Department of Defense
Calendar Year 2019
Annual Suicide Report

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Actions to Curtail Near and Long-Term Effects of COVID-19

- We recognize the potential impact of COVID-19 on the psychological well-being of our military community.
- Closely monitoring data and coordinating across DoD and external partners to mitigate impact of potential risk factors via a variety of initiatives.
- At this time, it is too early to determine whether suicide *rates* will increase in CY 2020.
  - While there can be a noticeable increase or decrease in suicide *counts* over time; counts do not account for changes in population size or provide enough time for essential investigations to determine cause of death.
  - These may not be statistically meaningful once investigations complete and we conduct necessary analyses.
  - DoD only assesses *suicide trends after accounting for changes in population size*. *Suicide rates* (as opposed to counts) are required, to determine whether a true increase or decrease in suicides have occurred.

<u>Initiatives Underway to Curtail Effects of COVID-19:</u>

- Providing virtual behavioral health, helplines and call centers, and developed tailored products/resources.
  - Sharing across variety of communication venues, including Military OneSource, websites, virtual leadership engagements, and Service/unit social media channels.
  - Examples: “Tips on Staying Safe and Connected” resource; Military OneSource non-medical counseling and peer support services; financial readiness resources from accredited financial counselors; Veterans/Military Crisis Line and the National Suicide Prevention Lifeline.
- Promoting connectedness to counter physical distancing.
  - Collaborating with partners (e.g., PREVENTS) to share communications that help individuals cope with stress and anxiety and seek support.
  - Leveraging DoD’s Suicide Prevention Month campaign to focus on promoting connectedness.

Actions Taken Since CY 2018 ASR

- Since last ASR, made progress in developing and fielding programs targeting populations of greatest concern in CY 2018, as well as our military families.
- 2019 Action – Increase skills for young and enlisted members:
  - Developed and ***initiated pilot of an educational program to teach foundational skills*** to deal with life stressors early in their military career, particularly those unique to our young, enlisted members.
  - Developed ***video training on how to recognize and respond to suicide warning signs*** on social media; "*Simple Things Save Lives"* now being evaluated before broader use across DoD.
- 2019 Action – Develop interagency partnership with Veterans Affairs to increase counseling access:
  - Since 2019, **14% increase in National Guard members receiving services during drill weekends and 44% increase at Vet Center locations**.
- 2019 Action – Support military families:
  - Trained 2,000 non-medical military providers to provide ***Counseling on Access to Lethal Means (CALM)*** to Service members and families. 90% of counselors increased knowledge/counseling skills.
  - Published ***Postvention Toolkit*** to increase resilience and awareness of support resources.
- 2019 Action – Better measure program effectiveness:
  - With Services, integrated the seven broad, evidence-informed strategies for suicide prevention from the Centers for Disease Control and Prevention (CDC) into the DoD-wide **program evaluation framework**.
    - **Baseline data** was collected/analyzed; starting point to track progress/effectiveness.
- Took proactive steps, including an information campaign, to mitigate well-being impacts of COVID-19.

Component Suicide Rates

↑ Statistical Increase
↓ Statistical Decrease
↔ No Statistical Increase or Decrease Over Time

CY 2014-2019 Component Suicide Rates, per 100,000 Service Members

LONGER-TERM
CY 2014-2019

AC ▶ ↑
R ▶ ↔
NG ▶ ↔

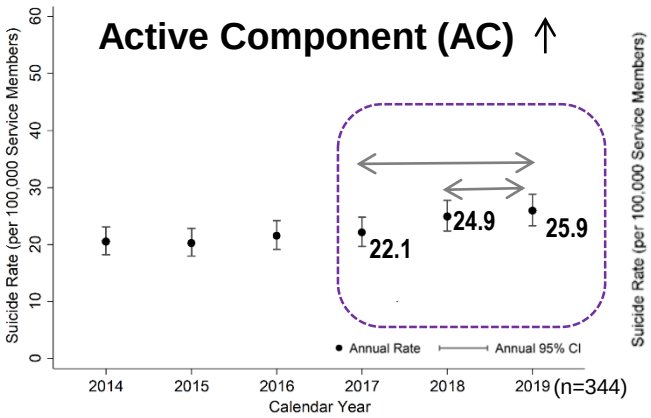
CY 2018 ASR: Same Findings

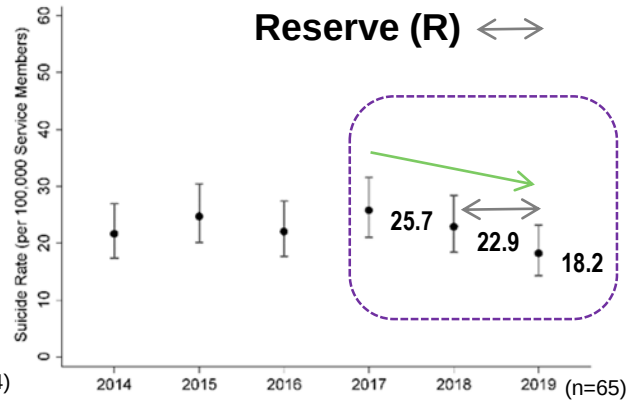
NEAR-TERM
CY 2017-2019

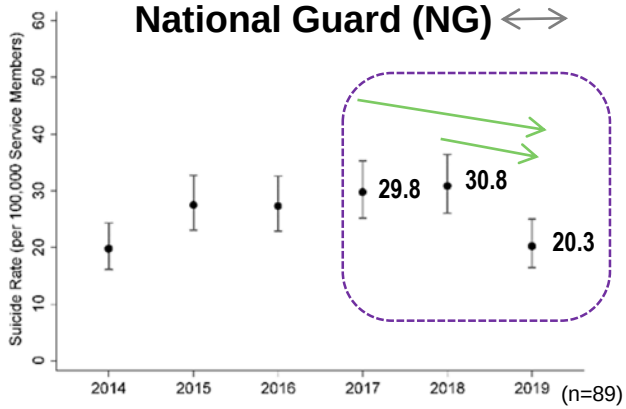
AC ▶ 2019 vs 2018 ↔
2019 vs 2017 ↔
R ▶ 2019 vs 2018 ↔
2019 vs 2017 ↓
NG ▶ 2019 vs 2018 ↓
2019 vs 2017 ↓

CY 2018 ASR: 2016-18 ↔

Strides have been made within NG, but focused on long-term sustained improvement







Comparison to US Population Rate
(PHCoE, CY 2019)

AC ↔
R ↓
NG ↔

Last year, NG was statistically higher than US population

US suicide rate also statistically increasing. (CDC, 2018)

Note: The 95% confidence interval (indicated by the vertical line for each point) represents the range in which the true suicide rate falls with 95% certainty.
Source: Rates obtained from the Armed Forces Medical Examiner System (AFMES). US population comparison obtained from DHA Psychological Health Center of Excellence (PHCoE).

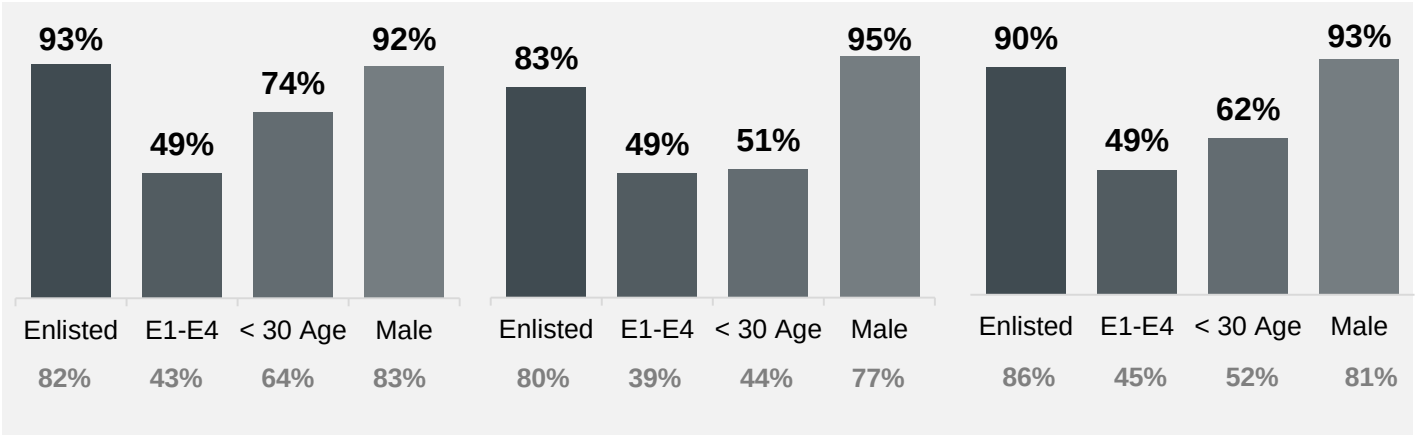
Key Service Member Findings

HIGH PROPORTION DEMOGRAPHICS

CY 2018 ASR:
Same Key Demographics

Enlisted, male, *and* < 30 yrs:
- 43% of military total
- 61% of suicide deaths

Military Totals for Comparison ►

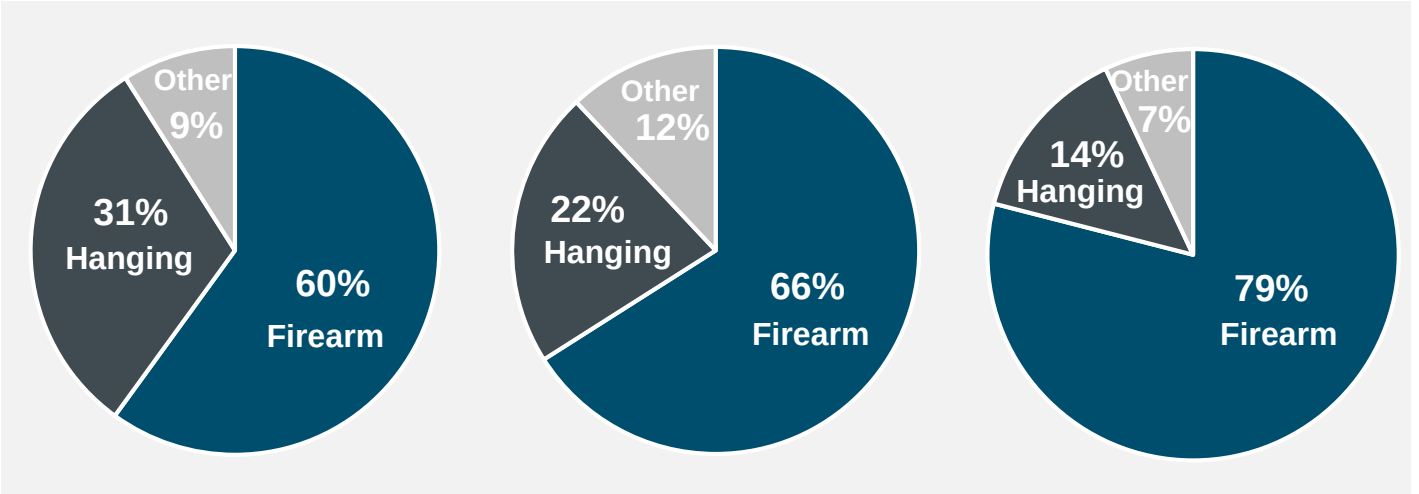


METHOD OF SUICIDE DEATH

CY 2018 ASR:
Same Primary Methods

Firearms (DoDSER CY18)
AC ► 92% personally-owned
R/NG ► 99% personally-owned

US population (age 17-59)
45% firearm
33% hanging/asphyxiation



Source(s): Active Component method of death from AFMES; Reserve and National Guard method of death from the Military Services; Civilian method of death obtained from CDC WISQARS. Other methods include: drugs/alcohol, sharp/blunt objects, poisoning, falling/jumping, unknown, and pending.

Key Military Family Findings

CY 2018: Family Member Suicide Rates

Second Year Reporting Military Family Data

Note: All rates have no statistical change from CY 2017

7.1 Total Force
per 100,000

6.9 Active Component
per 100,000

Spouse	Dependent
12.1	3.3

6.3 Reserve
per 100,000

Spouse	Dependent
-	-

8.5 National Guard
per 100,000

Spouse	Dependent
13.4	5.8

— = Not reported due to low counts

Spouse
n=128

12.1

- ► 58% female, 86% < 40 yrs
- ► 25% also Service members at death ⟷
- ► 48% with any service history

Dependent
minor/non-minor, 12-23yrs
n=65

3.9

- ► 75% male, 48% ≥ 18 yrs
- ► 65% of minors = 15-17 yrs
- ► Less than 5% also Service members at death

Note: Excluding those who were Service members (at time of death) did not statistically impact rates. Presented rates include all family members.

Female 8.0 ► **Rate comparable to US females ages 18-60** ⟷

Female - ► **Not reported due too low counts** (<20)
Rate is statistically unstable.

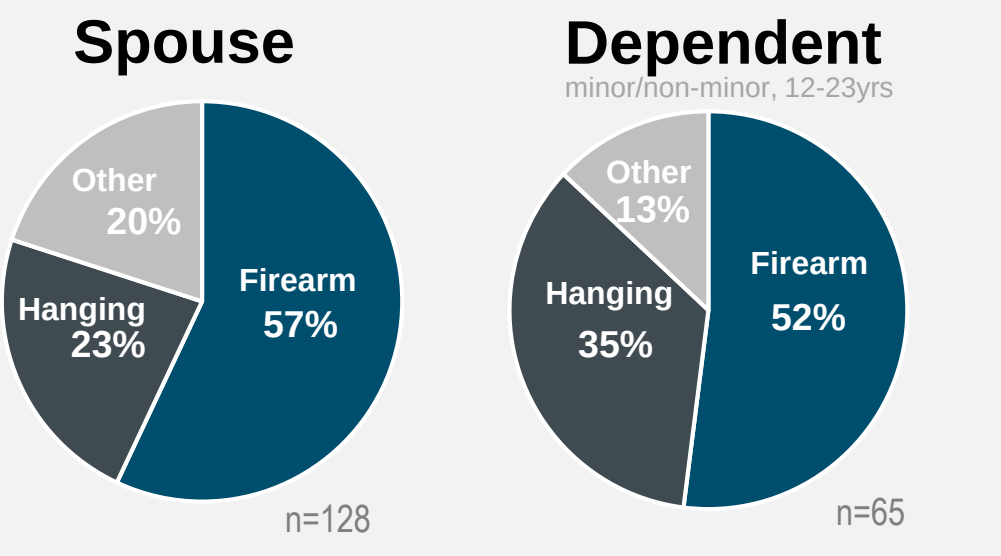
Male 40.9 ► **Rate statistically higher than US males ages 18-60** ↑

Male 5.8 ► **Rate statistically lower than US Males <23 yrs** ↓

- Source(s): CY 2018 suicide counts from DEERS/RAPIDS; Military Services Casualty Offices; and the CDC's National Death Index. Denominators for rate calculation were obtained from DMDC.
- Dependent includes minor and non-minor biological children, foster children, stepchildren, wards, pre-adoptive children and domestic partner children. Data includes children up to age 23 years as defined by Title 10.

Key Military Family Findings (Cont.)

METHOD OF SUICIDE DEATH: Military Family Members



- Suicide rates for Reserve and National Guard family members are reported regardless of the duty status of the military sponsor.
- Dependent includes minor and non-minor biological children, foster children, stepchildren, wards, pre-adoptive children and domestic partner children. Data includes children up to age 23 years as defined by Title 10.
- Other methods of death include drugs/alcohol, sharp/blunt objects, poisoning, falling/jumping, unknown, and pending.

COMPARISONS

- CY 2018 ASR:
  Same primary methods
- US population adults (aged 18-60)
  46% Firearm
  33% Hanging/asphyxiation
  - US population **FEMALE** adults
    32% Hanging/asphyxiation
    31% Firearm
    [Female military spouse=49%]
- US population <23 year
  (most comparable to dependents)
  45% Firearm
  40% Hanging/asphyxiation

Ongoing and Future DoD Suicide Prevention Efforts

Continue to build on last year's efforts while measuring effectiveness. **New efforts include:**

Support Population of Greatest Concern – Young and Enlisted Service Members:

- Pilot program to address Service members' perceived help-seeking barriers (e.g., career concerns, confidentiality) and encourage use of resources before challenges become overwhelming (also pilot program for spouses).
- Leverage new Prevention Collaboration Forum to develop integrated violence prevention approach to address risk and protective factors shared across readiness-detracting behaviors, such as suicide.
- Coordinate rollout of new "988" crisis line number (July 2022) to ensure support for military community.
- Support PREVENTS implementation to increase awareness of resources and bust misconceptions.

Support Military Families:

- Expand successful pilot program on risk factors and strategies to increase safe storage of lethal means to train "gatekeepers" in the military community (e.g., spouses, chaplains).
- Publish family safety resources (e.g., educational video and means safety guide for military members/families) to target awareness of risk factors and safe storage of firearms and medications.
- Teach risk factors to middle/high school students in DoD schools and encourage help-seeking.

Measure Effectiveness of Policies and Programs:

- Use DoD-Wide Program Evaluation Framework to continue to track progress and holistically measure program effectiveness of ongoing suicide prevention programs, and to pilot/evaluate new initiatives based on promising civilian practices.

Common Suicide Misconception and Facts

Misconception	Fact
✗ Suicide is not impulsive.	✓ **Research shows it can take less than 10 minutes between thinking about suicide to acting on it.** Putting time and distance between a person at risk and a means for suicide is an effective way to prevent death.[1]
✗ Owning a firearm is not associated with suicide risk.	✓ Owning a firearm does not cause someone to be suicidal; however, **storing a loaded firearm at home increases risk for dying by suicide four to six times.[1]**
✗ Suicidal behavior is hereditary.	✓ **There is no genetic predisposition to suicide.[2]** Although there may be over-representation of suicide in some families, behaviors such as suicide ideation and/or attempts do not transmit genetically.[3,4]
✗ Most military firearm deaths are by combat.	✓ **Most firearm deaths of Service members are the result of suicide (83.0%)**, as compared to combat (3.5%), accident (2.0%), homicide (9.0%).[5]
✗ Only mental health professionals can help individuals who are at risk for suicide.	✓ Everyone has a role to play in preventing suicide. **Engaging community stakeholders, like financial counselors, can be an impactful way to prevent suicide.[6]**

Sources: 1. Simon et al., 2001; 2. Edwards et al., 2019; 3. Brent & Mann, 2006; 4. Cheung et al., 2020; 5. Armed Forces Medical Examiner Service (AFMES), 2020; 6. Stone et al., 2017.

Common Suicide Misconception and Facts

Misconception	Fact
✗ The military suicide rate is higher than the US general population.	✓ Given the differences in composition between the US military and general population, any comparison of suicide rates must first account for age and sex. After controlling for differences in age and sex between these populations, **military suicide rates are roughly equivalent or lower** than the US population.
✗ Deployment increases suicide risk among Service members.	✓ Several studies have shown **being deployed (including combat experience, length of deployment, and number of deployments) is not associated with suicide risk among Service members.**[1, 2]
✗ The majority of Service members who die by suicide had a mental illness.	✓ Less than **half of military suicide decedents had a current or past mental health diagnosis**.[3]
✗ If you remove access to one lethal method of suicide, someone at risk for suicide will replace it with another.	✓ Research has debunked the misconception that people substitute methods of suicide. **If access to the preferred lethal means of suicide is limited, other forms are not substituted.**[4,5]
✗ Talking about suicide will lead to and encourage suicide.	✓ **Talking about suicide in a supportive way will not lead to suicide;** instead it gives the at-risk individual an opportunity to express thoughts and feelings about something they may have been keeping secret, as well as obtain help and support as needed.[6,7]

Sources: 1. LeardMann et al., 2012; 2. Reger et al., 2018; 3. Pruitt et al., 2019; 4. Owens et al., 2002; 5. Barber & Miller, 2014; 6. Dazzi et al., 2014; 7. Ramchand et al., 2017.