,009 | 2.18% |
| Indiana | 1,742 | 0.10% | Oklahoma | 34,402 | 2.03% |
| Iowa | 393 | 0.02% | Alaska | 30,553 | 1.80% |
| Kansas | 43,265 | 2.55% | Arizona | 29,669 | 1.75% |
| Kentucky | 72,780 | 4.29% | Louisiana | 26,996 | 1.59% |
| Louisiana | 26,996 | 1.59% | Missouri | 22,782 | 1.34% |
| Maine | 923 | 0.05% | D.C. | 21,901 | 1.29% |
| Maryland | 38,667 | 2.28% | Illinois | 20,172 | 1.19% |
| Massachusetts | 3,079 | 0.18% | Alabama | 16,541 | 0.98% |
| Michigan | 2,476 | 0.15% | New Mexico | 16,365 | 0.97% |
| Minnesota | 1,390 | 0.08% | Nevada | 13,853 | 0.82% |
| Mississippi | 12,945 | 0.76% | Mississippi | 12,945 | 0.76% |
| Missouri | 22,782 | 1.34% | Ohio | 12,413 | 0.73% |
| Montana | 3,936 | 0.23% | Nebraska | 9,460 | 0.56% |
| Nebraska | 9,460 | 0.56% | New Jersey | 9,022 | 0.53% |
| Nevada | 13,853 | 0.82% | North Dakota | 8,190 | 0.48% |
| New Hampshire | 1,510 | 0.09% | Arkansas | 7,702 | 0.45% |
| New Jersey | 9,022 | 0.53% | Connecticut | 7,462 | 0.44% |
| New Mexico | 16,365 | 0.97% | Utah | 7,413 | 0.44% |
| New York | 37,009 | 2.18% | Pennsylvania | 5,570 | 0.33% |

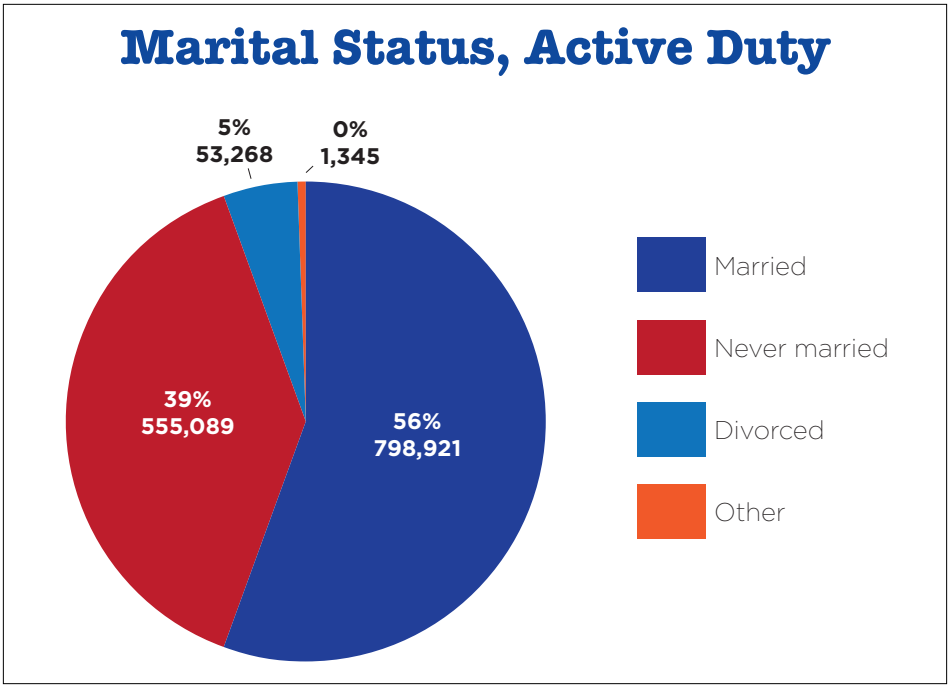
Continued...

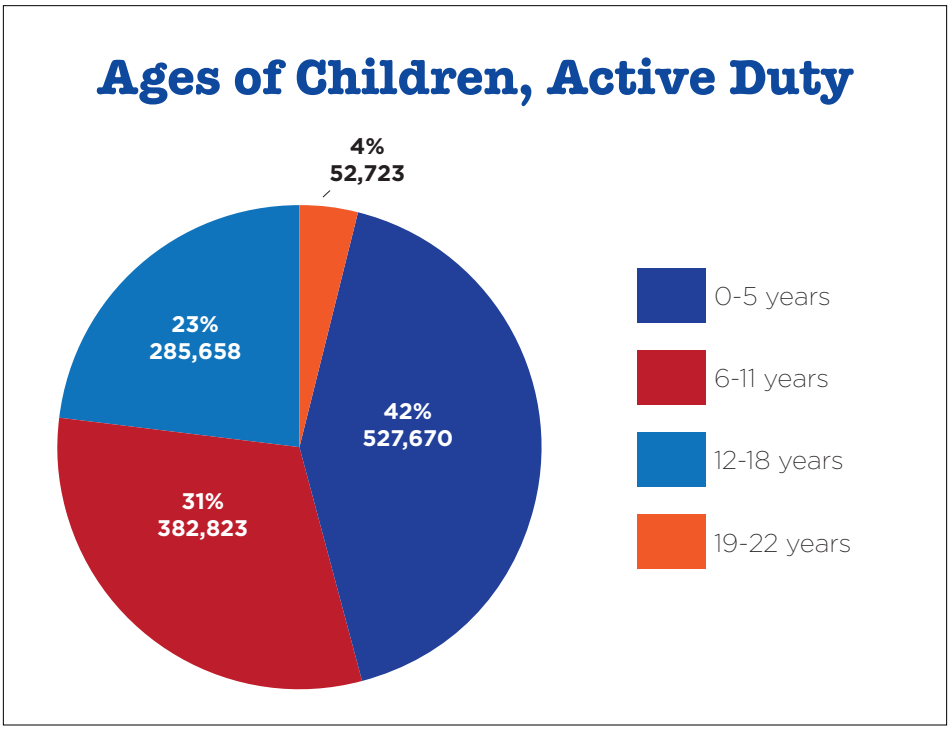
# Appendix II (continued)

| Military Families by State | | | Military Families by State Ranked highest to lowest | | |
|---|---|---|---|---|---|
| State | Dependents at Installations | % All States | State | Dependents at Installations | % All States |
| North Carolina | 153,036 | 9.03% | Idaho | 5,141 | 0.30% |
| North Dakota | 8,190 | 0.48% | Tennessee | 5,057 | 0.30% |
| Ohio | 12,413 | 0.73% | Delaware | 4,699 | 0.28% |
| Oklahoma | 34,402 | 2.03% | South Dakota | 4,590 | 0.27% |
| Oregon | 1,062 | 0.06% | Wyoming | 4,050 | 0.24% |
| Pennsylvania | 5,570 | 0.33% | Rhode Island | 3,950 | 0.23% |
| Rhode Island | 3,950 | 0.23% | Montana | 3,936 | 0.23% |
| South Carolina | 40,162 | 2.37% | Massachusetts | 3,079 | 0.18% |
| South Dakota | 4,590 | 0.27% | Michigan | 2,476 | 0.15% |
| Tennessee | 5,057 | 0.30% | Indiana | 1,742 | 0.10% |
| Texas | 183,166 | 10.80% | New Hampshire | 1,510 | 0.09% |
| Utah | 7,413 | 0.44% | Minnesota | 1,390 | 0.08% |
| Vermont | 146 | 0.01% | Wisconsin | 1,136 | 0.07% |
| Virginia | 193,479 | 11.41% | Oregon | 1,062 | 0.06% |
| Washington | 86,274 | 5.09% | Maine | 923 | 0.05% |
| West Virginia | 502 | 0.03% | West Virginia | 502 | 0.03% |
| Wisconsin | 1,136 | 0.07% | Iowa | 393 | 0.02% |
| Wyoming | 4,050 | 0.24% | Vermont | 146 | 0.01% |
| US Total | 1,695,640 | 100.00% | US Total | 1,695,640 | 100.00% |

Source: Department of Defense. (2010) Demographics 2010: Profile of the military community. Retrieved from www.militaryhomefront.dod.mil/12038/Project%20Documents/MilitaryHOMEFRONT/Reports/2010_Demographics_Report.pdf

# Appendix III




Source: Department of Defense. (2010) Demographics 2010: Profile of the military community. Retrieved from www.militaryhomefront.dod.mil/12038/Project%20Documents/MilitaryHOMEFRONT/Reports/2010_Demographics_Report.pdf

# Endnotes


[1]Armed Forces Health Surveillance Center. (Apr. 2012) Hospitalizations among members of the active component, U.S. Armed Forces, 2011. *Monthly Medical Surveillance Report, 9*(4). Retrieved from www.afhsc.mil/viewMSMR?file=2012/v19_n04.pdf#Page=10

[2]*Ibid.*

[3]Swofford, A. (May 2012) The epidemic of military suicides. *Newsweek*. Retrieved from www.thedailybeast.com/newsweek/2012/05/20/anthony-swofford-on-the-epidemic-of-military-suicides.html

[4]*Ibid.*

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