CALENDAR YEAR 2023

Annual Report on Suicide in the Military

Including the Department of Defense Suicide Event Report (DoDSER)

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U.S. Department of Defense Office of the Under Secretary of Defense for Personnel and Readiness

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REPORT ICON GUIDE

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About This Report

The public health approach starts with data

The U.S. Department of Defense (DoD) Annual Report on Suicide in the Military (ARSM) serves as the official source for annual DoD suicide counts and rates.

In addition, this report contains the calendar year (CY) 2023 Department of Defense Suicide Event Report (DoDSER) System Data Summary, which provides contextual information related to Service member suicide deaths and attempts.

The ARSM also highlights current and ongoing Department-wide efforts to reduce suicide risk among Service members and their families.

Transparency, accountability, commitment, and collaboration

This report reflects the Department's commitment to transparency, accountability, and preventing suicide in the military community. It was developed in collaboration with the military Departments, including the military Services, National Guard Bureau (NGB), Joint Chiefs of Staff, Office of the Assistant Secretary of Defense for Manpower and Reserve Affairs (OASD[M&RA]), Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]), Office of the Assistant Secretary of Defense for Readiness (OASD[R]), and the Defense Human Resources Activity.

Safe reporting on suicide

Words matter in suicide prevention. The Department follows best practices for safe reporting on suicide.

Service Member Data

Service Members (2023)

523 Service members died by suicide

363 Active | **69** Reserves | **91** National Guard

Suicide rates per 100,000 **25.6** Total Force

28.2 Active | **20.9** Reserves | **21.2** National Guard

KEY TAKEAWAYS

Suicide rates for **Active Component Service members gradually increased* from 2011 to 2023.** The rate in 2023 was higher than the rates in 2022† and 2021*.

Although rates fluctuated for the Reserves and National Guard between 2011 and 2023, the overall trend remained stable†. The Reserve rate in 2023 was higher† than the rate in 2022 and lower† than the rate in 2021. The National Guard rate in 2023 was lower than the rates in 2022† and 2021†.

Active, Reserve, and National Guard suicide rates were similar† to the U.S. population for most years between 2011 and 2022^. Comparisons were made after accounting for age and sex differences.

Young enlisted males accounted for the largest number of suicide deaths. Service members from all demographic groups can be impacted by increased risk for suicide.

Female Active Component members had a lower suicide rate than the overall Active Component.

Use of a firearm was the most common method of death across Components and military Services.

What does this tell us?

Suicide is a multifaceted issue. For this reason, DoD uses a comprehensive and integrated approach to suicide prevention. DoD's five lines of effort seek to:

- Foster a supportive environment.
- Improve the delivery of mental health care.
- Address stigma and other barriers to care.
- Revise suicide prevention training.
- Promote a culture of lethal means safety (LMS) practices.

Health and life stressors experienced by Service members who died by suicide in CY 2023, according to the DoDSER report:

42% Select mental health diagnoses	**44%** Relationship problems
24% Workplace issues	**29%** Administrative/ legal issues
12% Financial issues	**2%** Assault or harassment

*Statistically significant — High confidence that this is a true difference and not due to chance.

†Not statistically significant — Low confidence that this is a true difference (e.g., likely due to chance or normal variation).

^2022 was the most recent year of available U.S. population data.

Family Member Data

Family Members (2022^)

146 Family members died by suicide

93 Spouses | **53** Dependents

Suicide rates per 100,000 **5.8** **Family members** spouses and dependents

9.3 Spouses | **3.5** Dependents^^

KEY TAKEAWAYS

Suicide rates for family members overall (spouses and dependents combined) **gradually increased* from 2011 to 2022.**

Suicide rates for family members in 2022 were **slightly lower than in 2020* and 2021†.**

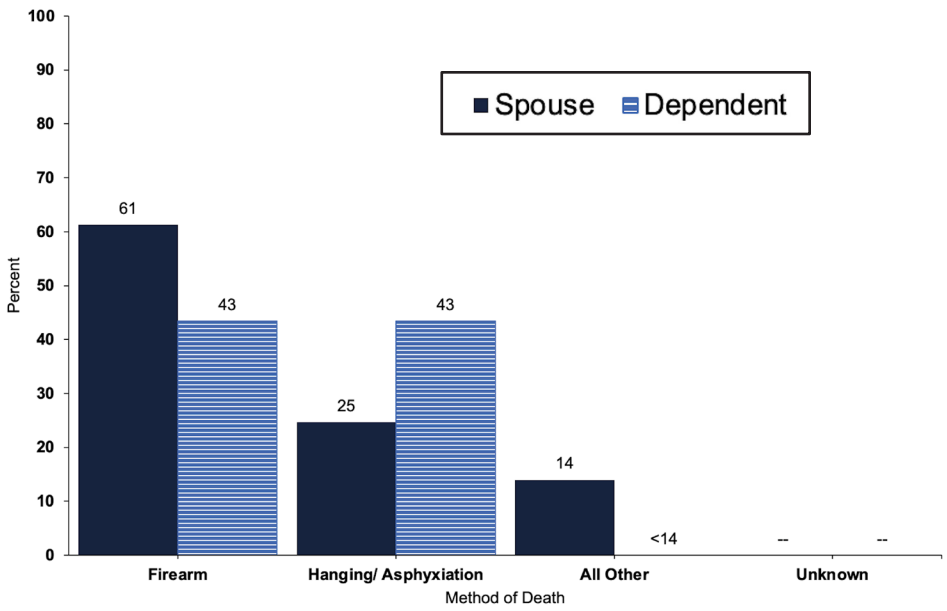
In most years, overall family member suicide rates **were similar† to the suicide rates in the U.S. population,** except in 2013, 2019, and 2020, when the family member suicide rates were higher*. Comparisons were made after accounting for age and sex differences.

Use of a firearm was the most common method of death for spouses. For dependents, firearms and hanging/asphyxiation were equally common as methods of suicide death.

Most spouses who died by suicide were either female or less than 40 years old. Those who either previously served in the military or were currently serving accounted for 57% of suicide deaths among spouses.

Most dependents were male and less than 18 years old. Less than 5% either previously served in the military or were currently serving.

Percent of Family Member Suicide Deaths by Method of Death, CY 2022



*Statistically significant — High confidence that this is a true difference and not due to chance.

†Not statistically significant — Low confidence that this is a true difference (e.g., likely due to chance or normal variation).

^Military family member data comes from civilian data sources, which lag one year relative to military data sources. For this reason, 2022 was the most recent year of available U.S. population data.

^^Includes minor (<18 years old) and non-minors (18 – 22 years old).

OVERVIEW

The Department's Suicide Prevention Efforts

The Department implements various suicide prevention efforts across five lines of effort (LOE). These five LOEs represent a comprehensive approach to suicide prevention that aims to increase protective factors and decrease risk factors among Service members. In March 2022, the Secretary of Defense formed the Suicide Prevention and Response Independent Review Committee (SPRIRC) to review all DoD suicide prevention efforts. Following the publication of the SPRIRC final report, the Secretary of Defense announced a new suicide prevention campaign plan across these five LOEs, supported by 83 enabling actions with full implementation expected by 2030. Enabling actions presently being implemented by the Department are described below.

Foster a Supportive Environment

Create a healthy, supportive, and fulfilling quality of life for Service members and their families. This includes developing support options and other services meant to address concerns before they become challenges, and before challenges escalate into crises. Examples of SPRIRC enabling actions supporting this LOE include:

- Improving schedule predictability and after-hours communication
- Promoting leadership focused on strengthening support to Service members and their families

The Department issued a memorandum on directing military leaders to address predictability and flexibility in work and training schedules and communications.

Improve the Delivery of Mental Health Care

Deliver the highest-quality services by improving access to and delivery of evidence-based mental and behavioral health care. Examples of SPRIRC enabling actions to support this LOE include:

- Recruiting and retaining behavioral health providers
- Improving coordination of care for Military Health System beneficiaries
- Increasing appointment availability by revising Military Treatment Facility (MTF) mental health staffing models

Address Stigma and Other Barriers to Care

Ensure easy and ready access to mental and behavioral health care by removing the barriers to asking for help – especially stigma and stigmatizing language within various policies. Examples of SPRIRC enabling actions supporting this LOE include expanding:

- Non-medical counseling for suicide prevention
- Mental health services in primary care
- Telehealth services for mental health
- "Episodes of care" treatment models

Revise Suicide Prevention Training

Continue to modernize education programs to keep pace with advances in knowledge and best practices for suicide prevention and postvention. Example of SPRIRC enabling actions supporting this LOE include:

- Modernizing training
- Training behavioral health technicians in evidence-based practices
- Creating tools for leaders to facilitate difficult discussions

Promote a Culture of Lethal Means Safety

Build a culture of LMS saves lives by ensuring that potentially lethal means are stored safely and not readily available in a moment of crisis. Examples of SPRIRC enabling actions supporting this LOE include:

- Incentivizing secure firearm storage
- Creating a safe storage campaign
- Promoting safety in installation barracks and dorms

KEY DATA

Service Members

In This Section

This section includes counts and rates of Service member suicide deaths for 2023 and updated counts and rates for 2022 and 2021. These results are organized by military population and Service branch. This section also includes rate comparisons across time within military populations, rate comparisons between the military and U.S. population, demographic and military characteristics, and methods of death in 2023.

See Appendix A for additional information on the following:

- Who verifies and reports Service member suicide deaths?
- What are suicide counts and rates? Why is it important to understand both?
- Overview of statistical analysis: calculating rates and counts, understanding variability and volatility and how it affects our interpretations, and understanding statistical significance.
- Why are counts not enough to understand suicide trends?
- What are unadjusted and adjusted rates? Why is it important to adjust rates when comparing suicide in the military to suicide in the U.S. population?

Service Member Suicide Counts and Rates

KEY TAKEAWAYS

Compared to 2022, the greater number of suicide deaths observed in 2023 appears to be driven by increases in the number of suicide deaths noted in the Active Component.

For the Active Component, the 2023 suicide rate was higher than in 2022† and 2021*.

For the Reserves, the 2023 suicide rate was higher than in 2022† and lower than in 2021†.

For the National Guard, the 2023 suicide rate was lower than in 2022† and 2021†.

When assessing short-term differences, it is important to consider the possibility of natural variability in the data (e.g., due to chance or normal variation) as opposed to real change (e.g., a sudden increase in external risk factors). Changes noted in suicide rates within the last 2 years were largely not statistically significant, suggesting natural variability in the data. Regardless of the nature of any short-term differences, DoD continuously monitors suicide rates and counts to inform prevention efforts.

It is important to note that short-term comparisons provide only a limited snapshot. **To account for the possibility of short-term data volatility, DoD examines additional years of data. This provides a more reliable understanding of how suicide rates in the military change over time and how these rates compare to the U.S. population.** Additional analyses addressing these questions are presented in the next section.

Table 1 | Annual Suicide Counts and Unadjusted Rates per 100,000 Service Members by Military Population and Service, CY 2021–CY 2023

Component and Service	CY 2021		CY 2022		CY 2023	
	Rate	Count	Rate	Count	Rate	Count
Active Component	**24.3**	328	**25.1**	331	**28.2**	363
Army	**36.1**	175	**28.9**	135	**34.8**	158
Marine Corps	**23.9**	43	**36.0**	63	**35.9**	61
Navy	**17.0**	59	**20.6**	71	**21.0**	70
Air Force	**15.3**	51	**19.0**	62	**22.5**	72
Space Force	--	0	--	0	--	2
Reserves	**21.2**	74	**19.4**	65	**20.9**	69
Army	**24.8**	46	**20.8**	37	**24.9**	44
Marine Corps	--	13	--	7	--	10
Navy	--	10	--	7	--	8
Air Force	--	5	--	14	--	7
National Guard	**27.3**	121	**22.2**	97	**21.2**	91
Army	**31.2**	105	**24.8**	82	**23.7**	77
Air Force	--	16	--	15	--	14

Notes: Data sourced from Armed Forces Medical Examiner System (AFMES). Table includes both confirmed *and* suspected suicides as of March 31, 2024. Both confirmed and suspected suicides are included so that counts and rates are not underestimated as cause-of-death investigations continue. Per U.S. Department of Defense Instruction (DoDI) 6490.16, rates are not reported ("--") when the number of suicide deaths is less than 20.[1] Such rates are generally considered unreliable due to statistical instability. Only DoD Services are reported here. The Coast Guard is under the U.S. Department of Homeland Security—unless operating under the Department of the Navy. For this reason, suicide rates for the Coast Guard are not included in this report. Calculating the size of a given Service is a necessary part of calculating Service-specific suicide rates. Due to missing population data, statistical imputation was used to determine the total size of the Army in CY 2022 and CY 2023. The population data for all other Services was provided in full by the Defense Manpower Data Center (DMDC).

*Statistically significant — High confidence that this is a true difference and not due to chance.

†Not statistically significant — Low confidence that this is a true difference (e.g., likely due to chance or normal variation).

ACTIVE COMPONENT
Suicide Rate Trends

KEY TAKEAWAYS

Long-term analyses provide a clearer picture of how rates are changing over time. Suicide rates for the Active Component gradually increased* from 2011 to 2023.

In most years between 2011 and 2022, the Active Component suicide rate was largely **similar† to the suicide rate in the U.S. population^,** except when the suicide rate was **higher*** in the Active Component in 2020.

The observed long-term increases were statistically significant, indicating this is likely real change, not natural variability. Unfortunately, given the complexity of suicidal behavior, it is not possible to identify a single root cause that might explain this trend.

DoD's ongoing mission to prevent suicide focuses on mitigating the full spectrum of risk factors (e.g., certain clinical diagnoses) and amplifying protective factors (e.g., developing strong social support).

Service members are not immune to all risk factors. DoD is actively working to promote a culture where help-seeking is viewed as a sign of strength and where supportive resources are readily accessible, whenever and wherever needed.

Figure 1 | Active Component Suicide Rates Over Time

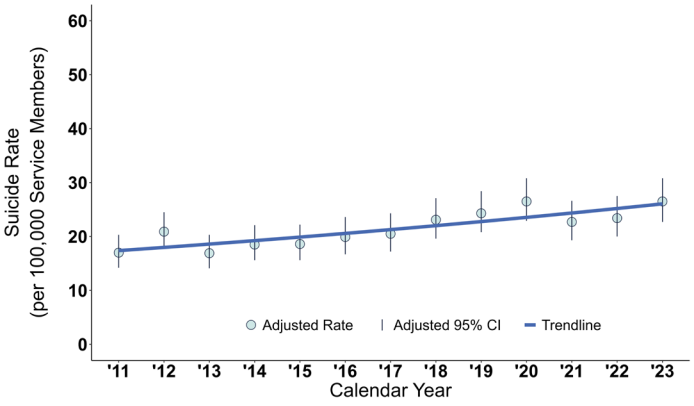
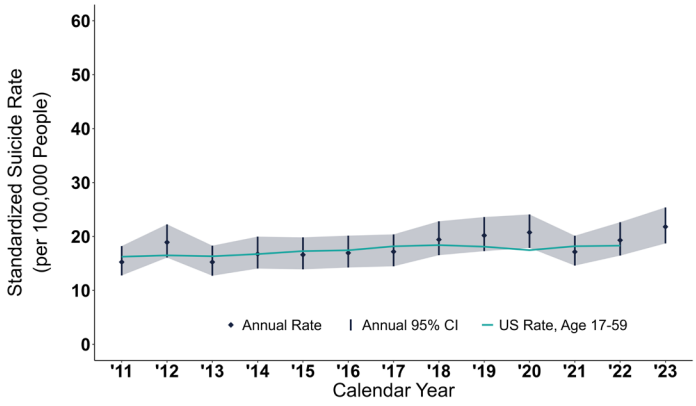


Figure 2 | Active Component Compared to U.S. Population Suicide Rates Over Time



Note: Figure 2 shows Active Component suicide rates, adjusted for age and sex differences, between the military and the U.S. population.

*Statistically significant — High confidence that this is a true difference and not due to chance.

†Not statistically significant — Low confidence that this is a true difference (e.g., likely due to chance or normal variation).

^2022 was the most recent year of available U.S. population data.

ACTIVE COMPONENT

Suicide Rate Trends by Service

KEY TAKEAWAYS

The figure below presents the suicide rates for each Service over the past 13 years. The solid line illustrates the direction of each long-term trend.

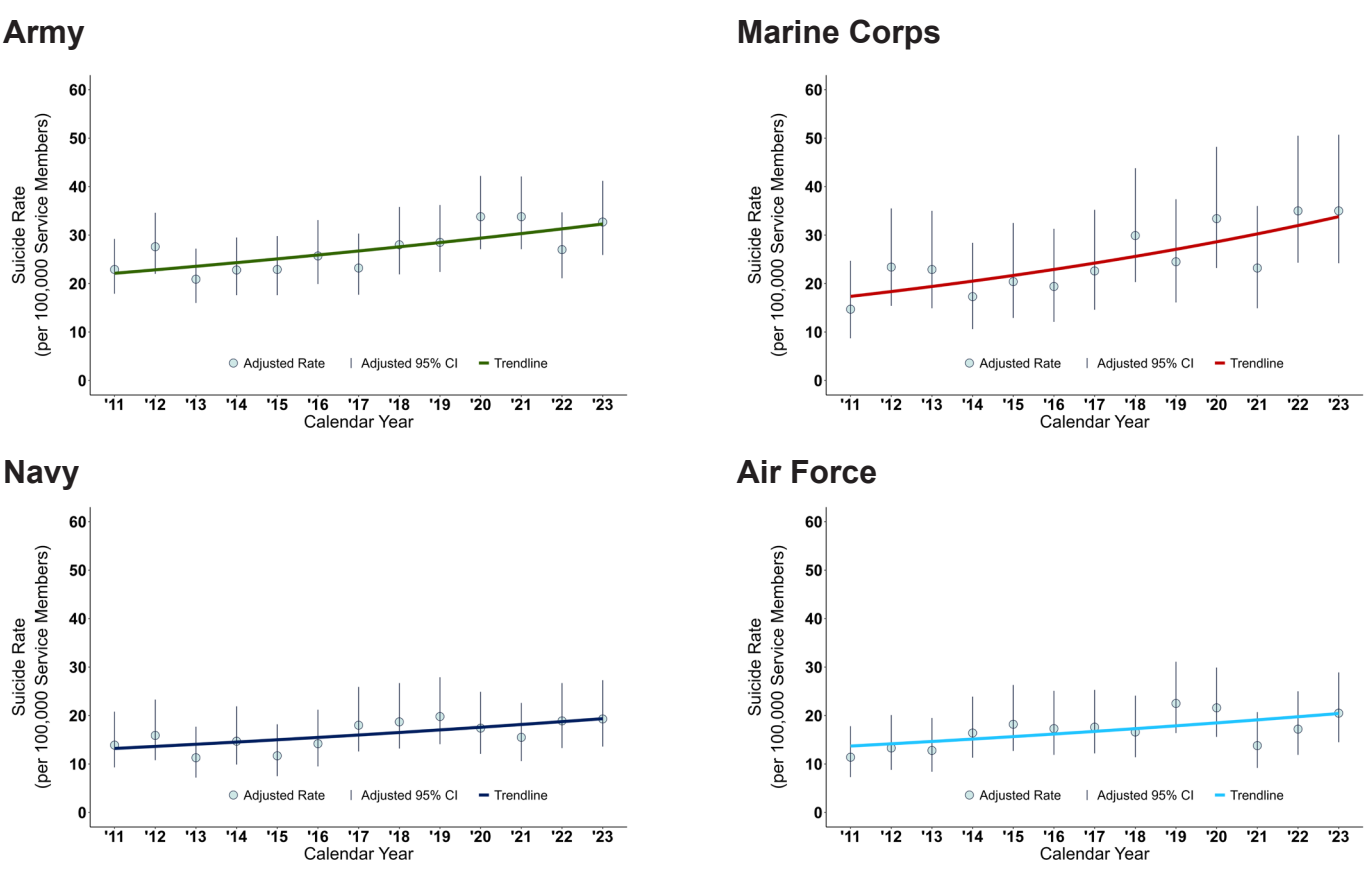
Although Service-specific suicide rates fluctuated year-to-year, suicide rates for **each Service gradually increased* in the long-term from 2011 to 2023.** Of note, the Army has the largest population of all the Services. Changes in the Army rate can drive change in the overall Active Component rate.

In short-term comparisons, between 2023 and 2022, no Service was found to have had a statistically significant difference in suicide rates.

Between 2011 and 2022, Service-specific rates were largely similar† to the U.S. population (data not shown).

In addition to DoD-wide efforts, each Service has also implemented its own suicide prevention initiatives. **These Service-specific efforts take into consideration the unique culture and needs of each Service.** Examples of these initiatives are highlighted in the Current and Ongoing Department Efforts section of this report.

Figure 3 | Active Component Suicide Rates Over Time by Service



Notes: Data sourced from AFMES (for military populations) and the Centers for Disease Control and Prevention (CDC; for U.S. population), ages 17 – 59. All rates are sex and age adjusted to account for differences within the military over time. Vertical bars around each rate indicate 95% confidence intervals.

*Statistically significant — High confidence that this is a true difference and not due to chance.

Trend analysis was not conducted for the Space Force. Established in 2019, the Space Force had no suicides from 2020 to 2022 and two suicides in 2023. Per DoDI 6490.16, no rates are calculated when the number/count of suicide deaths is under 20.[1]

†Not statistically significant — Low confidence that this is a true difference (e.g., likely due to chance or normal variation).

ACTIVE COMPONENT

Demographic and Contextual Characteristics

Table 2 | Demographic and Contextual Characteristics of Active Component Service Members Who Died by Suicide in CY 2023 (Rate per 100,000, count, percent)

Demographics	Rate	Count	Percent
Total	28.2	363	100%
Sex			
Male	32.1	339	93.4%
Female	10.5	24	6.6%
Age Group			
17–19	--	17	4.7%
20–24	37.4	150	41.3%
25–29	29.0	87	24.0%
30–34	23.2	49	13.5%
35–39	23.0	37	10.2%
40–44	--	16	4.4%
45–49	--	6	1.7%
50+	--	1	0.3%
Race			
White	29.0	253	69.7%
Black/African American	23.7	53	14.6%
Am. Indian/Alaska Native	--	4	1.1%
Asian/Pacific Islander	38.4†	24	6.6%
Other/Unknown	25.5	29	8.0%
Rank			
E (Enlisted)	31.4	326	89.8%
E1-E4	35.3	184	50.7%
E5-E9	27.5	142	39.1%
O (Commissioned Officer)	13.0	28	7.7%
W (Warrant Officer)	--	8	2.2%
Cadet	--	1	0.3%
Marital Status			
Never Married	29.3	173	47.7%
Married	25.7	161	44.4%
Divorced	45.1	28	7.7%
Legally Separated	--	1	0.3%
Widowed	--	0	0.0%
Unknown	--	0	0.0%

KEY TAKEAWAYS

Similar to previous years, most Service members who died by suicide in 2023 were enlisted males under the age of 30, representing about 60% of decedents (combined data not shown).

Consistent with historical data, divorced Active Component members had higher* suicide rates than the overall Active Component (data not shown).

Consistent with historical data, female Active Component members had lower* suicide rates than the overall Active Component (data not shown).

There was a greater number of Service members who were married at their time of death: 161 in 2023 compared to 147 in 2022.

DoD continuously monitors suicide risk across all demographic groups. This data surveillance is done to ensure that suicide prevention efforts remain responsive to the needs of all Service members. Suicide risk factors are not limited only to demographic groups with the highest percentage of suicide deaths. Risk factors can potentially impact Service members in any demographic group.

Notes: Data sourced from AFMES. Percentages may not add up to 100% due to rounding. Per DoDI 6490.16, rates are not reported ("--") when the number/count of suicide deaths is under 20.[1] Army has revised its racial/ethnic demographic reporting categories to align with new Federal standards. As of preparing this report, the Marine Corps, Navy, Air Force, and Space Force have not yet made changes to their categories. For this reason, the demographic profile of the Army may appear different relative to what was reported for the Army last year. Table 15 in Appendix C provides the Total Force demographics. †As a result of recent changes in the Federal classification of racial/ethnic categories, certain Asian/Pacific Islander Service members who died by suicide were reclassified into other racial/ethnic categories. The resulting decrease in the size of the newly classified Asian/Pacific Islander population may have contributed to what appears to be higher rate for Asian/Pacific Islander Service members compared to CY22.

*Statistically significant - High confidence that this is a true difference and not due to chance.

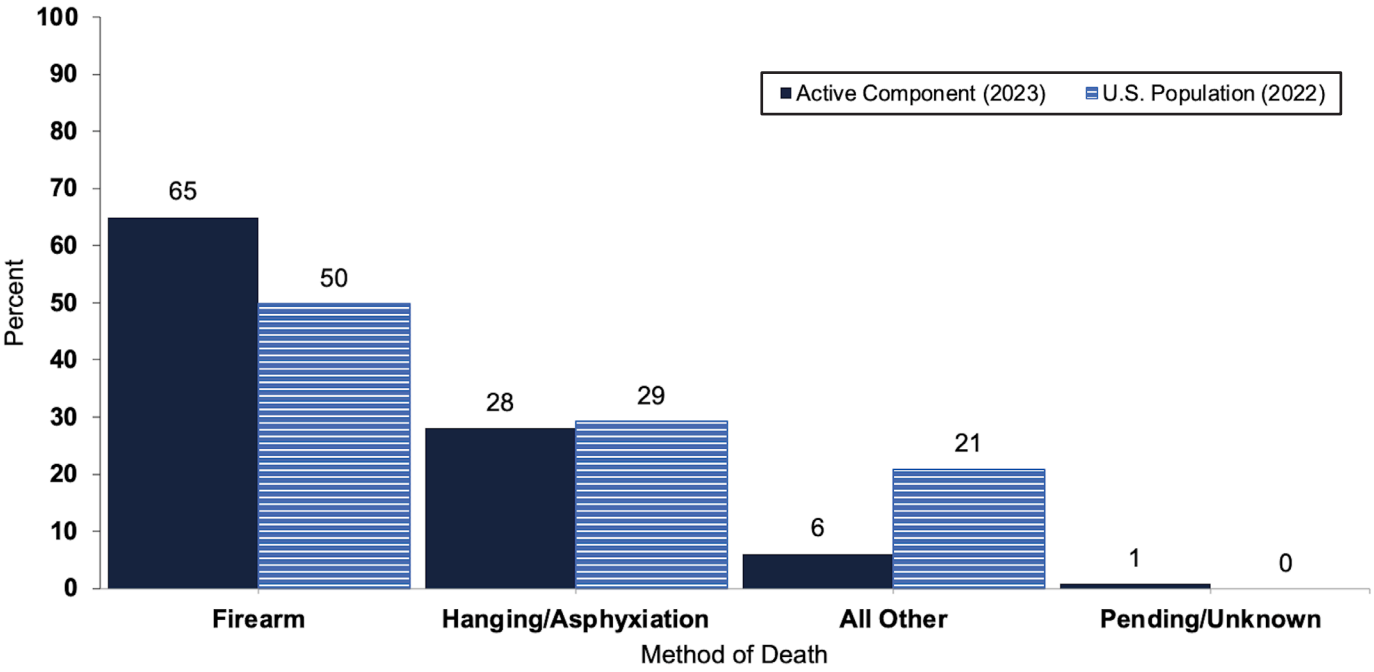
ACTIVE COMPONENT
Method of Death

KEY TAKEAWAYS

In 2023, use of a firearm was the most common method of death for the Active Component. This is consistent with previous years.

The percentage of suicide deaths by firearm was higher in the Active Component in 2023 than among the U.S. population in 2022^.

Figure 4 | Percent of Active Component and U.S. Population Suicide Deaths by Method of Death



The high percentage of suicide deaths by firearm shows the importance of promoting and implementing LMS in the military community. Such efforts can save lives by reducing access to the means for enacting lethal harm. Gun locks are one such example. In practice, a Service member who is experiencing life challenges might ask that a family member hold the key to their gun lock, thereby reducing the chance of acting on impulse in a time of crisis.

Notes: Data sourced from AFMES. "All Other" methods of death include overdose, poisoning, blunt/sharp objects, and falling/jumping.

*Statistically significant — High confidence that this is a true difference and not due to chance.

†Not statistically significant — Low confidence that this is a true difference (e.g., likely due to chance or normal variation).

^2022 was the most recent year of available U.S. population data.

ACTIVE COMPONENT

Suicide Death Characteristics and Contextual Data from the DoDSER

Data on this page pertain to *deaths* by suicide, as documented in the DoDSER system.

Based on data submitted to the DoDSER system within the last year, Active Component Service members who died by suicide in 2023 experienced:

42%

One or more **mental health diagnoses,** to include alcohol use disorder, depressive disorder, anxiety disorder, adjustment disorder, or posttraumatic stress disorder

29%

Administrative/legal problems, such as non-judicial punishment, under investigation, or administrative separation

44%

Intimate relationship problems

24%

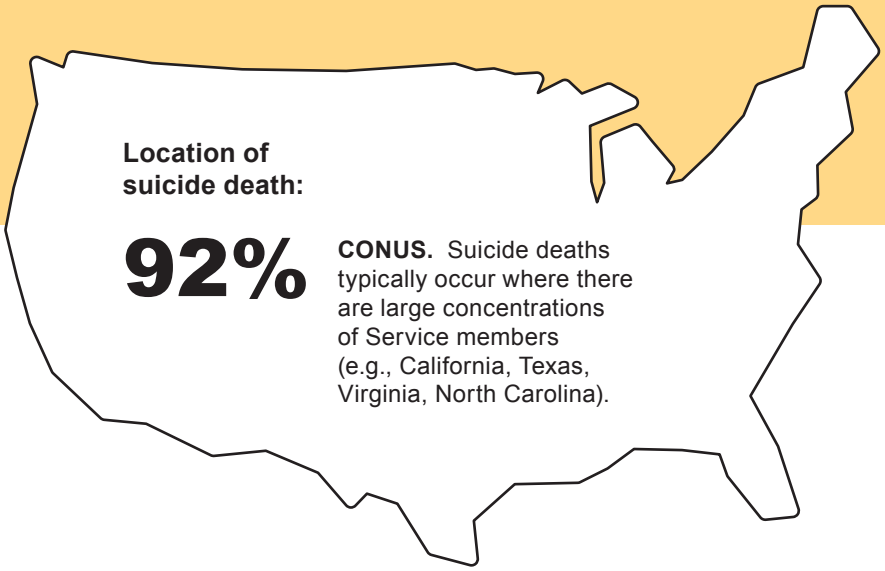
Workplace difficulties

12%

Financial difficulties

2%

Assault or harassment



Location of suicide death:

92%

CONUS. Suicide deaths typically occur where there are large concentrations of Service members (e.g., California, Texas, Virginia, North Carolina).

Communicated intent

Service members who died by suicide communicated intent for self-harm in 28% of cases. This intent was communicated to one or more of the following groups (subcategories are not mutually exclusive): mental health staff (5%), friend (10%), and/or spouse/partner (11%).

Information contained in the DoDSER continues to help shape understandings of suicide risk:

5%

Identified as **gay, lesbian, or bisexual**

12%

Experienced abuse before age 18

Stress is a normal part of life and living. Experiencing health or life stressors does **not** mean that someone is suicidal. DoD supportive services are designed to help Service members and their families manage stress at all levels. **Behavioral and mental health concerns are treatable and can be addressed before turning into a crisis.** Non-clinical support options (e.g., financial counseling) are also available for healthy stress management. **Seeking help is a sign of strength.**

Suicide Attempt Characteristics and Contextual Data from the DoDSER

Data on this page pertain to suicide *attempts*, as documented in the DoDSER system.

Based on data submitted to the DoDSER system, there were 1,373 suicide attempts reported among Active Component Service members in 2023.

Due to the small number of Space Force suicide attempts reported, the 3 suicide attempt cases were not included in the following results.

383	264	287
Army	Marine Corps	Navy

436	3
Air Force	Space Force

Among 1,370 suicide attempts reported:

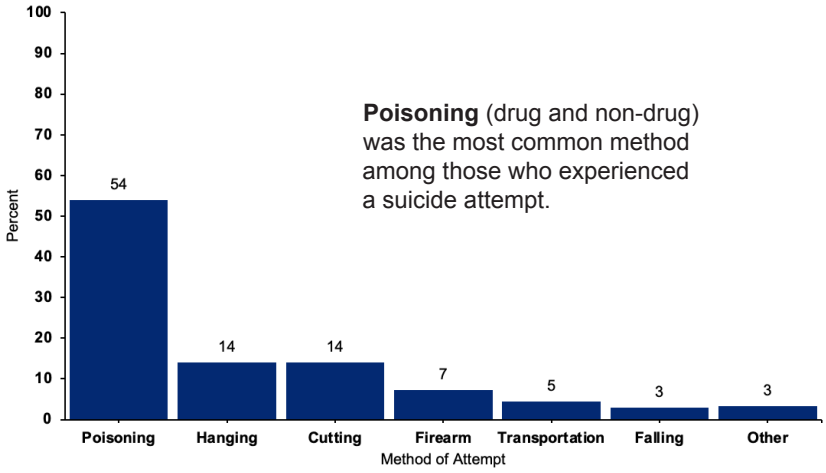
29%
Female Service members

71%
Male Service members

Based on data submitted to the DoDSER system within the last year, **Active Component Service members with a reported suicide attempt in 2023** experienced:

- **67%** One or more select **mental health diagnoses** (see previous page)
- **33%** **Intimate relationship problems**
- **20%** **Workplace difficulties**
- **19%** **Administrative/ legal problems** (see previous page)
- **9%** **Assault or harassment**
- **11%** **Financial difficulties** (within a year before the reported attempt)

Figure 5 | Percent of Active Component Attempts by Method of Attempt, CY 2023



Poisoning (drug and non-drug) was the most common method among those who experienced a suicide attempt.

Although the majority of suicide deaths take place with a firearm, most suicide attempts happen through poisoning. This again reinforces the need for LMS — such as safe storage of firearms, sharp objects, medications, and other materials that can be used to harm oneself. For example, suicide attempts by poisoning might be reduced by keeping medication securely stored at all times and using proper containers for storage.

Suicide Rate Trends

KEY TAKEAWAYS

Long-term analyses provide a clearer picture of how rates are changing over time. For the Reserves and National Guard, despite fluctuations from year to year, **the overall trend between 2011 and 2023 remained stable†.**

Between 2011 and 2022, **Reserve suicide rates were similar† to suicide rates in the U.S. population.**

National Guard suicide rates were largely similar† to suicide rates in the U.S. population, with the exception of 2012 and 2013 when National Guard rates were higher*.

Army Reserve rates followed the same† near- and long-term trend patterns as the overall Reserve rates (data not shown). **Army National Guard** rates followed the same† near- and long-term patterns as the overall National Guard rates (data not shown). Consistent with guidelines in DoDI 6490.16, **Marine Corps Reserve, Navy Reserve, Air Force Reserve,** and **Air National Guard** rates over time are not reported due to low Service-specific counts.[1]

Reserves

Figure 6 | Reserve Suicide Rates Over Time

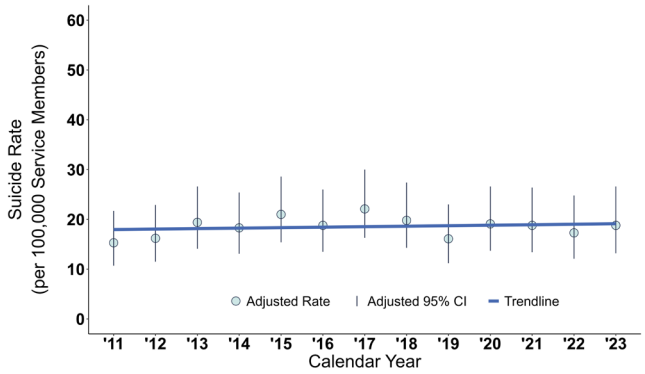
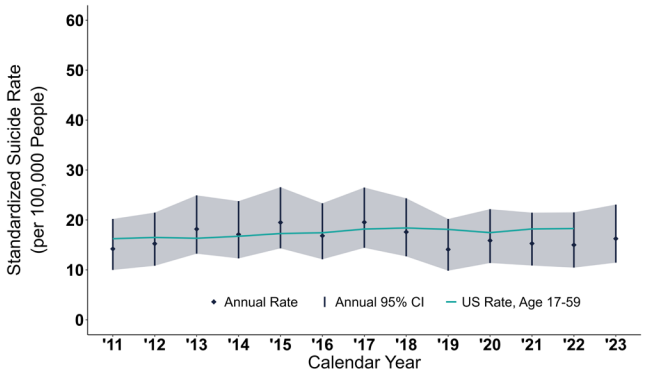


Figure 7 | Reserve Compared to U.S. Population Suicide Rates



National Guard

Figure 8 | National Guard Suicide Rates Over Time

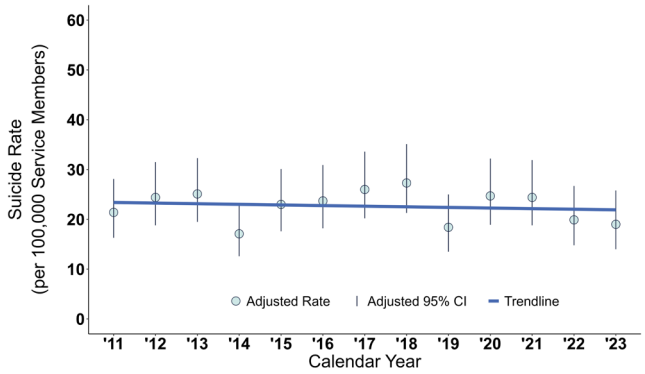
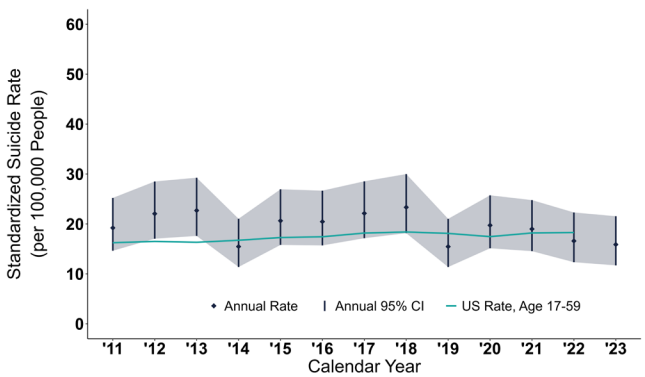


Figure 9 | National Guard Compared to U.S. Population Suicide Rates



Notes: Data sourced from AFMES (military populations) and CDC (U.S. population), ages 17–59. All rates are adjusted for sex and age to account for differences within the military over time.

*Statistically significant — High confidence that this is a true difference and not due to chance.

†Not statistically significant — Low confidence that this is a true difference (e.g., likely due to chance or normal variation).

Suicide Rate Trends

The lack of statistically significant long-term differences indicates that the observed differences in suicide rates this year among Reserve and National Guard suicide rates are likely due to natural variation.

DoD recognizes the unique challenges of service in the Reserves and National Guard. These members combine the responsibilities of military service with civilian life. Certain resources, such as Military OneSource, remain accessible to all Reserve Component Service members as well as their family members, regardless of duty status. Other supportive services can only be fully accessed during periods of activation, such as clinical support though the Military Health System or self-initiated referrals.

In some cases, Reserve Component Service members might have to access private health care providers. This may further be complicated by lack of private insurance coverage (i.e., not all Reserve Component Service members are eligible for TRICARE coverage).

DoD remains committed to suicide prevention across the Total Force. Where applicable, SPRIRC efforts include the Reserve Component. The NGB efforts highlighted in this report are intended to help National Guard members more effectively bridge the divide which sometimes exists between their military and civilian responsibilities.

Demographic and Contextual Characteristics

KEY TAKEAWAYS

Similar to previous years, enlisted males under the age of 30 accounted for the largest demographic segment National Guard members who died by suicide in 2023.

For Reserve members, enlisted males under the age of 30 accounted for 46% of those who died by suicide.

Enlisted males under the age of 30 account for approximately 40% of the Total Force.

Table 3 | Demographic Characteristics of Reserve and National Guard Service Members Who Died by Suicide in CY 2023 (Rate per 100,000, count, percent)

Demographics	Reserves			National Guard		
	Rate	Count	Percent	Rate	Count	Percent
Total	20.9	69	100%	21.2	91	100%
Sex						
Male	24.7	62	89.9%	24.5	84	92.3%
Female	--	7	10.1%	--	7	7.7%
Age Group						
17–19	--	2	2.9%	--	3	3.3%
20–24	--	18	26.1%	29.8	32	35.2%
25–29	--	16	23.2%	28.3	23	25.3%
30–34	--	12	17.4%	--	9	9.9%
35–39	--	6	8.7%	--	8	8.8%
40–44	--	6	8.7%	--	9	9.9%
45–49	--	6	8.7%	--	4	4.4%
50+	--	3	4.3%	--	3	3.3%
Race						
White	22.4	49	71.0%	17.5	58	63.7%
Black/African American	--	11	15.9%	38.9	24	26.4%
Am. Indian/Alaska Native	--	0	0.0%	--	3	3.3%
Asian/Pacific Islander	--	1	1.4%	--	4	4.4%
Other/Unknown	--	8	11.6%	--	2	2.2%
Rank						
E (Enlisted)	22.9	59	85.5%	22.9	84	92.3%
E1-E4	25.7	30	43.5%	25.0	45	49.5%
E5-E9	20.5	29	42.0%	20.9	39	42.9%
O (Commissioned Officer)	--	9	13.0%	--	6	6.6%
W (Warrant Officer)	--	1	1.4%	--	1	1.1%
Marital Status						
Never Married	23.9	36	52.2%	23.8	55	60.4%
Married	19.2	30	43.5%	16.1	28	30.8%
Divorced	--	2	2.9%	--	8	8.8%
Legally Separated	--	0	0.0%	--	0	0.0%
Widowed	--	0	0.0%	--	0	0.0%
Unknown	--	1	1.4%	--	0	0.0%

Notes: Data sourced from AFMES. Per DoDI 6490.16, rates are not reported ("--") when the number/count of suicide deaths is under 20.[1] Percentages may not add up to 100% due to rounding. Table 15 in Appendix C provides the Total Force demographics.

Demographics

The demographics for the Reserves and National Guard are similar to the demographics of Active Component Service members who also died by suicide.

See the DoDSER enclosure for more contextual information for the Reserves and National Guard. In instances where there is incomplete information or a low number of events, some of the descriptive data, like percentages, may not be representative or may have limited reliability.

DoD continues to promote help-seeking as a sign of strength, expand clinical and non-clinical support options, and make accessing appropriate and available services easier for Service members.

Method of Death

KEY TAKEAWAYS

In 2023, use of a firearm was the most common method of death among the Reserves and National Guard. This is consistent with previous years.

The percentage of suicide deaths by firearm was respectively higher in the Reserves and National Guard in 2023 than in the U.S. population in 2022^.

Compared to the U.S. population, one possible explanation for the more frequent use of firearms as a method of death may be that Service members are more familiar with handling firearms.[2] Accordingly, **the need to promote LMS extends to all Service members** — Active Duty, Reserve, and National Guard alike. LMS can save lives by putting time and distance between an individual in crisis and the means to die by suicide.

Figure 10 | Percent of Reserve and U.S. Population Suicide Deaths by Method of Death

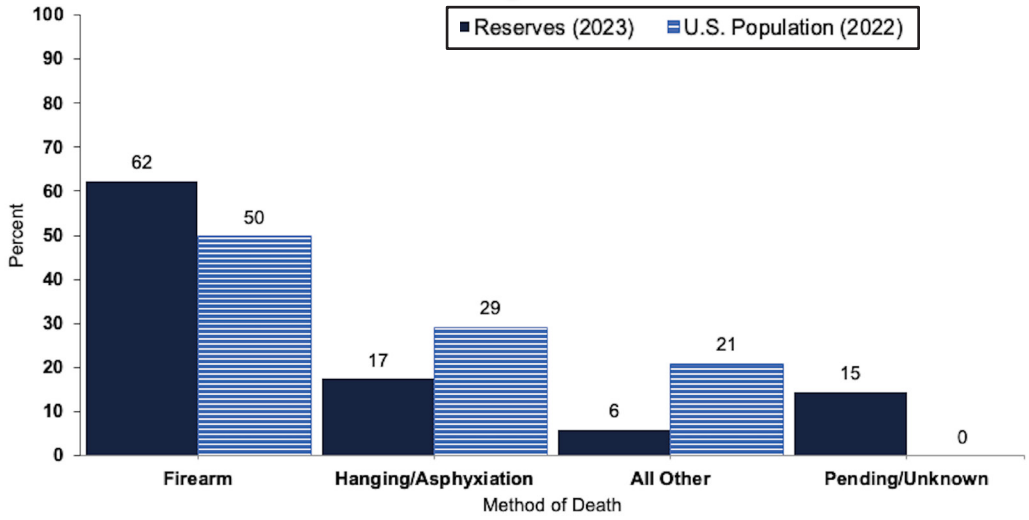
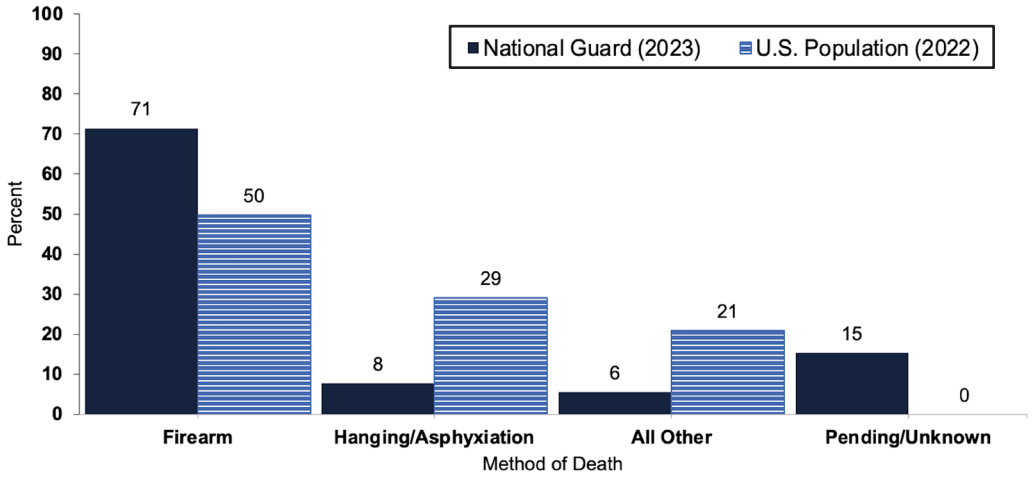


Figure 11 | Percent of National Guard and U.S. Population Suicide Deaths by Method of Death



Notes: Data sourced from AFMES. "All Other" methods of death include overdose, poisoning, blunt/sharp objects, and falling/jumping.

^2022 was the most recent year of available U.S. population data.

KEY DATA

Family Members

In This Section

Section 567 of the Carl Levin and Howard P. “Buck” McKeon National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2015, Public Law 113-291, requires DoD collect and report suicide death data involving military family members. Data were first available in 2017, sourced from the CDC National Center for Health Statistics National Death Index (NDI; a database of death record information compiled from state offices). Additional data was acquired in 2024 to examine trends going back to 2011. Due to the time it takes to process data, the latest available NDI data is from 2022 (i.e., lagging one year relative to military data sources). Appendix A describes some of the challenges associated with reporting suicide deaths involving military family members.

For this report, military family members are limited to spouses and dependent children (minor and non-minor) who are eligible to receive military benefits under Title 10 U.S. Code and who are registered in the Defense Enrollment Eligibility Reporting System (DEERS). DEERS is a database of military sponsors and eligible family members who have registered to receive military benefits. For ease of reporting, dependent spouses are referred to in this report as “spouses” and dependent children are referred to as “dependents.” Appendix A provides a more detailed explanation of who qualifies as a military family member.

OVERVIEW

Military Family Members Suicide Counts and Rates^

KEY TAKEAWAYS

Across the Total Force, the number of military family members overall (spouses and dependents) who died by suicide in 2022 was lower than in 2020 and 2021.

The 2022 Total Force suicide rate for military family members overall was also lower than in 2020* and 2021†.

Between 2011 and 2022, there was an increasing* long-term trend in suicide rates for military family members overall.

Compared to the U.S. population suicide rate, military family members overall had largely similar† suicide rates for most years between 2011 and 2022, except for 2013, 2019, and 2020, when the military family member suicide rate was higher* than the U.S. population suicide rate.

This is the first year in which there is enough data to reliably examine long-term trends in military family member suicide rates. Only short-term differences were examined in previous reports, which provided a limited understanding of how suicide rates change over time. These new analyses indicate that suicide rates for military family members overall have gradually increased* between 2011 and 2022.

Table 4 | Military Family Member Suicide Rates per 100,000 Individuals by Their Service Member's Military Population, CY 2020–CY 2022

Military Population	CY 2020		CY 2021		CY 2022	
	Rate	Count	Rate	Count	Rate	Count
Total Force	**7.7**	200	**6.4**	165	**5.8**	146
Spouse	**12.8**	131	**11.0**	112	**9.3**	93
Dependent	**4.3**	69	**3.4**	53	**3.5**	53
Active Component	**7.9**	129	**6.2**	101	**6.0**	95
Spouse	**12.9**	86	**11.4**	76	**9.7**	63
Dependent	**4.4**	43	**2.6**	25	**3.4**	32
Reserves	**8.2**	37	**8.1**	36	**6.0**	26
Spouse	**14.4**	24	**12.3**	20	**--**	--
Dependent	**--**	13	**--**	16	**--**	--
National Guard	**6.5**	34	**5.4**	28	**4.9**	25
Spouse	**11.1**	21	**--**	16	**--**	13
Dependent	**--**	13	**--**	12	**--**	12

Notes: Data sourced from NDI (suicide counts) and DMDC (denominators only). Per CDC requirements and to protect the confidentiality of military family members, counts under 10 are suppressed, and corresponding percentages are also suppressed or masked (e.g., < 1.0%). Only DoD Services are reported here (i.e., Coast Guard family member suicide rates are not included in this report).

Due to missing data for Army, sponsor status of some Service members could not be verified. Reliably accounting for all military family member deaths was therefore not possible. As a result, counts and rates reported here for spouses and dependents should be interpreted with caution.

*Statistically significant — High confidence that this is a true difference and not due to chance.

†Not statistically significant — Low confidence that this is a true difference (e.g., likely due to chance or normal variation).

^2022 was the most recent year of available U.S. population data.

Military Family Members Suicide Counts and Rates^

Figure 12 | Military Family Member Suicide Rates Over Time

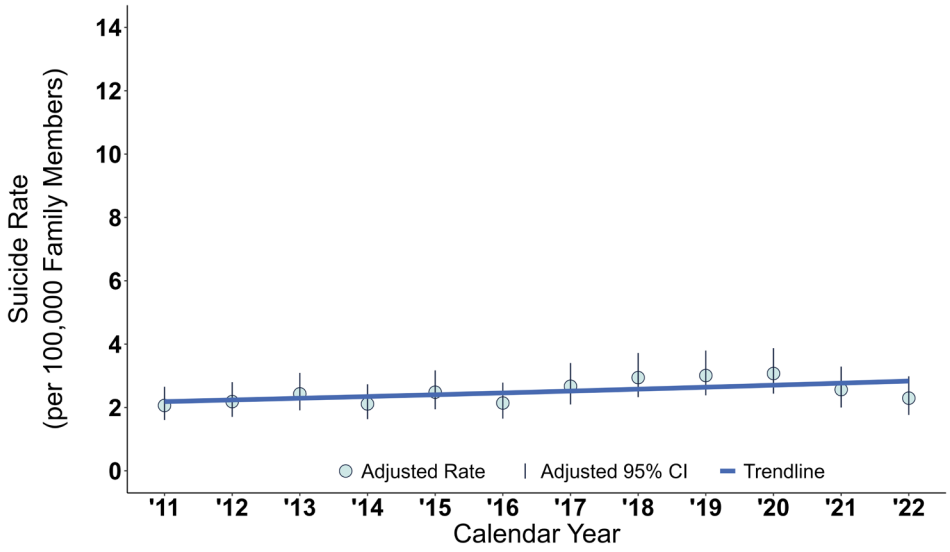
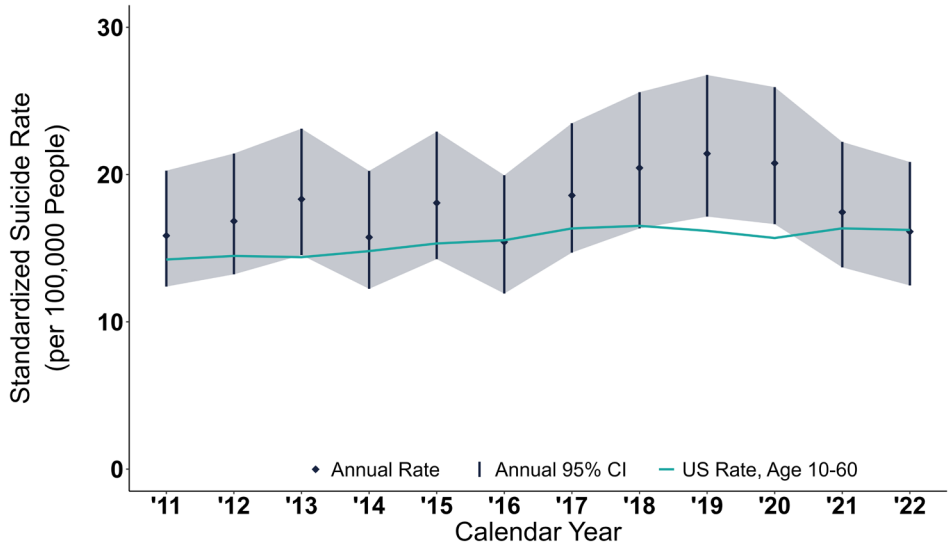


Figure 13 | Military Family Member Compared to U.S. Population Suicide Rates



The mission to prevent suicide in the military community also extends to military families. The Department has long recognized that military service is an experience shared by families and not limited only to the Service member. In many ways, military families navigate life experiences (e.g., permanent change of station) differently from those of their civilian counterparts. The Department recognizes these differences and has support options available for both military spouses and dependents.

Notes: Data sourced from NDI (suicide counts) and DMDC (denominators only). Per CDC requirements and to protect the confidentiality of military family members, counts under 10 are suppressed, and corresponding percentages are also suppressed or masked (e.g., < 1.0%). Only DoD Services are reported here (i.e., Coast Guard family member suicide rates are not included in this report).

Spouses: Demographic and Contextual Characteristics^

KEY TAKEAWAYS

Males accounted for about 47% of suicides among spouses. This is noteworthy because only 14% of military spouses across the DoD are male (data not shown).

About 79% of spouses who died by suicide were under 40 years old. Across the DoD, this age group accounts for a similar percentage of all military spouses.

About 57% of spouses who died by suicide had any service history (i.e., prior or current service history).

More than 85% of male military spouses who died by suicide had any service history (data not shown). Among female military spouses, about 31% had any service history (data not shown).

The 2022 Total Force suicide rate for military spouses was lower† than in 2021 and lower* than in 2020. This was similar for female and male spouses, but only statistically significant for male spouses for 2022 compared to 2020.

Table 5 | Military Spouse Suicide Counts and Percentages by Demographics, CY 2022

Demographics	Count	Percent
Sex		
Male	44	**47.3%**
Female	49	**52.7%**
Age Group		
<40	73	**78.5%**
≥40	20	**21.5%**
Service History		
Any Service History	53	**57.0%**
Prior Service (Not Currently Serving)	25	**26.9%**
Currently Serving	28	**30.1%**
No Service History	40	**43.0%**

The Department recognizes that most military spouses who died by suicide have a history of military service. This suggests that some military spouses might be experiencing military-specific stressors. Understanding suicide risk among spouses with prior military service is a focus of ongoing research.

DoD actively collaborates with the Department of Veterans Affairs (VA) to ensure that these individuals with a service history are aware of the support options available to them as Veterans, including inTransition and Military OneSource. Of note, even after they have completed their own military service, spouses of Service members may be entitled to continued access to certain military benefits and programs.

Table 6 | Military Spouse Suicide Rates per 100,000 Individuals by Sex, CY 2020–CY 2022

DoD Component	CY 2020		CY 2021		CY 2022	
	Male	Female	Male	Female	Male	Female
Total Force	**46.6**	**7.6**	**40.3**	**6.4**	**31.7**	**5.7**
Active Component	47.5	7.7	43.3	6.6	34.3	5.9
Reserves	--	--	--	--	--	--
National Guard	--	--	--	--	--	--

Notes: Data sourced from NDI (suicide counts) and DMDC (denominators only). Per CDC requirements and to protect the confidentiality of military family members, counts under 10 are suppressed (marked with "--"), and corresponding percentages are also suppressed or masked (e.g., < 1.0%). Per DoDI 6490.16, no rates are calculated when the number/count of suicide deaths is under 20.[1] Only DoD Services are reported here (i.e., Coast Guard family member suicide rates are not included in this report).

To capture the full extent of suicide among military family members, the tables also include family members who were themselves Service members. Of military spouses who died by suicide in 2022, 57% had any history of service, compared to 50% in 2021 and 47% in 2020. Of military spouses who died by suicide in 2022, 30% were serving at the time of their death, compared to 24% in 2021, and 19% in 2020.

*Statistically significant — High confidence that this is a true difference and not due to chance.

†Not statistically significant — Low confidence that this is a true difference (e.g., likely due to chance or normal variation).

^2022 was the most recent year of available U.S. population data.

Spouses: Suicide Rate Trends^

KEY TAKEAWAYS

While overall family member suicide rates gradually increased* between 2011 and 2022, spouse rates alone have remained stable† over this time period.

When examined based on gender, male spouse rates increased* between 2011 and 2022 (data not shown). Female spouse rates notably remained stable† (data not shown).

Between 2011 and 2022, suicide rates for military spouses overall were similar† to the U.S. population aged 18-60.

However, in most years (i.e., 2012, 2013, 2015, 2018, 2019, and 2020), male military spouses had higher* suicide rates than the U.S. male population (data not shown). In remaining years, male military spouses had suicide rates similar† to the U.S. male population.

Over this same period, suicide rates for female military spouses were similar† to the U.S. female population (data not shown).

Figure 14 | Military Spouse Suicide Rates Over Time

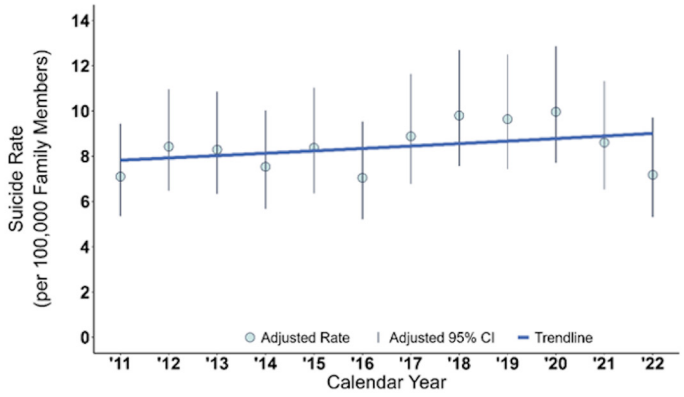
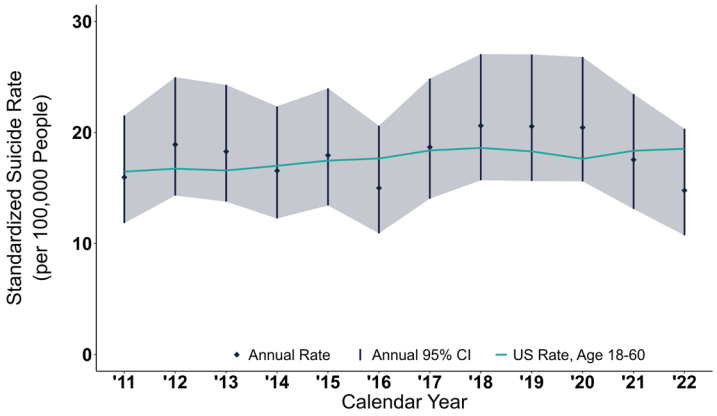


Figure 15 | Military Spouse Compared to U.S. Population Suicide Rates



The data draw attention to how male military spouses are disproportionately burdened by suicide risk. Life stressors that might impact military spouses include navigating career challenges, the burden of frequently moving, and far-reaching issues of personal identity. In families with children, stressors might also include sole parenting duties while the Service member is deployed. The Department actively promotes supportive services for military spouses and is making a concentrated effort to ensure spouses know where and how to access these services, this includes working to better understand the potential gaps in support for male military spouses.

Notes: Data sourced from NDI (suicide counts) and DMDC (denominators). Only DoD Services are reported here (i.e., Coast Guard family member suicide rates are not included in this report).

*Statistically significant — High confidence that this is a true difference and not due to chance.

†Not statistically significant — Low confidence that this is a true difference (e.g., likely due to chance or normal variation).

^2022 was the most recent year of available U.S. population data.

Dependents: Demographic and Contextual Characteristics^

KEY TAKEAWAYS

Males accounted for about 72% of dependent suicide deaths in 2022.

About 55% of dependents who died by suicide were under 18 years old.

Less than 5% of dependents who died by suicide had any service history (data not shown).

The 2022 Total Force suicide rate for military dependents was lower than in 2020* and slightly higher than in 2021†.

Across the Total Force, the 2022 suicide rate for male dependents was higher† than in 2021 but lower† than in 2020. Due to low counts, rates could not be calculated for female dependents.

Table 7 | Military Dependent Suicide Counts and Percentages by Demographics, CY 2022

Demographic	Count	Percent
Sex		
Male	38	71.7%
Female	15	28.3%
Age Group		
<18	29	54.7%
18-23	24	45.3%
History of Service		
No Service	51	96.2%
History of Service	--	< 5.0%
Currently Serving	--	< 5.0%

Military dependents face their own unique life stressors. The impact of these stressors and experiences (e.g., parental deployment) can vary by age. For this reason, different strategies are applied to prevent suicide among dependents. For example, outreach to parents includes fact sheets for how to discuss mental health and identify warning signs of suicide among children.[3] In DoD schools, students are also taught to identify and address negative feeling in themselves and others in a safe and healthy way.[4] Dependents can access a range of supportive resources, including therapeutic services.

Table 8 | Military Dependent Suicide Rates per 100,000 Individuals by Sex, CY 2020–CY 2022

DoD Component	CY 2020		CY 2021		CY 2022	
	Male	Female	Male	Female	Male	Female
Total Force	**6.2**	**--**	**4.6**	**--**	**4.9**	**--**
Active Component	5.9	--	4.3	--	4.9	--
Reserves	--	--	--	--	--	--
National Guard	--	--	--	--	--	--

Notes: Data sourced from NDI (suicide counts) and DMDC (denominators only). Per CDC requirements and to protect the confidentiality of military family members, counts under 10 are suppressed, and corresponding percentages are also suppressed or masked (e.g., < 1.0%). Per DoDI 6490.16, no rates are calculated when the number/count of suicide deaths is under 20.[1] Only DoD Services are reported here (i.e., Coast Guard family member suicide rates are not included in this report). To capture the full extent of suicide among military family members, the table also includes dependents who were themselves Service members. Of military dependents who died by suicide in 2022, less than 5% had any history of service, similar to 2021 and 2020. Similarly, of military dependents who died by suicide in 2022, less than 5% were serving at the time of their death, similar to 2021 and 2020.

*Statistically significant — High confidence that this is a true difference and not due to chance.

†Not statistically significant — Low confidence that this is a true difference (e.g., likely due to chance or normal variation).

^2022 was the most recent year of available U.S. population data.

Dependents: Suicide Rate Trends^

KEY TAKEAWAYS

Between 2011 and 2022, there was an increasing* long-term trend in suicide rates for military dependents overall (female and male). This was found for female and male dependents separately as well (data not shown).

Between 2011 and 2022, military dependents overall had a higher* suicide rate than comparable U.S. population groups in 2013, 2015, 2018, 2019, and 2020. This rate was similar† in remaining years.

Relative to comparable U.S. population groups, male dependents had largely similar† suicide rates, except for when the male dependent rate was higher* in 2013, 2019, and 2020 (data not shown).

Due to suppression rules for small counts, no analyses were conducted comparing female dependent rates with the U.S. population.

Long-term trends for dependents appear to largely mirror that of the U.S. adolescent and young adult population. The CDC finds that suicide rates for these groups increased* from 2007 to 2021.[5] Still, the Department recognizes that, for several years, military dependents had higher suicide rates than their counterparts in the U.S. population. DoD actively promotes its mental health services to the whole of the military family to support dependents who might be struggling with stressors.

Figure 16 | Military Dependent Suicide Rates Over Time

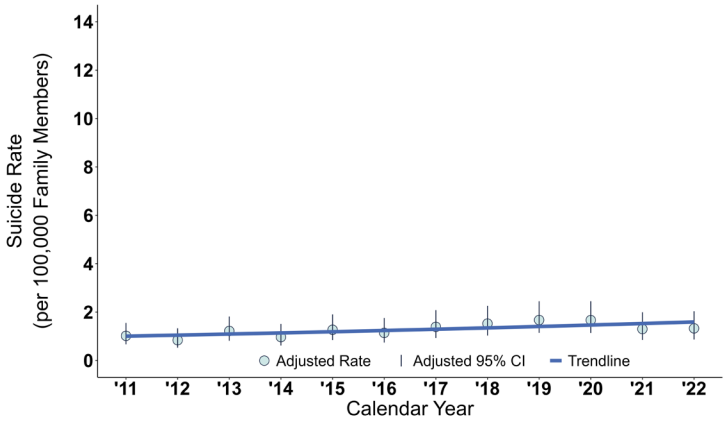
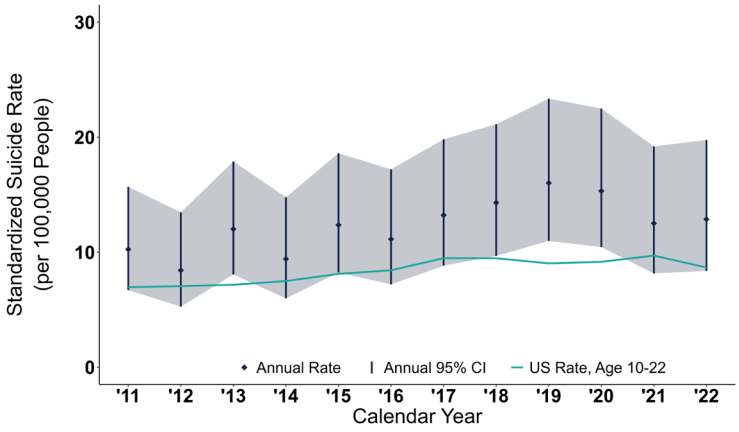


Figure 17 | Military Dependent Compared to U.S. Population Suicide Rates



Notes: Data sourced from NDI (suicide counts) and DMDC (denominators). Per CDC requirements and to protect the confidentiality of military family members, counts under 10 are suppressed, and corresponding percentages are also suppressed or masked (e.g., < 1.0%).

Only DoD Services are reported here (i.e., Coast Guard family member suicide rates are not included in this report).

*Statistically significant — High confidence that this is a true difference and not due to chance.

†Not statistically significant — Low confidence that this is a true difference (e.g., likely due to chance or normal variation).

^2022 was the most recent year of available U.S. population data.

MILITARY FAMILY MEMBERS

Method of Death^

KEY TAKEAWAYS

Similar to previous years, use of a firearm was the most common method of death among military family members overall.

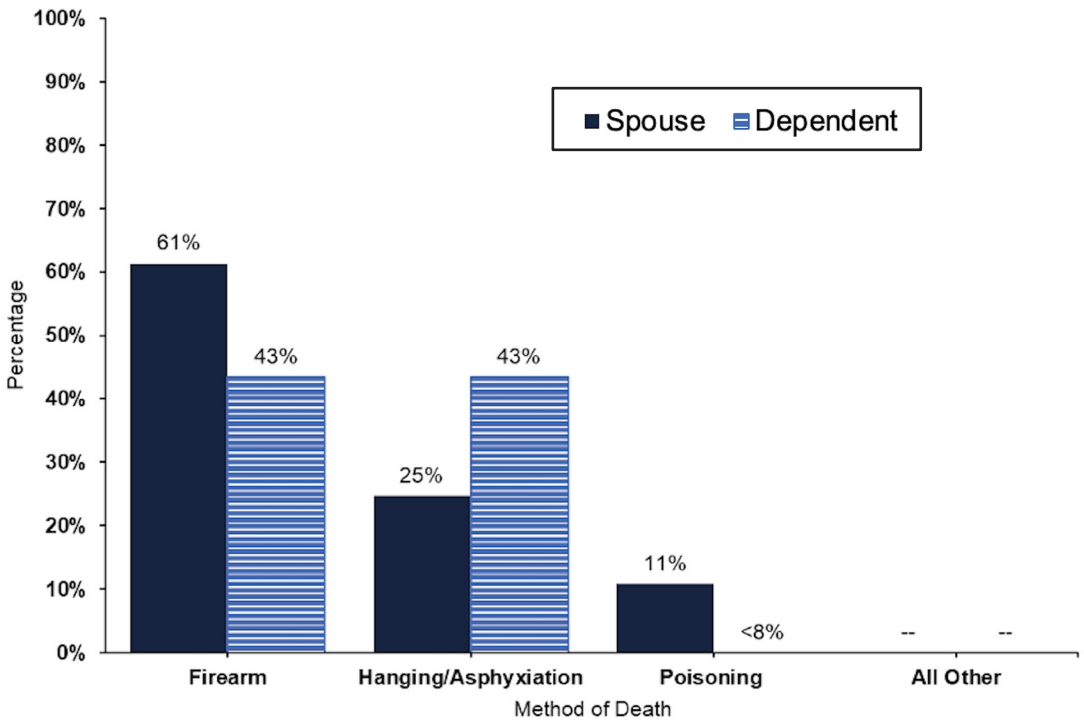
Among military spouses, use of a firearm was the most common method of death. This is similar to previous years.

About 53% of female military spouses who died by suicide used a firearm (data not shown).

In 2022, the proportion of deaths by hanging/asphyxiation resembles that of firearms.

Among military family members overall, use of a firearm was the most common method of death which mirrors results seen in the Service member and U.S. populations. However, there are some notable differences. First, it appears that a larger proportion of female military spouses died by suicide using a firearm relative to a comparable group in the U.S. population. Specifically, a firearm was used by only 34% of women aged 18–60 in the U.S. who died by suicide (data not shown). Secondly, among dependents, the proportion of deaths by firearms was equal to that of deaths by hanging/asphyxiation for the first time. In previous years, hanging/asphyxiation was second to firearms as a method of death.

Figure 18 | Percent of Spouse and Dependent Suicide Deaths by Method of Death, CY 2022



Notes: Data sourced from AFMES. "All Other" methods of death include overdose, blunt/sharp objects, and falling/jumping. Per CDC requirements and to protect the confidentiality of military family members, counts under 10 are suppressed, and corresponding percentages are also suppressed or masked (e.g., < 1.0%).

^2022 was the most recent year of available U.S. population data.

KEY DATA

Current and Ongoing Department Efforts

Various Departmental efforts across five LOEs are ongoing to address suicide prevention. These LOEs are (1) Foster a Supportive Environment, (2) Improve the Delivery of Mental Health Care, (3) Address Stigma and Other Barriers to Care, (4) Revise Suicide Prevention Training, and (5) Promote a Culture of LMS. Together, these five LOEs represent a comprehensive approach to suicide prevention that aims to increase protective factors and decrease risk factors among Service members. In this section, we highlight DoD suicide prevention efforts, share updates from implementation of SPRIRC recommendations as approved by the Secretary of Defense, and provide examples of efforts underway in each of the Services.

EFFORTS IN PREVENTING SUICIDE

The Department engages in a variety of suicide prevention and response efforts across five LOEs. This includes, but is not limited to, implementation of SPRIRC enabling actions. Informed by evidence and driven by research and data, each of these efforts represent DoD's alignment with national-level strategic plans, goals, and priorities. For example, DSPO represented DoD in supporting the development of the 2024 National Strategy for Suicide Prevention (NSSP), released in April 2024 alongside the Federal Action Plan. The NSSP provides a 10-year whole-of-society approach to suicide prevention and promotes a coordinated and comprehensive approach in communities across the country. Here we draw attention to some of these other efforts as well as which LOE they support. Examples of SPRIRC actions are described in further detail on page 31.

Foster a Supportive Environment

- A year-round media campaign called "Joining Your Fight: Connect to Protect" to raise awareness of suicide prevention resources. The focus of this campaign is on connection, collaboration, and hope.
- DoD continued evaluating the progress of implementing its comprehensive, integrated primary prevention program. This included completing over 60 site visits as part of the On-Site Installation Evaluation process. Follow up assessment of the first set of sites is ongoing.
- The Integrated Primary Prevention Workforce (IPPW) works with leaders to build strong command climates and environments free from abuse and harm. The military Services are hiring prevention personnel and, as of summer 2024, 1,000 IPPW professionals have been hired with a goal of 2,500 by 2028.

Improve the Delivery of Mental Health Care

- Implementation of the Brandon Act allows Service members to self-initiate a referral for mental health care through a commanding officer or Supervisor in the grade of E-6 or above.
- Expanded tele-behavioral health (TBH) services to reduce barriers for accessing mental health care.
- The Department is developing guidance on a Credentialing Program for Prevention Personnel. To date, over 75% of the hired IPPW (Strategic, Operational, and Tactical) have received Defense-Credentialing Program for Prevention Personnel certification, ensuring standardization across command structures.

Address Stigma and Other Barriers to Care

- Enhanced collaboration between clinical and non-clinical efforts to strengthen suicide prevention messaging, reduce stigma, and encourage help-seeking via the DoD's anti-stigma public mental health Real Warriors Campaign.
- Collaboration with external (e.g., VA, Sesame Street) and internal (e.g., DoD Education Activity) partners to address stigma. For example, DoD helped develop safety fact sheets and resources for supporting young children when a family member dies by suicide.

  Link to fact sheet on "Talking to Children About a Military Death by Suicide" https://www.dspo.mil/Portals/113/Documents/SPM%202022/Military%20Death%20by%20Suicide%20Overview%20(1).pdf?ver=jhyV4EUquHRlwl_ZMVRZFA%3d%3d

Revise Suicide Prevention Training

- DSPO initiated an environmental scan of the current state of suicide prevention training throughout the Department and conducted a literature review aimed at understanding training effectiveness and recommendations for future approaches to suicide prevention training programs.
- In July 2024, VA and DoD co-hosted the 2024 biennial Suicide Prevention Conference in Portland, OR. Over 2,300 registrants participated in the Nation's only conference dedicated to military and Veteran suicide prevention. The conference highlighted innovative ways to increase outreach to at-risk Service member and Veteran populations, especially historically underserved populations.

Promote a Culture of Lethal Means Safety

- Released a fact sheet on "Firearm Safety During a Permanent Change of Station." This fact sheet was developed with partner organizations, including the VA's Rocky Mountain Mental Illness Research, Education, and Clinical Center, and the DoD Education Activity.

  Link to fact sheet on "Firearm Safety During a Permanent Change of Station" https://www.dspo.mil/Portals/113/Documents/081823%20DSPO-PCSandLethalMeansSafetyFactSheet-FINAL.pdf
- An in-depth review of LMS-related guidance and policies at the Service, Component, and installation levels. The results of this review informed policy updates across DoD. In particular, this review informed updates to program evaluation policy and capabilities.
- Supported a DSPO-funded evaluation study of LMS efforts across the Services, including evaluation of the Navy and Marine Corps gun lock distribution program.

IMPLEMENTATION OF SPRIRC RECOMMENDATIONS APPROVED BY THE SECRETARY OF DEFENSE

In this section, we provide further detail on SPRIRC enabling actions across the five LOEs that guide suicide prevention activities for the Department. These enabling actions focus on a wide range of actions to improve Service member well-being. This information describes progress up to and as of August 22, 2024. Planning activities were completed and 83 enabling actions have been slated for implementation across the 5 LOEs.

In FY 2024, the SPRIRC received $17.8M to begin implementation of 10 enabling actions centered around developing a multimedia public education LMS campaign, integrating the Behavioral Health Data Portal into the Military Health System's electronic health record, and creating leader-focused trainings and materials on implementing postvention activities after a suicide death. The majority of SPRIRC enabling actions will begin receiving funding in FY 2025. A total of $261.5M and 313 positions have been allocated to assist with implementation of enabling actions across all five LOEs. A timeline of the SPRIRC as well as additional SPRIRC accomplishments are highlighted in Appendix D.

Foster a Supportive Environment

The focus of this LOE is to create and sustain a healthy, supportive, and fulfilling quality of life for Service members and their families. This LOE also aims to empower leaders to address any possible signs of suicide risk among Service members. The overarching goal is to address concerns before they become challenges, and before challenges escalate into crises. Ongoing support efforts include multiple programs that address improvement of career stabilization options. Specific examples include:

- Improving work schedule predictability and after-hours communication with commands.
- Actioning retention incentives and bonuses to retain key talent and improve assignment processes.

Improve the Delivery of Mental Health Care

This LOE centers on improving access to and delivery of evidence-based mental and behavioral health services. Enabling actions contributing to progress in this LOE include supporting, recruiting, and retaining behavioral health providers and improving coordination of care. Specific examples include updating IT and communication systems at MTFs, timelier processing of TRICARE payment claims, regularly updating TRICARE provider information available to Service members and families, and increasing appointment availability by revising mental health staffing models.

The Department greatly expanded its telehealth footprint by expanding the Behavioral Health Resources and Virtual Experience (BRAVE) Program to service Active Duty family member and pediatric patient populations as well as expand the system's portfolio of OCONUS supported sites and support to more austere locations. Additionally, DHA Office of General Council began addressing issues around delivery of TBH across state lines and from the United States to a foreign country. Lastly, DHA's Virtual Health Branch began establishing partnerships between Military Treatment Facilities (MTFs), Defense Health Networks, Managed Care Support Contractors, and regional healthcare systems that can deliver evidence based TBH services.

Address Stigma and Other Barriers to Care

DoD is working to promote a culture where help-seeking is viewed as a sign of strength. Key to this is removing barriers to asking for help, such as the stigma sometimes associated with help-seeking behavior. A core component of this effort is ensuring easy and ready access to mental and behavioral health care. This effort specifically includes expanding evidence-informed support options and non-medical counseling (e.g., financial counseling), expanding mental health services in primary care settings, and expanding telehealth services for mental health. Other efforts include expanding use of the "episodes of care" approach where individuals are able to schedule multiple behavioral health appointments at the outset of care.

Revise Suicide Prevention Training

DoD continuously modernizes the delivery of its trainings as knowledge and understanding of suicide prevention and postvention continue to develop. Enabling actions supporting this LOE focus on modernizing training content, delivery, and dosage. Additional actions focus on integrating primary prevention principles, training health technicians in evidence-based practices, and providing Service leaders with tools to facilitate difficult conversations (e.g., leadership-focused postvention training). To ensure that all suicide prevention training remains most relevant to the needs of Service members and their families, DoD monitors and assesses suicide prevention training requirements. Moving forward, DoD will continue to focus on stressors and risk factors that Service members face daily.

Promote a Culture of Lethal Means Safety

LMS is a crucial part of suicide prevention. LMS involves enacting measures to ensure that individuals in crisis do not have ready access to the means of dying by suicide (e.g., safely storing prescription medications, secure firearm storage). Enabling actions supporting progress in this LOE include incentivizing secure firearm storage (e.g., secure storage vouchers), implementing enhanced firearm proficiency training, and developing and implementing a multimedia public education campaign.

HIGHLIGHTS FROM EFFORTS IN THE SERVICES

In addition to efforts implemented across the DoD enterprise, each of the Services has also implemented its own suicide prevention programs. A variety of unique efforts are currently underway across each of the Services including the Reserve Component. Although by no means an exhaustive list, this section highlights some examples of these efforts.

Army

Financial Readiness Program

Economic and financial uncertainty is linked to higher suicide rates. For this reason, the Army has incorporated mandatory financial education into initial entry at all levels of enlisted professional military education, and at 10 personal and professional milestones, such as marriage, promotion, and permanent change of station. This training sets common baseline knowledge for all Soldiers and their family members to work towards financial well-being. Soldiers experiencing a financial crisis can also receive no-cost personal financial counseling, including short-term support from Army Emergency Relief. As part of postvention support, the Army also provides Soldiers and their families with education and counseling on finances, planning, and how to recognize life changes that could potentially lead to financial instability.

LMS Toolkit

The Army's Directorate of Prevention, Readiness and Resilience published the LMS Toolkit to bolster LMS efforts and build capacity across the suicide prevention workforce. The toolkit was developed with input from Suicide Prevention Program Managers and Coordinators, the Office of the Chief of Chaplains, and safety, behavioral health, and Command stakeholders. It includes general education on suicide prevention and LMS, conversation starters in times of crisis and non-crisis, state maps for off-post firearm storage options, and community partnership materials. The toolkit also includes a catalog of LMS communication materials aimed at increasing LMS behaviors and awareness for Army Commanders and family members.[6,7]

Crisis Response and Intervention Training (CRIT)

CRIT is a program for Army police, providing alternatives to arrest when interacting with persons in crisis. The program is designed to provide crisis intervention and assistance to persons experiencing a mental health crisis who may have been involved in domestic violence incidents or who are experiencing other health and welfare issues. The CRIT concept requires Army police to partner with expert stakeholders from behavioral health services, family advocacy programs, and other community agencies. CRIT support may include immediate access to mental health resources, peer support, and non-emergency medical care.

Marine Corps

Marine Corps Total Fitness (MCTF)

The MCTF program takes an integrated approach to wellness and considers all aspects of mental, physical, spiritual, and social health. The implementation of the Total Fitness Strategic plan, adopted in October 2023, is intended to support and strengthen Marines and their families against stressors that might increase suicide risk. As part of MCTF, "integrated performance" facilities are opening in areas with high concentrations of Marines. These facilities bring together subject matter experts – from physical trainers to spiritual advisors and social support coordinators – to provide Marines with ready access to classes, training sessions, and events to support their fitness in all domains.[8]

Death by Suicide Review Board (DSRB)

The Marine Corps DSRB meets annually to review every suicide death among Active Component Marines. DSRB is staffed by subject matter experts and other stakeholders who collaboratively engage with unit leadership in supporting Marines. The DSRB aims to identify any common factors among deceased Marines or gaps in care or support. This information is used to inform and improve suicide prevention in the Marine Corps.[9,10]

Recruit Depots Leadership and Ethics Courses

The Marine Corps Behavioral Programs Office partnered with the Lejeune Leadership Institute to reinforce prevention efforts at Marine Corps Recruit Depots through leadership and ethics courses. All Marines receive leadership and ethics courses that cover topics including critical thinking, emotional intelligence, and servant leadership. The integration of suicide awareness and prevention throughout these courses ensures that all Marines have a base understanding of suicide prevention as they start their military careers.[11,12]

Navy

Sailor Assistance and Intercept for Life (SAIL) Program

The SAIL program is an evidence-based outreach effort that aims to help Active Duty Sailors who experienced suicide ideation or an attempt. SAIL supports Sailors reintegrating back into their lives through caring contacts, ongoing risk assessment, and care coordination. SAIL case managers maintain contact with Sailors, health care providers, and command leadership. Although Sailors are initially referred to the program by their commands, participation is entirely voluntary.[13]

Quality of Service

In May 2023, The Secretary of the Navy and Chief of Naval Operations issued a joint memorandum for "setting a new course for Navy quality of service." This is meant to improve the Service experiences of Sailors and their families, both in and outside the workplace. Target outcomes include strategies for strengthening mental and physical health (e.g., strategies to give every Sailor the opportunity to go to sea, the opportunity to live off ship while in an industrial environment, support for Sailors unable to perform normally assigned duties). Other considerations include access to convenient, affordable, and nutritious food, and access to free, high-speed internet.[14]

Mental Health Playbook

The Navy Mental Health Playbook was published in 2023 and provides leaders at all levels with valuable information on preventing, mitigating, and addressing mental health issues within their commands. The playbook covers topics such as how to have conversations about mental health and where to find supportive resources. The playbook supports Navy's Suicide Prevention Program, especially efforts to ensure that commanders are prepared for suicide crisis response, suicide-related behavior response, re-integration, and suicide postvention.[15]

Air Force and Space Force

Mental Health Overview Guide (MHOG)

The Air Force Medical Service published the MHOG to help Airmen and Guardians better understand mental health care. The guide explains the spectrum of staying mentally healthy – it explains various terms associated with mental health, describes the various clinical and non-clinical services available, and provides tips for navigating these resources. The MHOG also describes mental health standards and provides guidance on how mental and behavior health issues potentially impact retention, ability to engage in duties, and deployment.[16]

Mental Health Targeted Care

Targeted Care is designed to improve access and delivery of mental health care by managing resources in a way that connects Airmen and Guardians to an appropriate level of care. Active Duty members who access care at a mental health clinic are first assessed to determine their needed support, then matched with available resources. This can include individual clinical services, evidence-based group therapies, and/or engagement with "provider extenders," such as mental health technicians. Targeted Care was pilot tested at nine Air Force bases.[17] The Defense Health Agency (DHA) has also begun implementing Targeted Care in MTFs across DoD.

Suicide Prevention Virtual Reality (SPVR) Training

SPVR training is designed to provide Airmen and Guardians with a realistic virtual environment to learn and practice "Ask, Care, Escort" behavior. Participants engage with a Service member avatar and receive real-time feedback. In the spring of 2024, the Department of the Air Force compared training outcomes for SPVR and traditional suicide prevention training. Initial evaluation results indicate that SPVR participants reported greater willingness to intervene in a crisis compared to those who completed traditional training. The Air Force and Space Force plan to expand availability of SPVR training and continue evaluation efforts to understand whether training advantages persist over time.[18]

National Guard Bureau

Connectedness and Relationship Education (CARE)

CARE is a program that trains non-commissioned and commissioned officers to recognize harmful unit behaviors and how to intervene early. The program teaches trust building, communication, and other leadership skills to help leaders improve unit relationships through individual counseling with Service members. These skills assist in identifying risky behaviors, such as substance misuse, and provides leaders with skills and resources to mitigate these behaviors when they are identified. This program has been associated with improvements in interpersonal relationships and connectedness. The CARE program is currently available in 17 states.[19,20]

Star Behavioral Health Providers (SBHP)

SBHP is a training program for civilian behavioral health providers. Multiple levels of trainings are offered, most of which are available online. This program educates providers on military culture, the deployment cycle, and treatment options for military personnel. It also trains civilian providers in therapies found to be most effective with military families. SBHP maintains a registry of providers who have completed this training. SBHP is presently available across 46 states and territories.[21]

Project SafeGuard

Project SafeGuard is a multi-pronged suicide prevention program that provides training, peer counseling, and gun locks to interested Service members. The program encourages voluntary safe storage practices of lethal means, such as guns, potentially lethal medications, and sharp objects. Service members who participate in the program are additionally trained in motivational interviewing techniques that can be used in peer-to-peer counseling. The program fosters the development of protective environments by encouraging Service members to spread their knowledge to other Service members. Project SafeGuard is presently available to National Guard members in four states.[19,22]

Army Reserve

Psychological Health Program (PHP)

The PHP is an initiative specific to the Army Reserve that addresses the unique stressors encountered by Army Reserve Soldiers. This program aims to maintain a resilient and fit Reserve force by offering confidential behavioral health services to Soldiers and their families, supporting operational leadership with command consultation on behavioral health matters, providing clinical assessment and referral services, accepting referrals from various programs and reports, and responding immediately to behavioral health emergencies. These efforts are designed to ensure that Soldiers and their families receive the necessary behavioral health support while maintaining confidentiality and enhancing overall unit cohesion and resilience.

Operation Well-Being

Operation Well-Being was designed to address potential risky behavior and maintain unit readiness through education and training. It ensures timely safety by promptly accounting for all Army Reserve Soldiers on battle drills. Commanders must ensure that leaders understand and execute the Well-Being Battle Drill to account for all Soldiers within one hour of being notified of their absence. For Soldiers expressing suicidal ideations or intention to harm themselves, Commanding General Policy dictates the rapid response required to ensure appropriate care and immediate safety (e.g., Ask-Care-Escort process, clinical referral).

Suicide Prevention Liaison (SPL)

In August 2023, the SPL was implemented in the Army Reserve to advise commanders on how to manage suicide prevention requirements, training, campaigns, and events. Two Soldiers are appointed in every unit, working together with Soldier and Family Readiness Group leaders as well as chaplaincy/religious affairs specialists. They maintain a list of Federal, State, and local resources for Soldier and family member referrals, serve as the primary point of contact to assist with coordination of postvention activities and requirements, protect Soldiers against recrimination for seeking professional counseling, and raise suicide prevention awareness and vigilance.

Appendix

APPENDIX A: METHODOLOGICAL APPROACH

This appendix describes common topics related to suicide data collection in the military and provides a brief overview of the analytic methods used within this report.

Suicide Data and Interpretation

Reporting Suicide Deaths for Service Members

By DoD policy, AFMES determines the counts and rates for Service member suicide deaths. This includes cadets and midshipmen. All suicide deaths are reported to AFMES by the individual Service branch. In the case of Active Component Service members and Reserve Component (i.e., the Reserves and NGB) members that are on Active Duty at the time of death, AFMES additionally reviews and verifies any cause-of-death determination.[a] For Reserve Component members not on Active Duty status at the time of death, AFMES relies on cause-of-death determinations made by local medical or legal authorities. Suicide counts and rates for Reserve and National Guard members include members of the Selected Reserve with Active Duty status and non-duty status.

Reporting Suicide Deaths for Military Family Members

To determine the counts and rates for military family member suicide deaths, DSPO compiles data from the CDC National Center for Health Statistics NDI (a database of death record information compiled from state offices). Data were first available in 2017 and lag one year relative to Service member data due to the time lag in collection and processing of NDI data.

Of note, no single data source fully captures suicide deaths for military spouses and dependents. The majority of military family members are civilians whose deaths do not occur on a military installation and DoD does not have visibility of or jurisdiction over all these death investigations. For this reason, suicide counts and rates presented in this report may be underestimated for this population and may not account for all suicide deaths included in the definition in section 1072(2) of title 10, U.S. Code.

Defining Military Family Member

For the purposes of this report, "military family member" is a person who is sponsored by the Service member, is enrolled in DEERS, and is eligible for benefits under section 1072 of title 10, U.S. Code.

In this report, "dependent spouses" are referred to as "spouses" and "dependent children" as "dependents." To align with CDC standards on reporting suicide deaths, the present analysis only considers suicide deaths among dependents aged 10 years or older.[5] The family members of Reserve Component Service members in both Active Duty and non-duty status were included in identifying family members.

Counts versus Rates

Suicide death *counts* represent the number of people that died by suicide (also known as "absolute magnitude"). Suicide death *rates* represent the number of people that died for every 100,000 people in that group/population in a year.

Counts alone are not enough to compare two groups or to understand if suicide is changing over time. In fact, comparisons based on counts alone can be misleading. Using a rate ensures that any observed differences in suicide are not the result of one group being larger or smaller than the other.

For this report, to calculate a crude rate, the number of deaths is first divided by the size of the group, then multiplied by 100,000. Although rates account for differences in size, they do not explain why changes occur over time and do not account for many other factors that may affect suicide rates. For example, it would be misleading to compare suicide rates between groups that do not have a similar proportion of people with shared characteristics. To fix that, suicide rates are statistically adjusted during analysis to make the groups more like each other based on chosen characteristics. In the case of this report, rates are adjusted for the age and sex composition of each group. A rate that is not adjusted is called an unadjusted or crude rate.

Understanding Variability in Suicide Rates

All data related to human behavior have some natural variability. This can include, for example, a basic change in the frequency of the behavior or outcome (e.g., decrease in suicide deaths in a given year). It can also reflect variability in how standardized criteria are applied in examining the behavior (e.g., medical examiners determining suicide as the cause of death). This results in natural variability from year to year in the rates being examined. Variability can happen in either direction, resulting in an increase or decrease in the

[a]Service member deaths occur in either military or civilian jurisdictions. AFMES conducts about 15%–20% of all investigations to determine cause of death (i.e., suicide or another cause). The remainder of investigations are completed by civilian medical and legal authorities, then reported to AFMES by the respective military Service.

[b]Additional criteria may apply (see section 1072(2) of Title 10, U.S. Code).

number of recorded suicide deaths. In effect, a rate is considered volatile when even a small change in the total number of suicide deaths creates a noticeable shift in the suicide rate (e.g., a difference of two or three suicide deaths changes the rate within one decimal place). This is true for suicide rates in the military for which the overall number of suicide deaths is mathematically small compared to the size of the entire military population.

The possibility of volatility in suicide rates in the military can, in certain instances, make it difficult to reliably understand what is real change ("signal") and what is simply a natural variation in data ("noise"). This does not automatically mean that suicide rate data are somehow unreliable or unusable. It means that interpretation of this data, especially across short time frames or between smaller groups, should be made with caution and with as much context as possible to reliably inform policy, programs, or decision-making.

Understanding Statistical Significance

"Statistical significance" is a scientific term that describes how confident we are that a result is not purely due to chance or natural variability. A statistically significant result does not tell the reader whether a result is subjectively important.

A result can be statistically significant while still only representing a small difference or effect; on the other hand, a result may suggest a large difference or effect, but the data may be too limited to say whether the result is statistically significant. In such cases, more data or observations may be required to confirm any findings.

Statistical tests—as part of larger study design, sampling, and conceptual considerations—help researchers answer a variety of questions. For example, some tests can help us determine the extent to which findings are generalizable (e.g., whether a survey about the attitudes of young, male Service members can be generalized to all Service members). Statistical tests, like effect sizes, can also tell us about the strength of particular relationships.

In this report, statistical significance is determined by interpreting results using *p* values— which represent a predetermined level of probability. We identify statistically significant findings in this report with an asterisk (*). Findings that are not statistically significant are identified with an obelus (†).

What are p values?

The probability with which the result could have occurred due to chance or natural variability. A common threshold for determining statistical significance is $p < 0.05$. This means, if a result is statistically significant (or, in other words, $p < 0.05$), the chances of obtaining this result when no real difference exists is less than 5%.

What are 95% confidence intervals?

A level of uncertainty is associated with suicide rates due to random error and/or volatility. An example of random error includes the possible misclassification of suicide as a cause of death. Confidence intervals provide a range of possible values for the suicide rate that accounts for such uncertainty. Within a 95% confidence interval, one can be confident that the range of values will include the true suicide rate 95% of the time.

Analysis

Calculating Unadjusted and Adjusted Suicide Rates

In this report, anytime suicide rates were compared, an **adjusted rate** was used. Unadjusted suicide death rates represent the number of people that died for every 100,000 people in that group/population in a given year. Adjusted rates are estimated using a generalized log-linear regression model based on the Poisson distribution (i.e., change is linear in the log of the rate) and a large matrix or contingency table with decedent and population totals by strata (e.g., year, age category, sex, Component or Service). When adjusting for age and sex, the model also uses weighted effects coding.[c] A Poisson distribution is well suited to estimate counts or rates for rare or low base rate events, such as suicide. See **Figure 1** for an example showing age- and sex-adjusted rates for each year.

Estimating Change Over Time in Suicide Rates

A line of best fit using log-linear modeling, which is well suited for rate data with a low base rate, was calculated to describe trends in suicide rates over time. This approach models the observed event count, with consideration for the population size, and uses the distribution as a weight, which is well suited to account for high variance in low count data. More specifically, the log-linear model is achieved by using a Generalized Linear Model with a log-link function and is used to account for population size as well as suicide death counts. The estimated rates are obtained by exponentiating the log rates from the trend analysis, and the trend of the rates is then a slight curve. This approach assumes that change over time is log-linear in nature and that it follows a Poisson distribution. As part of statistical analysis, a Poisson distribution is used to determine the probability of rare events and allows for contingency tables or a matrix to adjust for multiple variables, such as age and sex. This method was applied to describe trends from CY 2011 to CY 2023 (see the Service Member Suicide Data section) and was the same analytic approach that was used in DoDSER Annual Reports up to and including CY 2019. To describe shorter or more near-term changes, this report

[c]Link to research article describing weighted effects coding: https://journal.r-project.org/archive/2017/RJ-2017-017/RJ-2017-017.pdf

compared the rate for a given year to each of those for the last two years using a pairwise comparison approach. The result of the trend analysis, for both the near and long term, was a single estimated rate of change for the period, also known as the incidence rate ratio. A statistical test was then performed to determine if the trend direction (increasing or decreasing) was statistically significant for the period of interest. In all cases, rates were adjusted to account for age and sex differences across the period of interest.

Assessing Risk for Death by Suicide Among Specific Demographics Groups

Rate ratios comparing the rate for each demographic group (listed in Table 2) with the average population rate were calculated to assess suicide risk for a specific demographic group. Rate ratios are a statistical tool used to assess whether a given demographic group is at a higher risk of dying by suicide relative to another group. More specifically, rate ratios are a measure of association which can be used to quantify the relationship between two groups in the occurrence of suicide. For the purposes of analyses in this report, the suicide rate for decedents from a specific demographic group was compared to the overall suicide rate for the Component in which they served. For these analyses, an overall, combined suicide rate was calculated for the Reserves and National Guard. This was done owing to the relatively small number of decedents in each of these groups, thereby ensuring meaningful interpretation of findings.

A generalized log-linear regression model based on the Poisson distribution was used to obtain the rate estimates for each group that was compared. Weighted effects coding was applied to each of the demographic groups to ensure the rate ratios reflected a risk relative to the population average. The model's parameter estimates (regression coefficients) describe the ratio of the suicide rate of any given demographic group to that of the population average (i.e., the rate ratio). For example, see the "Demographic and Military Characteristics" section within the Service Member Suicide Data section of this report for an assessment of whether male Service members have a higher risk for suicide.

Comparing Military Suicide Rates to the U.S. Population

Accounting for sex and age is vital when comparing suicide rates between the military and the U.S. population because the military has more men and more young people (i.e., under 30). This requires standardizing for age and sex differences between the military and U.S. population, then adjusting for age and sex differences in suicide rates within the military. Without such standardization and adjustment, the comparisons between the unadjusted or crude rates in the military and the U.S. population suicide rates would be misleading or distorted.

When making comparisons between the military and U.S. populations, we used **indirect standardization** to account for differences in the demographic makeup because the number of suicide deaths within subsets of the military population are very small. A Poisson distribution along with the military age- and sex-specific stratum population size was then used to estimate the standardized mortality ratio between the military and U.S. populations. This mirrors the approach used in last year's Annual Report on Suicide in the Military and DoDSER up to and including CY 2019. For more details, see CY 2019 DoDSER Appendix D (DoD, OUSD[P&R], 2021).

In this report, military suicide rates are purposefully standardized and adjusted for comparisons with U.S. population suicide rates. For this reason, they should not be compared with rates for other populations or groups. We statistically test for a significant difference between the indirectly standardized rates for the military and U.S. populations. In the process of that statistical test, we calculate the 95% confidence interval associated with the standardized rate, which is used to illustrate differences between the two populations. If the span of the confidence interval for the military population did not cover the U.S. population rate, then the probability of observing a difference, in the absence of a true difference, was less than 5%—in other words, one can be 95% confident that the two rates are statistically different. For an example of this analysis, see the Suicide Rates Over Time section within the Service Member Suicide Data section of this report. U.S. population data were obtained using CDC Wide-ranging ONline Data for Epidemiologic Research.

Notes on Army data in the CY 2023 ARSM

Due to missing population data, statistical imputation was used to determine the total size of the Army in CY 2022-2023 and sponsor status of some Service members could not be verified. As a result, counts and rates reported here for spouses and dependents should be interpreted with caution.

APPENDIX B: UNADJUSTED AND ADJUSTED RATES OVER TIME

Tables 9–11 present unadjusted and adjusted rates for the CY 2011–CY 2023 trend analyses presented in the Service Member Suicide Data section of this report. A rate is considered unadjusted when it is calculated using only the raw number of suicide deaths that occurred and the total size of the population. However, Service member populations fluctuate over time. The number of Service members of a certain age or sex can vary across years. Since both age and sex are associated with suicide risk, when making comparisons across years, it is important to adjust rates for age and sex differences (i.e., adjusted rates). This avoids potentially misleading comparisons of unadjusted rates.

Suicide rates from the CY 2011–CY 2023 trend analyses were adjusted for age and sex over the defined time period. The unadjusted rates, presented below, may not match the unadjusted rates in **Table 1** of the report because the unadjusted suicides rates for the CY 2011–CY 2023 trend analyses were limited to ages 17–59 for the purpose of these analyses. Additionally, as new years of data are added to the analysis (e.g., CY 2023), the adjusted rates will change to incorporate the population and their associated demographic characteristics from that year. See **Appendix A** for more information about adjusting for age and sex.

Table 9 | Annual Suicide Rates by Component, Rates per 100,000 Service Members, CY 2011–CY 2023

Year	Active Component		Reserves		National Guard	
	Unadjusted	Adjusted	Unadjusted	Adjusted	Unadjusted	Adjusted
2011	18.7	17.0	18.1	15.3	24.9	21.4
2012	22.9	20.9	19.3	16.2	28.2	24.4
2013	18.4	16.9	23.1	19.4	28.9	25.1
2014	20.2	18.5	21.6	18.3	19.6	17.1
2015	20.2	18.6	24.8	21.0	26.4	23.0
2016	21.5	19.9	22.0	18.8	27.1	23.7
2017	22.1	20.5	25.8	22.1	29.6	26.0
2018	24.9	23.1	22.9	19.8	30.8	27.3
2019	26.2	24.3	18.5	16.1	20.5	18.4
2020	28.5	26.5	21.7	19.1	27.5	24.7
2021	24.4	22.7	21.3	18.8	27.3	24.4
2022	25.1	23.4	19.4	17.3	22.2	19.9
2023	28.3	26.5	20.9	18.8	21.2	19.0

Notes: Data sourced from AFMES. Unadjusted rates are age bound to 17–59. Adjusted rates are age bound to 17–59 and adjusted for age and sex.

Table 10 | Active Component Service Member Suicide Rates per 100,000 Service Members by Service, CY 2011–CY 2023

Year	Army		Marine Corps		Navy		Air Force	
	Unadjusted	Adjusted	Unadjusted	Adjusted	Unadjusted	Adjusted	Unadjusted	Adjusted
2011	24.8	22.9	15.4	14.7	16.0	13.9	12.9	11.4
2012	29.9	27.6	24.3	23.4	18.1	15.9	15.0	13.3
2013	22.5	20.9	23.6	22.9	12.8	11.3	14.4	12.8
2014	24.4	22.8	17.9	17.3	16.6	14.7	18.5	16.4
2015	24.4	22.9	21.2	20.4	13.1	11.7	20.6	18.2
2016	27.4	25.7	20.1	19.4	15.9	14.2	19.4	17.3
2017	24.7	23.2	23.4	22.6	20.1	18.0	19.6	17.6
2018	29.9	28.0	30.8	29.9	20.7	18.7	18.5	16.6
2019	30.5	28.5	25.3	24.5	21.8	19.8	25.1	22.5
2020	36.2	33.8	34.5	33.4	19.0	17.4	24.0	21.6
2021	36.1	33.8	23.9	23.2	17.0	15.5	15.3	13.8
2022	28.9	27.0	36.0	35.0	20.7	18.9	19.0	17.2
2023	34.8	32.7	35.9	35.0	21.0	19.3	22.5	20.5

Table 11 | Army Reserve and Army National Guard Suicide Rates per 100,000 Service Members by Service, CY 2011–CY 2023

Year	Army Reserve		Army National Guard	
	Unadjusted	Adjusted	Unadjusted	Adjusted
2011	21.4	18.5	27.4	23.6
2012	24.7	21.3	30.8	26.6
2013	29.6	25.5	33.7	29.3
2014	21.4	18.6	21.5	18.7
2015	27.2	23.6	28.7	25.0
2016	20.6	18.0	31.3	27.3
2017	32.1	28.2	35.5	31.2
2018	25.3	22.5	35.6	31.5
2019	19.4	17.3	22.9	20.5
2020	22.2	20.0	31.5	28.3
2021	24.8	22.5	31.3	28.0
2022	20.8	18.9	24.8	22.2
2023	25.0	22.7	23.8	21.3

Notes: Data sourced from AFMES. Unadjusted rates are age bound to 17–59. Adjusted rates are age bound to 17–59 and adjusted for age and sex.

Per DoDI 6490.16, Space Force, Marine Corps Reserve, Navy Reserve, Air Force Reserve, and Air National Guard rates are not reported due to low counts.[1]

APPENDIX C: DEMOGRAPHICS OF SUICIDE DECEDENTS BY SERVICE

Tables 12–14 present the counts, percentages, and rates of suicide decedents by demographic subgroups for each Service and Component. All data are sourced from AFMES.

Table 12 | Active Component Service Member Suicide Counts by Service, Rates per 100,000 Service Members and Percentages, CY 2023

Demographics	Army			Marine Corps			Navy			Air Force		
	Rate	Count	Percent	Rate	Count	Percent	Rate	Count	Percent	Rate	Count	Percent
Total	**34.8**	**158**	**100%**	**35.9**	**61**	**100%**	**21.0**	**70**	**100%**	**22.5**	**72**	**100%**
Sex												
Male	37.7	144	91.1%	38.4	59	96.7%	25.4	67	95.7%	27.1	68	94.4%
Female	--	14	8.9%	--	2	3.3%	--	3	4.3%	--	4	5.6%
Age Group												
17-19	--	5	3.2%	--	7	11.5%	--	2	2.9%	--	3	4.2%
20-24	43.9	59	37.3%	43.1	34	55.7%	29.6	29	41.4%	31.7	28	38.9%
25-29	33.9	37	23.4%	--	14	23.0%	--	15	21.4%	26.6	21	29.2%
30-34	33.8	26	16.5%	--	3	4.9%	--	9	12.9%	--	9	12.5%
35-39	36.1	20	12.7%	--	3	4.9%	--	5	7.1%	--	9	12.5%
40-44	--	8	5.1%	--	0	0.0%	--	7	10.0%	--	1	1.4%
45-49	--	2	1.3%	--	0	0.0%	--	3	4.3%	--	1	1.4%
50+	--	1	0.6%	--	0	0.0%	--	0	0.0%	--	0	0.0%
Race												
White	35.9	109	69.0%	31.7	43	70.5%	23.3	48	68.6%	23.2	51	70.8%
Black or African American	33.5	32	20.3%	--	8	13.1%	--	5	7.1%	--	8	11.1%
American Indian / Alaska Native	--	3	1.9%	--	0	0.0%	--	1	1.4%	--	0	0.0%
Asian / Pacific Islander	--	5	3.2%	--	8	13.1%	--	5	7.1%	--	6	8.3%
Other / Unknown	--	9	5.7%	--	2	3.3%	--	11	15.7%	--	7	9.7%
Rank												
E(Enlisted)	38.7	138	87.3%	40.5	60	98.4%	22.7	62	88.6%	25.5	65	90.3%
E1-E4	39.7	71	44.9%	46.0	45	73.8%	26.1	31	44.3%	29.6	37	51.4%
E5-E9	37.7	67	42.4%	--	15	24.6%	20.1	31	44.3%	21.5	28	38.9%
O (Commissioned Officer)	--	13	8.2%	--	1	1.6%	--	7	10.0%	--	6	8.3%
W (Warrant Officer)	--	7	4.4%	--	0	0.0%	--	1	1.4%	--	0	0.0%
Cadet	--	0	0.0%	--	0	0.0%	--	0	0.0%	--	1	1.4%
Marital Status												
Never Married	32.7	66	41.8%	30.0	29	47.5%	23.5	37	52.9%	30.3	40	55.6%
Married	35.7	81	51.3%	35.6	24	39.3%	19.4	31	44.3%	14.3	24	33.3%
Divorced	--	11	7.0%	--	7	11.5%	--	2	2.9%	--	8	11.1%
Legally Separated	--	0	0.0%	--	1	1.6%	--	0	0.0%	--	0	0.0%
Widowed	--	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%
Unknown	--	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%

Note: No demographic information is presented for Space Force due to low counts.

Table 13 | Reserve Service Member Suicide Counts by Service, Rates per 100,000 Service Members and Percentages, CY 2023

Demographics	Army Reserve			Marine Corps Reserve			Navy Reserve			Air Force Reserve		
	Rate	Count	Percent	Rate	Count	Percent	Rate	Count	Percent	Rate	Count	Percent
Total	**24.9**	**44**	**100%**	**--**	**10**	**100%**	**--**	**8**	**100%**	**--**	**7**	**100%**
Sex												
Male	28.9	38	86.4%	--	10	100%	--	7	87.5%	--	7	100.0%
Female	--	6	13.6%	--	0	0.0%	--	1	12.5%	--	0	0.0%
Age Group												
17-19	--	1	2.3%	--	1	10.0%	--	0	0.0%	--	0	0.0%
20-24	--	11	25.0%	--	6	60.0%	--	1	12.5%	--	0	0.0%
25-29	--	9	20.5%	--	2	20.0%	--	2	25.0%	--	3	42.9%
30-34	--	7	15.9%	--	1	10.0%	--	3	37.5%	--	1	14.3%
35-39	--	3	6.8%	--	0	0.0%	--	2	25.0%	--	1	14.3%
40-44	--	6	13.6%	--	0	0.0%	--	0	0.0%	--	0	0.0%
45-49	--	4	9.1%	--	0	0.0%	--	0	0.0%	--	2	28.6%
50+	--	3	6.8%	--	0	0.0%	--	0	0.0%	--	0	0.0%
Race												
White	25.5	29	65.9%	--	8	80.0%	--	6	75.0%	--	6	85.7%
Black or African American	--	9	20.5%	--	1	10.0%	--	0	0.0%	--	1	14.3%
American Indian / Alaska Native	--	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%
Asian / Pacific Islander	--	0	0.0%	--	1	10.0%	--	0	0.0%	--	0	0.0%
Other / Unknown	--	6	13.6%	--	0	0.0%	--	2	25.0%	--	0	0.0%
Rank												
E (Enlisted)	26.2	36	81.8%	--	9	90.0%	--	8	100%	--	6	85.7%
E1-E4	--	17	38.6%	--	7	70.0%	--	3	37.5%	--	3	42.9%
E5-E9	--	19	43.2%	--	2	20.0%	--	5	62.5%	--	3	42.9%
O (Commissioned Officer)	--	7	15.9%	--	1	10.0%	--	0	0.0%	--	1	14.3%
W (Warrant Officer)	--	1	2.3%	--	0	0.0%	--	0	0.0%	--	0	0.0%
Marital Status												
Never Married	28.2	24	54.5%	--	9	90.0%	--	2	25.0%	--	1	14.3%
Married	--	18	40.9%	--	1	10.0%	--	5	62.5%	--	6	85.7%
Divorced	--	1	2.3%	--	0	0.0%	--	1	12.5%	--	0	0.0%
Legally Separated	--	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%
Widowed	--	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%
Unknown	--	1	2.3%	--	0	0.0%	--	0	0.0%	--	0	0.0%

A correction was made to Table 13 on December 20, 2024 following the release of this report on November 14, 2024. The previous version mislabeled the Marine Corps Reserve and Navy Reserve columns. The data in the columns have been corrected.

Table 14 | National Guard Service Member Suicide Counts by Service, Rates per 100,000 Service Members and Percentages, CY 2023

Demographics	Army National Guard			Air National Guard		
	Rate	Count	Percent	Rate	Count	Percent
Total	**23.7**	**77**	**100%**	**--**	**14**	**100%**
Sex						
Male	28.0	73	94.8%	--	11	78.6%
Female	--	4	5.2%	--	3	21.4%
Age Group						
17-19	--	2	2.6%	--	1	7.1%
20-24	30.4	28	36.4%	--	4	28.6%
25-29	34.4	22	28.6%	--	1	7.1%
30-34	--	6	7.8%	--	3	21.4%
35-39	--	7	9.1%	--	1	7.1%
40-44	--	6	7.8%	--	3	21.4%
45-49	--	4	5.2%	--	0	0.0%
50+	--	2	2.6%	--	1	7.1%
Race						
White	19.4	48	62.3%	--	10	71.4%
Black or African American	42.4	22	28.6%	--	2	14.3%
American Indian / Alaska Native	--	2	2.6%	--	1	7.1%
Asian / Pacific Islander	--	4	5.2%	--	0	0.0%
Other / Unknown	--	1	1.3%	--	1	7.1%
Rank						
E (Enlisted)	25.6	71	92.2%	--	13	92.9%
E1-E4	25.2	39	50.6%	--	6	42.9%
E5-E9	26.0	32	41.6%	--	7	50.0%
O (Commissioned Officer)	--	5	6.5%	--	1	7.1%
W (Warrant Officer)	--	1	1.3%	--	0	0.0%
Cadet	--	0	0.0%	--	0	0.0%
Marital Status						
Never Married	24.7	48	62.3%	--	7	50.0%
Married	21.1	24	31.2%	--	4	28.6%
Divorced	--	5	6.5%	--	3	21.4%
Legally Separated	--	0	0.0%	--	0	0.0%
Widowed	--	0	0.0%	--	0	0.0%
Unknown	--	0	0.0%	--	0	0.0%

Table 15 | Service Member Suicide Rates per 100,000 Service Members, Counts, Percentages, and Total Force Counts and Percentages by Demographic Characteristics, CY 2023

Demographics	Active Component					Reserves					National Guard				
	Suicide			Total Force		Suicide			Total Force		Suicide			Total Force	
	Rate	Count	Percent	Count	Percent	Rate	Count	Percent	Count	Percent	Rate	Count	Percent	Count	Percent
Total	**28.2**	**363**	**100%**	**1,285,309**	**100%**	**20.9**	**69**	**100%**	**330,575**	**100%**	**21.2**	**91**	**100%**	**429,280**	**100%**
Sex															
Male	32.1	339	93.4%	1,057,377	82.3%	24.7	62	89.9%	251,171	76.0%	24.5	84	92.3%	342,550	79.8%
Female	10.5	24	6.6%	227,932	17.7%	--	7	10.1%	79,404	24.0%	--	7	7.7%	86,730	20.2%
Age Group															
17-19	--	17	4.7%	84,529	6.6%	--	2	2.9%	12,035	3.6%	--	3	3.3%	30,692	7.1%
20-24	37.4	150	41.3%	401,255	31.2%	--	18	26.1%	62,023	18.8%	29.8	32	35.2%	107,410	25.0%
25-29	29.0	87	24.0%	299,700	23.3%	--	16	23.2%	61,447	18.6%	28.3	23	25.3%	81,287	18.9%
30-34	23.2	49	13.5%	210,756	16.4%	--	12	17.4%	56,571	17.1%	--	9	9.9%	69,282	16.1%
35-39	23.0	37	10.2%	160,684	12.5%	--	6	8.7%	53,798	16.3%	--	8	8.8%	58,008	13.5%
40-44	--	16	4.4%	83,274	6.5%	--	6	8.7%	39,940	12.1%	--	9	9.9%	39,496	9.2%
45-49	--	6	1.7%	30,450	2.4%	--	6	8.7%	21,130	6.4%	--	4	4.4%	20,435	4.8%
50+	--	1	0.3%	14,660	1.1%	--	3	4.3%	23,629	7.1%	--	3	3.3%	22,671	5.3%
Race															
White	29.0	253	69.7%	871,210	67.8%	22.4	49	71.0%	218,928	66.2%	17.5	58	63.7%	330,610	77.0%
Black / African American	23.7	53	14.6%	223,780	17.4%	--	11	15.9%	63,226	19.1%	38.9	24	26.4%	61,708	14.4%
American Indian /Alaska Native	--	4	1.1%	13,971	1.1%	--	0	0.0%	2,938	0.9%	--	3	3.3%	2,982	0.7%
Asian / Pacific Islander	38.4	24	6.6%	62,481	4.9%	--	1	1.4%	14,175	4.3%	--	4	4.4%	19,355	4.5%
Other / Unknown	25.5	29	8.0%	113,867	8.9%	--	8	11.6%	31,308	9.5%	--	2	2.2%	14,625	3.4%
Rank															
E (Enlisted)	31.4	326	89.8%	1,037,472	80.7%	22.9	59	85.5%	258,180	78.1%	22.9	84	92.3%	366,280	85.3%
E1-E4	35.3	184	50.7%	521,897	40.6%	25.7	30	43.5%	116,841	35.3%	25.0	45	49.5%	179,667	41.9%
E5-E9	27.5	142	39.1%	515,575	40.1%	20.5	29	42.0%	141,339	42.8%	20.9	39	42.9%	186,613	43.5%
O (Commissioned Officer)	13.0	28	7.7%	215,106	16.7%	--	9	13.0%	68,449	20.7%	--	6	6.6%	54,120	12.6%
W (Warrant Officer)	--	8	2.2%	19,625	1.5%	--	1	1.4%	3,946	1.2%	--	1	1.1%	8,879	2.1%
Cadet	--	1	0.3%	13,106	1.0%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Marital Status															
Never Married	29.3	173	47.7%	591,422	46.0%	23.9	36	52.2%	150,347	45.5%	23.8	55	60.4%	231,521	53.9%
Married	25.7	161	44.4%	627,542	48.8%	19.2	30	43.5%	156,236	47.3%	16.1	28	30.8%	173,453	40.4%
Divorced	45.1	28	7.7%	62,071	4.8%	--	2	2.9%	23,120	7.0%	--	8	8.8%	23,622	5.5%
Legally Separated	--	1	0.3%	696	0.1%	--	0	0.0%	160	0.0%	--	0	0.0%	156	0.0%
Widowed	--	0	0.0%	831	0.1%	--	0	0.0%	442	0.1%	--	0	0.0%	398	0.1%
Unknown	--	0	0.0%	2,748	0.2%	--	1	1.4%	271	0.1%	--	0	0.0%	129	0.0%

APPENDIX D: TIMELINE OF SPRIRC ACTIONS IMPLEMENTATION

MARCH 22, 2022

SPRIRC Established

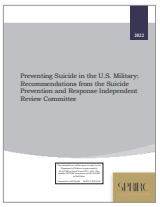
In March 2022, the Secretary of Defense established the SPRIRC. Composed of leading subject matter experts in suicide prevention, the Committee conducted a comprehensive review of clinical and non-clinical suicide prevention and response programs across the DoD.

Link to memorandum by the Secretary of Defense on Establishment of the Suicide Prevention and Response Independent Review Committee
https://media.defense.gov/2022/Mar/22/2002961288/-1/-1/0/ESTABLISHMENT-OF-THE-SUICIDE-PREVENTION-AND-RESPONSE-INDEPENDENT-REVIEW-COMMITTEE.PDF

JANUARY 4, 2023

Final Report Published

As required by the National Defense Authorization Act for Fiscal Year 2022, Section 738, the SPRIRC first provided their final report to the Secretary of Defense in December 2022. It was published and provided to Congress in January 2023. The report included 127 encompassing recommendations meant to enhance DoD suicide prevention and response efforts by improving Service member well-being. These recommendations covered such domains as points of strength in the U.S. Military, overarching DoD issues, healthy and empowered individuals, families and communities, clinical and community preventative services, treatment and support services, and surveillance, research and evaluation.

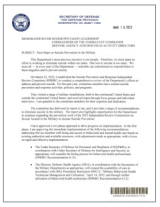


Link to the final report of the Suicide Prevention and Response Independent Review Committee
https://media.defense.gov/2023/Feb/24/2003167430/-1/-1/0/SPRIRC-FINAL-REPORT.PDF

MARCH 13, 2023

Next Steps

Soon after the SPRIRC final report was published, the Secretary of Defense called for the immediate and ongoing implementation of 10 recommendations focused on enhancing Service member well-being and access to behavioral and mental health care.



Link to memorandum by the Secretary of Defense on Next Steps on Suicide Prevention in the Military
https://media.defense.gov/2023/Mar/16/2003180466/-1/-1/1/MEMORANDUM-NEXT-STEPS-ON-SUICIDE-PREVENTION-IN-THE-MILITARY.PDF

The Department immediately implemented 10 recommendations and is making progress in the following areas:

1. Expedite hiring processes for behavioral health professionals
2. Expand availability of care and further use of behavioral health technicians
3. Improve processes to enhance access to mental health care
4. Improve access to mental health care by improved alignment of clinic scheduling
5. Use the “Episodes of care” model — multiple appointments are scheduled at the outset of care
6. Ensure empirically supported treatment interventions are aligned with the recently published 2024 VA/DoD “Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide”
7. Ensure MTFs screen for unhealthy alcohol use in Primary Care Clinics
8. Ensure availability of evidence-based care for those seeking treatment or support for unhealthy drinking
9. Expand opportunities to treat common mental health conditions in primary care
10. Promote mission readiness through healthy sleep

The Secretary of Defense also called for the creation of a Suicide Prevention Implementation Working Group to assess if and how the remaining SPRIRC recommendations might be practically implemented across DoD.

TIMELINE OF SPRIRC ACTIONS IMPLEMENTATION

SEPTEMBER 26, 2023

Enabling Actions

The Secretary of Defense approved 83 key enabling actions, adapted and modified from the remaining SPRIRC recommendations. These actions were categorized within and intended to strengthen five LOEs which guide DoD's suicide prevention work:

- Foster a supportive environment
- Improve the delivery of mental health care
- Address stigma and other barriers to care
- Revise suicide prevention training
- Promote a culture of LMS

More information on the five LOEs is provided in the earlier section on "Implementation of SPRIRC Recommendations."


DOD Announces New Actions to Prevent Suicide in the Military

Link to memorandum by the Secretary of Defense on New DoD Actions to Prevent Suicide in the Military
https://www.defense.gov/News/Releases/Release/Article/3541077/dod-announces-new-actions-to-prevent-suicide-in-the-military

JULY 8, 2024

Planning Completed

DoD completed planning for the implementation of the key enabling actions, pending availability of funds. Thus far, DoD has:

- Approved and funded short- and long-term implementation plans to address the approved SPRIRC recommendations into action
- Documented standard operating procedures for oversight and implementation
- Articulated outcomes of the actions and identified associated outcome metrics

SPRIRC ACCOMPLISHMENTS

Summary	
Foster a Supportive Environment	
Improve career stabilization options	Examples on how each Service/Military Department has taken action on these topics, to include: • **Command Assignments:** Each Service has an assessment program in place to review which leaders are best suited for command assignments. • **Monetary/Non-monetary Incentives:** Each service has retention incentives/bonuses to retain key talent & improve assignments processes. • **Promote Leadership to Support SMs and Families:** Each Service has pursued programs to strengthen support for SMs and families, such as improving childcare programs in the Air Force, investing in quality family housing in the Army, and reforms to the Human Resources Development Process for USMC. • **Leader Selection/Development:** Each Service outlined steps they are taking to implement stronger assessments of their command positions, such as beta testing the Squadrom Command Assessment Test in the Air Force.
Continue Service-managed approaches to command assignments	
Monetary and non-monetary incentives for retention	
Promote leadership focused on strengthening support for SMs and families	
Leader selection and development	• This action is focused on making updates to the pay systems to ensure that financial burdens do not increase suicide risk for Service Members.
Improve pay and reimbursement processes	• This is being accomplished by the Quadrennial Review of Military Compensation (QRMC) which reviews the military basic pay table to ensure it is properly structured, as well as a study to analyze whether updates to the current basic pay model meet the needs of the current employment market. • The QRMC is underway and will conclude at the end of CY24.
Review military pay tables to ensure economic security	• This is being accomplished by the QRMC which reviews the military basic pay table to ensure it is properly structured, as well as a study to analyze whether updates to the current basic pay model meet the needs of the current employment market. • The QRMC is underway and will conclude at the end of CY24.

SPRIRC ACCOMPLISHMENTS

Summary	
Foster a Supportive Environment	
Modernize and reform the military promotion system through DEI sprint initiatives	Accessibility Sprint and Talent Management Initiatives will achieve the desired end state.
Provide greater flexibility in military career trajectories through DEI sprint initiatives	
Review military pay tables to strengthen Service members' economic security	
Revise Suicide Prevention Training	
Improve pay and reimbursement processes	• This is being accomplished by the QRMC which reviews the military basic pay table to ensure it is properly structured, as well as a study to analyze whether updates to the current basic pay model meet the needs of the current employment market. • The QRMC is underway and will conclude at the end of CY24.
Improve the Delivery of Mental Health Care	
Continue phased rollout of a centralized credentials verification service	DHA stood up a centralized credentials verification service which allows centralized contract functions to perform primary source verification of credentials, removing burden from MTFs.
Functionality of IT and communication systems	• SPRIRC observations occurred during transition to Medical 365 for email and office automation. • Conducted survey with sites visited by SPRIRC following the tech transition, no issues with email or computer accessibility reported.
Ensure technological availability in MTFs	The Military Health System acquired new end user devices, including 130k PCs, as well as monitors and docking stations.
Timely processing of TRICARE Payment Claims	TRICARE Operations Manual states that the contractor shall process to completion 98% of claims within 30 days". This standard was exceeded in CY2022, and a quarterly audit is conducted.
Regular updates to TRICARE provider rosters	Contract requires that the provider directory is refreshed no less than once every 24 hours, and Network providers can access systems. .

APPENDIX E: GLOSSARY

Acronyms

AFMES – Armed Forces Medical Examiner System
ARSM – Annual Report on Suicide in the Military
CARE – Connectedness and Relationship Education
CDC – Centers for Disease Control and Prevention
CONUS/OCONUS – Continental United States/Outside Continental United States
CRIT – Crisis Response and Intervention Training
CY – Calendar Year
DEERS – Defense Enrollment Eligibility Reporting System
DHA – Defense Health Agency
DMDC – Defense Manpower Data Center
DoD – Department of Defense
DoDI – Department of Defense Instruction
DoDSER – Department of Defense Suicide Event Report
DSN – Defense Switching Network
DSRB – Death by Suicide Review Board
DSPO – Defense Suicide Prevention Office
FY – Fiscal Year
IPPW – Integrated Primary Prevention Workforce
LMS – Lethal Means Safety
LOE – Lines of Effort
MCTF – Marine Corps Total Fitness
MHOG – Mental Health Overview Guide
MTF – Military Treatment Facility
NDAA – National Defense Authorization Act
NDI – National Death Index
NGB – National Guard Bureau
NSSP – National Strategy for Suicide Prevention
OASD(HA) – Office of the Assistant Secretary of Defense for Health Affairs
OASD(M&RA) – Office of the Assistant Secretary of Defense for Manpower and Reserve Affairs
OASD(R) – Office of the Assistant Secretary of Defense for Readiness
OPR – Office of Primary Responsibility
OUSD(P&R) – Office of the Under Secretary of Defense for Personnel and Readiness
PHP – Psychological Health Program
QRMC – Quadrennial Review of Military Compensation
SAIL – Sailor Assistance and Intercept for Life
SBHP – Star Behavioral Health Providers
SPL – Suicide Prevention Liaison
SPRIRC – Suicide Prevention and Response Independent Review Committee
SPVR – Suicide Prevention Virtual Reality
TBH – Tele-behavioral Healthcare
USD(P&R) – Under Secretary of Defense for Personnel and Readiness
VA – Department of Veterans Affairs

Terms and Definitions[d]

Active Component: Refers collectively to the Active Duty segments of the Army, Marine Corps, Navy, Air Force, and Space Force, that are funded directly from DoD Active Duty military personnel appropriations pursuant to Section 115(a) of Title 10, U.S. Code (DoDI 1120.1115).

Active Duty: Full-time duty in the active military service of the United States. This includes full-time training duty, annual training duty, and attendance, while in the active military service, at a school designated as a service school by law or by the Secretary of the military department concerned. Such term does not include full-time National Guard duty (Section 101(d)(1) of Title 10, U.S. Code).

Adjusted and Unadjusted Suicide Rates: A rate is considered unadjusted when it is calculated using only the raw number of suicide deaths that occurred and the total size of the population. However, Service member populations fluctuate over time. For this reason, to ensure accurate comparisons across years or subpopulations, it is important to account or adjust for differences between the groups being compared. In this report, rates were adjusted for sex and age.

Armed Forces Medical Examiner System: The AFMES is established as a subordinate element of the DHA to: (1) Perform forensic pathology investigations in accordance with Section 1471 of Title 10, U.S. Code (2) Exercise DoD scientific authority for the identification of remains of DoD-affiliated personnel in deaths from past conflicts and other designated conflicts as provided in Section 1509 of Title 10, U.S. Code (DoDI 5154.30).

Defense Enrollment Eligibility System: A computerized database of military sponsors (Active Duty, retired, or member of the Reserve Component) and their eligible family members. DEERS registration is required for certain military benefits, including TRICARE (https://www.tricare.mil/deers/).

Department of Defense Suicide Event Report System Data Summary: A report that characterizes Service member suicide data through a coordinated, web-based data collection system (DoDI 6490.16).

Effort: In the context of DoD military suicide prevention, an effort is a collection of actions and programs that aim to support defined Service member needs.

Enabling actions: Refers here to a series of tasks – adopted and modified from recommendations included in the SPRIRC final report – to be implemented within each of the five DoD suicide prevention lines of effort. These tasks were approved by the Secretary of Defense in a 26 September 2023 memorandum (https://media.defense.gov/2023/Sep/28/2003310249/-1/-1/1/NEW-DOD-ACTIONS-TO-PREVENT-SUICIDE-IN-THE-MILITARY.PDF).

Integrated Primary Prevention: Refers to prevention activities that simultaneously address multiple self-directed harm and prohibited abusive or harmful acts or the inclusion of prevention activities across self-directed harm and prohibited abusive or harmful acts into a cohesive, comprehensive approach that promotes unity of effort, avoids unnecessary duplication, and lessens training fatigue (DoDI 6400.09).

Lines of effort: Refers here to five categories of services and supportive options which constitute the core of DoD's suicide prevention program: foster a supportive environment, improve the delivery of mental health care, address stigma and other barriers to care, revise suicide prevention training, and promote a culture of LMS.

Military Family Members (or Military Dependents): For purposes of this report, military family members (also known as military dependents) are those who are sponsored by a Service member, are enrolled in DEERS, and meet the requirement for a military dependent as defined by Section 1072(2) of Title 10, U.S. Code. In this report, "dependent spouses" are referred to as "spouses" and "dependent children" as "dependents" (DoDI 6490.16).

National Death Index: A centralized database of death record information on file in state vital statistics offices (DoDI 6490.16).

Postvention: Response activities that should be undertaken in the immediate aftermath of a suicide that has impacted the unit. Postvention has two purposes: to help suicide attempt survivors cope with their grief and to prevent additional suicides. It also may provide an opportunity to disseminate accurate information about suicide, encourage help-seeking behavior, and provide messages of resilience, hope, and healing. It is also known as "tertiary prevention" (DoDI 6490.16).

[d]Definitions lacking a parenthetical source reference were developed by the authors for the purposes of this report.

Primary Prevention: Stopping a self-directed harm and prohibited abusive or harmful act before it occurs. Can be implemented for an entire group or population without regard to risk (universal primary prevention) or can be implemented for individuals, groups, or a population that is at risk (selected primary prevention) (DoDI 6400.09).

Program: In the context of DoD military suicide prevention, a program typically refers to a collection of actions performed by dedicated personnel at an installation-wide or Service-wide level, supported with DoD funding and resources, that aim to support a defined Service member need.

Protective Factors: Individual or environmental characteristics, conditions, or behaviors that reduce the effects of stressful life events (e.g., inclusion, help-seeking behavior, financial literacy). These factors increase the ability to avoid risks and promote healthy behaviors to thrive in all aspects of life (DoDI 6400.09).

Public Health Approach: A prevention approach that impacts groups or populations of people versus treatment of individuals. Public health focuses on preventing suicidal behavior before it ever occurs (primary prevention) and addresses a broad range of risk and protective factors. The public health approach values multi-disciplinary collaboration, which brings together many different perspectives and experiences to enrich and strengthen the solutions for the many diverse communities (DoDI 6490.16).

Reserves: In this report, refers collectively to the Army Reserve, Marine Corps Reserve, Navy Reserve, and Air Force Reserve.

Risk Factors: Factors caused by stress, trauma, or other circumstances that cause a schism in protective factors. Factors that make it more likely those individuals will develop a disorder or pre-dispose one to high-risk for self-injurious behaviors. Risk factors may encompass biological, psychological, or social factors in the individual, family, and environment (DoDI 6490.16).

Selected Reserve: Those units and individuals within the Ready Reserve designated by their respective Services and approved by the Joint Chiefs of Staff as so essential to initial wartime missions that they have priority over all other Reserves (DoDI 6490.16).

Statistically Significant: A comparison is considered statistically significant if the probability of observing that difference, or a more extreme difference, is less than 5% if there is no actual difference in the population.

Stigma: A set of negative and often untrue beliefs that a society or group of people have about something (DoDI 6400.09). In the military context, this is often the negative perception that seeking mental health care or other supportive services will negatively affect or end their careers (DoDI 6490.16).

Suicidal Behaviors: Behaviors related to suicide, including preparatory acts, suicide attempts, and death (DoDI 6490.16).

Suicide: Death caused by self-directed injurious behavior with an intent to die as a result of the behavior (DoDI 6490.16).

Suicide Attempt: A non-fatal, self-directed, potentially injurious behavior with any intent to die as a result of the behavior (DoDI 6490.16).

Suicide Decedent: An individual who died by suicide.

Suicide Event Status (Pending and Confirmed) (DoDI 6490.16)

- **Pending Confirmation of Suicide:** A designation by AFMES as the manner of death when the circumstances are consistent with suicide but the determination is not yet final. Final determination may take many months. Importantly, suspected suicides are included by DSPO and AFMES when reporting suicide counts.
- **Confirmed Suicide:** A designation by AFMES that assigns suicide as the final determination of the manner of death.

Suicide Rate: The average number of deaths by suicide in a fixed population per unit of time. As suicide is relatively rare, the suicide rate is commonly standardized to deaths per 100,000 persons per year. As presented in this report, suicide rates are calculated by dividing the number of deaths by suicide in the unit of time (in DoD, typically a calendar year) by the size of the population (in DoD, the average of 12 monthly totals of the number of personnel in that population [i.e., end-strengths]).

Total force: All Active Component and Selected Reserve military Service members (DoDI 6025.19).

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Enclosure: DoDSER

Calendar Year 2023 Department of Defense Suicide Event Report

The following tables contain summary data from the Department of Defense Suicide Event Report (DoDSER). Tables 1-8 display data for Active-Component events, and tables 9-12 display data for National Guard and Reserve events. Only events with a form submitted by March 31, 2024, are included in the tables. The total event counts may not correspond to the official event counts used to calculate rates.

The tables display percentages corresponding to affirmative responses to selected items in DoDSER event forms. In the tables, negative responses include instances where information was not available or not provided. Where possible, data for nested response options are provided. We did not provide data for items or categories with fewer than ten events or where there were concerns about individual-level identification. In some circumstances, we provide partial data for an item or response category and suppress low event frequencies with an asterisk (*).

The Space Force uses the DoDSER for event reporting. For calendar year (CY) 2023, Space Force data was not included due to the low event count.

The Defense Suicide Prevention Office (DSPO) incorporated DoDSER data and analysis into the Annual Suicide Report for CY 2023. The tables below provide reference data. The Psychological Health Center of Excellence, Research Support Division, Research & Engineering Directorate, Defense Health Agency prepared this document.

Table 1. Demographic characteristics, suicide deaths, Active Component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Sex					
Female	7.1	9.3	*	*	*
Male	92.9	90.7	*	*	*
Identify as gay, lesbian, or bisexual	4.7	*	*	*	*
Age					
17-24	47.5	41.1	67.7	43.5	46.8
25-29	22.8	21.2	*	*	*
30-59	29.7	37.7	*	*	*
Race					
Asian/Pacific Islander	6.8	*	*	*	*
Black/African American	15.7	*	*	*	*
White/Caucasian	68.0	68.2	69.4	67.7	66.1
Other/Unknown	9.5	7.9	*	17.7	*
Hispanic ethnicity	17.8	16.6	25.8	*	*
Education					
High school graduate or less	74.8	70.9	88.7	72.6	72.6
Some college	10.4	13.9	*	*	*
4-year degree or more	11.0	*	*	*	*
Unknown	3.9	*	*	*	*
Marital status					
Never married	45.4	37.7	45.2	54.8	54.8
Married	44.5	53.6	40.3	40.3	30.6
Separated/divorced/widowed	8.6	*	*	*	*
Unknown	1.5	*	*	*	*
Rank/grade					
E1-E4	48.4	41.1	71.0	40.3	51.6
E5-E9	40.4	45.7	25.8	43.5	38.7
Officer	9.8	*	*	*	*
Unknown	1.5	*	*	*	*
Number of contingency operations[a]					
0	70.0	68.9	88.7	71.0	53.2
1	16.6	19.9	*	*	17.7
2 or more	13.4	11.3	*	*	29.0
History of direct combat	7.7	13.2	*	*	*

Note: Percentages based on 337 total forms (151 Army, 62 Marine Corps, 62 Navy, and 62 Air Force). Two Space Force events are not included in the table because of small event counts.
[a]Number of contingency operations outside the U.S. based on the Contingency Tracking System.
*Data suppressed to restrict individual-level identification.

UNCLASSIFIED

Table 2. Event characteristics, suicide deaths, Active Component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Occurred in the continental United States	91.7	92.7	95.2	93.5	83.9
Event occurred at a military installation	34.7	36.4	51.6	22.6	25.8
Mechanism of injury					
Falling	3.0	*	*	*	*
Firearm	64.4	66.9	61.3	61.3	64.5
Suffocation/asphyxiation/hanging	27.0	25.2	33.9	25.8	25.8
Other/unknown	5.6	*	*	*	*
Communicated intent for self-harm[a]	27.6	26.5	29.0	24.2	32.3
Mental health staff	5.3	7.3	*	*	*
Friend	10.1	7.9	*	16.1	*
Spouse/partner	11.3	11.9	*	*	*
Duty environment[a]					
Garrison	78.9	82.1	79.0	69.4	80.6
Training	4.7	*	*	*	*
Other/unknown	22.0	*	*	*	*

Note: Percentages based on 337 total forms (151 Army, 62 Marine Corps, 62 Navy, and 62 Air Force). Two Space Force events are not included in the table because of small event counts.
[a]Subcategories are not mutually exclusive.
*Data suppressed to restrict individual-level identification.

Table 3. Behavioral health characteristics,[a] suicide deaths, Active Component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Any behavioral health diagnosis[b]	41.5	45.0	43.5	30.6	41.9
Alcohol use disorder	10.4	12.6	*	*	*
Depressive disorder	19.3	21.2	25.8	*	*
Anxiety disorder	17.8	23.2	*	*	*
Adjustment disorder	20.8	25.2	21.0	*	*
Posttraumatic stress disorder	6.8	7.9	*	*	*
Psychotropic medication prescription at time of event[b]	18.1	19.9	*	*	21.0
Antidepressant	16.3	16.6	*	*	21.0
Anxiolytic	6.2	9.3	*	*	*
Family history of mental illness	11.0	12.6	*	*	*
Prior self-harm	14.8	15.9	22.6	*	*
Primary care encounter, last 90 days	67.4	68.2	64.5	54.8	80.6
Outpatient mental health encounter, last 90 days	34.4	40.4	33.9	22.6	32.3
Discharged from inpatient mental health, last 90 days	8.3	7.3	*	*	*

Note: Percentages based on 337 total forms (151 Army, 62 Marine Corps, 62 Navy, and 62 Air Force). Two Space Force events are not included in the table because of small event counts.
[a]Data for all items except family history and prior self-harm from the Military Health System Medical Data Repository.
[b]Subcategories are not mutually exclusive.
*Data suppressed to restrict individual-level identification.

UNCLASSIFIED

Table 4. Contextual factors, suicide deaths, Active Component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Intimate relationship problems, last year	43.6	42.4	59.7	37.1	37.1
Death by suicide of friend or family member, last year	5.9	*	*	*	*
Administrative/legal problems, last year[a]	29.4	33.8	30.6	19.4	27.4
Nonjudicial punishment	8.6	11.3	*	*	*
Under investigation	16.3	21.2	*	*	*
Administrative separation	5.9	8.6	*	*	*
Financial difficulties, last year	11.6	10.6	21.0	*	*
Workplace difficulties, last year	23.7	27.2	24.2	17.7	21.0
Experienced abuse before age 18[a]	11.6	13.9	*	*	*
Physical	4.5	*	*	*	*
Sexual	3.6	*	*	*	*
Emotional	9.5	11.3	*	*	*
Experienced physical or sexual assault or sexual harassment, last year	1.8	*	*	*	*
Perpetrator of physical or sexual assault or sexual harassment, last year	3.3	*	*	*	*

Note: Percentages based on 337 total forms (151 Army, 62 Marine Corps, 62 Navy, and 62 Air Force). Two Space Force events are not included in the table because of small event counts.
[a]Subcategories are not mutually exclusive.
*Data suppressed to restrict individual-level identification.

UNCLASSIFIED

Table 5. Demographic characteristics, suicide attempts, Active Component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Sex					
Female	29.1	23.0	20.1	37.3	34.6
Male	70.6	76.8	79.9	62.4	64.9
Identify as gay, lesbian, or bisexual	8.4	5.7	6.4	7.7	12.4
Age					
17-24	64.1	63.2	83.0	59.2	56.7
25-29	20.1	20.9	12.5	22.0	22.9
30-59	15.4	*	*	*	*
Unknown	0.4	*	*	*	*
Race					
Asian/Pacific Islander	6.7	5.0	5.3	9.8	7.1
Black/African American	22.3	19.3	14.8	31.7	23.2
White/Caucasian	59.2	64.0	74.6	47.4	53.4
Other/Unknown	11.8	11.7	5.3	11.1	16.3
Hispanic ethnicity	20.9	18.3	25.4	20.2	21.1
Education					
High school graduate or less	82.2	78.6	95.8	82.6	76.8
Some college	7.2	7.3	*	*	11.0
4-year degree or more	6.5	6.8	*	*	7.6
Unknown	4.2	7.3	*	*	4.6
Marital status					
Never married	57.0	55.9	72.0	53.3	51.4
Married	35.5	34.5	26.1	41.1	38.5
Separated/divorced/widowed	4.2	4.2	*	*	6.7
Unknown	3.3	5.5	*	*	3.4
Rank/grade					
E1-E4	69.8	66.3	86.4	63.4	67.0
E5-E9	23.6	24.3	10.2	31.0	26.1
Officer	3.4	3.9	*	*	3.4
Unknown	3.3	5.5	*	*	3.4
Number of contingency operations[a]					
0	78.1	77.8	92.0	84.0	66.1
1	11.6	12.8	4.2	9.1	16.7
2 or more	7.0	3.9	*	*	13.8
History of direct combat	3.6	4.4	*	*	5.7

Note: Percentages based on 1,370 total forms (383 Army, 264 Marine Corps, 287 Navy, and 436 Air Force). Space Force events are not included in this table because of small event counts.

[a]Number of contingency operations outside the U.S. based on the Contingency Tracking System.

*Data suppressed to restrict individual-level identification.

UNCLASSIFIED

Table 6. Event characteristics, suicide attempts, Active Component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Occurred in the continental United States	73.9	64.5	79.2	79.1	75.7
Event occurred at a military installation	56.4	69.5	74.6	48.1	39.2
Mechanism of injury					
Cutting/piercing	14.0	17.0	11.7	11.1	14.7
Falling	3.0	*	*	4.2	2.8
Firearm	7.3	6.8	5.3	7.3	8.9
Transportation	4.5	4.4	*	*	5.3
Poisoning	53.9	52.7	58.3	53.7	52.3
Suffocation/asphyxiation/hanging	14.1	14.1	14.8	15.3	12.8
Other/unknown	3.3	*	*	*	3.2
Communicated intent for self-harm[a]	13.5	15.4	7.2	7.7	19.5
Mental health staff	3.5	3.4	*	*	6.2
Friend	5.5	5.7	*	*	8.9
Spouse/partner	4.2	5.0	*	*	5.3
Duty environment[a]					
Garrison	65.4	68.1	59.1	44.6	80.5
Training	5.3	6.8	*	*	4.4
Other/unknown	12.1	10.7	8.3	12.5	15.4

Note: Percentages based on 1,370 total forms (383 Army, 264 Marine Corps, 287 Navy, and 436 Air Force). Space Force events are not included in this table because of small event counts.
[a]Subcategories are not mutually exclusive.
*Data suppressed to restrict individual-level identification.

UNCLASSIFIED

Table 7. Behavioral health characteristics,[a] suicide attempts, Active Component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Any behavioral health diagnosis[b]	67.1	68.4	59.8	65.9	71.1
Alcohol use disorder	16.1	21.1	14.0	19.2	11.0
Substance use disorder	3.4	5.5	*	4.2	*
Depressive disorder	39.1	37.1	32.6	40.8	43.6
Anxiety disorder	31.0	29.5	25.8	28.6	37.2
Adjustment disorder	42.1	42.3	40.2	43.2	42.4
Posttraumatic stress disorder	9.9	8.1	8.3	10.8	11.9
Personality disorder	4.6	4.4	6.1	6.3	2.8
Psychotropic medication prescription at time of event[b]	30.4	26.4	29.2	29.6	35.3
Antidepressant	28.4	24.8	26.1	27.9	33.3
Anxiolytic	6.9	4.4	8.7	8.0	7.3
Family history of mental illness	26.0	26.1	16.7	16.7	37.6
Prior self-harm	24.5	28.7	23.1	18.5	25.7
Primary care encounter, last 90 days	73.9	75.5	83.3	51.2	81.7
Outpatient mental health encounter, last 90 days	54.8	60.8	48.1	46.7	58.9
Discharged from inpatient mental health, last 90 days	12.7	12.3	14.0	13.2	11.9

Note: Percentages based on 1,370 total forms (383 Army, 264 Marine Corps, 287 Navy, and 436 Air Force). Space Force events are not included in this table because of small event counts.

[a]Data for all items except family history and prior self-harm from the Military Health System Medical Data Repository.

[b]Subcategories are not mutually exclusive.

*Data suppressed to restrict individual-level identification.

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Table 8. Contextual factors, suicide attempts, Active Component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Intimate relationship problems, last year	33.0	35.8	20.1	23.3	44.7
Death by suicide of friend or family member, last year	5.6	7.3	*	*	7.6
Administrative/legal problems, last year[a]	18.9	19.6	17.4	12.9	23.2
Nonjudicial punishment	8.0	7.8	7.2	7.3	9.2
Under investigation	9.0	8.4	7.6	4.2	13.5
Administrative separation	7.8	11.5	*	*	7.3
Financial difficulties, last year	10.6	11.5	4.5	9.1	14.4
Workplace difficulties, last year	20.2	22.5	10.2	10.8	30.5
Experienced abuse before age 18[a]	29.8	31.9	21.2	18.8	40.4
Physical	19.0	21.1	11.7	12.5	25.7
Sexual	15.5	15.4	11.7	10.1	21.6
Emotional	22.5	24.5	14.8	11.8	32.3
Experienced physical or sexual assault or sexual harassment, last year[a]	9.4	9.9	9.1	5.2	11.9
Physical assault	3.7	4.4	*	*	4.6
Sexual assault	5.9	5.0	6.4	3.8	7.8
Sexual harassment	3.1	3.1	*	*	3.9
Perpetrator of physical or sexual assault or sexual harassment, last year	1.5	2.6	*	*	*

Note: Percentages based on 1,370 total forms (383 Army, 264 Marine Corps, 287 Navy, and 436 Air Force). Space Force events are not included in this table because of small event counts.
[a]Subcategories are not mutually exclusive.
*Data suppressed to restrict individual-level identification.

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Table 9. Demographic characteristics, National Guard (NG) and Reserve (R), suicide events, percent

Item	NG, Suicide	R, Suicide	NG, Suicide attempt	R, Suicide attempt
Service				
Army	74.5	53.7	41.1	34.8
Marine Corps	NA	*	NA	*
Navy	NA	*	NA	*
Air Force	25.5	*	58.9	32.6
Sex				
Female	*	*	44.6	30.4
Male	*	*	55.4	69.6
Identify as gay, lesbian, or bisexual	*	*	*	*
Age				
17-24	40.4	29.3	35.7	32.6
25-29	21.3	26.8	26.8	23.9
30-59	38.3	43.9	37.5	43.5
Race				
Asian/Pacific Islander	*	*	*	*
Black	27.7	*	19.6	*
White	63.8	70.7	66.1	56.5
Other/unknown	*	*	*	*
Hispanic ethnicity	*	*	*	*
Education				
High school graduate or less	57.4	73.2	33.9	65.2
Some college	*	*	50.0	*
4-year degree or more	*	*	*	23.9
Unknown	*	*	*	*
Marital status				
Never married	61.7	48.8	51.8	47.8
Married	31.9	48.8	39.3	52.2
Separated/divorced/widowed	*	*	*	*
Unknown	*	*	*	*
Rank/grade				
E1-E4	46.8	43.9	42.9	43.5
E5-E9	46.8	41.5	46.4	50.0
Officer	*	*	*	*
Unknown	*	*	*	*
One or more contingency operations[b]	31.9	26.8	25.0	26.1
History of direct combat	*	*	*	*

Note: Data based on 47 death and 56 attempt forms (National Guard) and 41 death and 46 attempt forms (Reserve). NA indicates that a category was not applicable.

[a]Number of contingency operations outside the U.S. based on the Contingency Tracking System.

*Data suppressed to restrict individual-level identification.

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Table 10. Event characteristics, National Guard (NG) and Reserve (R), suicide events, percent

Item	NG, Suicide	R, Suicide	NG, Suicide attempt	R, Suicide attempt
Occurred in the continental United States	91.5	97.6	85.7	89.1
Event occurred at a military installation	*	*	32.1	32.6
Mechanism of injury				
Firearm	89.4	70.7	*	*
Poisoning	*	*	41.1	45.7
Suffocation/asphyxiation/hanging	*	*	21.4	*
Other/unknown	*	*	*	*
Communicated intent for self-harm	44.7	*	30.4	26.1
In a duty status at time of event	59.6	56.1	71.4	80.4

Note: Data based on 47 death and 56 attempt forms (National Guard) and 41 death and 46 attempt forms (Reserve).
*Data suppressed to restrict individual-level identification.

Table 11. Behavioral health characteristics,[a] National Guard (NG) and Reserve (R), suicide events, percent

Item	NG, Suicide	R, Suicide	NG, Suicide attempt	R, Suicide attempt
Any behavioral health diagnosis[b]	27.7	36.6	55.4	47.8
Depressive disorder	*	*	46.4	32.6
Anxiety disorder	*	*	28.6	30.4
Adjustment disorder	*	*	23.2	*
Posttraumatic stress disorder	*	*	17.9	*
Psychotropic medication prescription at time of event	*	*	23.2	30.4
Antidepressant	*	*	19.6	30.4
Family history of mental illness	*	*	28.6	*
Prior self-harm	21.3	*	23.2	21.7
Primary care encounter, last 90 days	21.3	29.3	66.1	58.7
Outpatient mental health encounter, last 90 days	*	*	42.9	39.1
Discharged from inpatient mental health, last 90 days	*	*	*	*

Note: Data based on 47 death and 69 attempt forms (National Guard) and 26 death and 45 attempt forms (Reserve).
[a]Data for all items except family history and prior self-harm from the Military Health System Medical Data Repository. Data are likely incomplete given that the majority of Reserve Component Service Members do not receive their health care from the Military Health System.
[b]Subcategories are not mutually exclusive.
*Data suppressed to restrict individual-level identification.

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Table 12. Contextual factors, National Guard (NG) and Reserve (R), suicide events, percent

Item	NG, Suicide	R, Suicide	NG, Suicide attempt	R, Suicide attempt
Intimate relationship problems, last year	40.4	43.9	33.9	32.6
Death by suicide of friend or family member, last year	*	*	*	*
Administrative/legal problems, last year	23.4	31.7	*	21.7
Financial difficulties, last year	31.9	*	25.0	*
Workplace difficulties, last year	*	*	23.2	23.9
Experienced physical, sexual, or emotional abuse before age 18	*	*	37.5	32.6
Experienced physical or sexual assault or sexual harassment, last year	*	*	*	*
Perpetrated physical or sexual assault or sexual harassment, last year	*	*	*	*

Note: Data based on 47 death and 69 attempt forms (National Guard) and 26 death and 45 attempt forms (Reserve).
*Data suppressed to restrict individual-level identification.

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Methods

Suicide Case Definition

Death by suicide included all deaths where the manner was confirmed or suspected (pending confirmation) as suicide. This report does not included events that occurred among service members in a permanent absent-without-leave or deserter status. The Armed Forces Medical Examiner System (AFMES) maintains a case list of deaths by suicide among service members in the Active Component or active-duty National Guard and Reserve. Service-specific Suicide Prevention Program Managers provide information on deaths by suicide that occur among members of the National Guard and Reserve who were not in a duty status at the time of death.

Suicide Attempt Case Definition

Per the Centers for Disease Control and Prevention, a suicide attempt is defined as a self-inflicted, potentially injurious behavior with a nonfatal outcome for which there is evidence of intent to die.

Data Collection

Behavioral health providers and command officials on military installations and at medical treatment facilities collect data for each case of suicide and suicide attempt. Common sources of data for these cases include medical, personnel, and investigative records. If authorized, information from interviews with spouses, extended family, friends, and/or peers may also be used to inform the report.

Other Data Sources

The AFMES provides data about the official manner and cause of death. These data come from military or civilian autopsy reports, death certificates, written reports from military investigative agencies, or a verbal report from a civilian death investigator or coroner.

DMDC provides relevant data from the Defense Enrollment Eligibility Reporting System for all events submitted to the DoDSER system.

Data from the Military Health System Medical Data was extracted data on healthcare utilization, behavioral health diagnoses, and psychotropic medication use. The Department coded behavioral health diagnoses using the World Health Organization International Statistical Classification of Diseases, 10th Revision as aligned to the American Psychiatric Association Diagnostic and Statistical Manual of Mental Health Disorders, Fifth Edition, Text Revision. Finally, the Department identified psychotropic medications using the American Hospital Formulary Service classification codes.

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