CALENDAR YEAR 2024

Annual Report on Suicide in the Military

Including the Department of Defense Suicide Event Report

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

If You or Someone You Know Needs Help

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Crisis Services
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For the latest overseas calling information, please check https://www.militarycrisisline.net/

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REPORT ICON GUIDE

Key Takeaway **Important Context** **Caution**

Any reference to or images of non-Federal entities, including the appearance of external hyperlinks, does not constitute an endorsement by the U.S. Department of War (DOW) of any organization, the linked websites, or the information and images of products and services contained therein. DSN = Defense Switching Network.

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About This Report

The public health approach starts with data

The Annual Report on Suicide in the Military (ARSM) is the official source for annual suicide counts and rates.

This report contains the CY 2024 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 and other DOW stakeholders.

Brief review of counts and rates

Rates are a statistical measure that can be used to describe the prevalence of an event in a given population. *Unadjusted* suicide rates represent the number of people that died for every 100,000 in that population in a given year. But when comparing rates between different groups, it is important to use *adjusted* suicide rates. Adjusting is a statistical process used to account for differences in the age, sex, and size of the groups being compared.

This report only uses adjusted rates for comparative analyses (e.g., between groups, across years). Any observed differences are then described in terms of statistical significance. Rates should not be confused with counts, which only present the number of people that died by suicide in a given year. See Appendix A for a detailed review of the statistical methodology used in this report.

Safe reporting on suicide

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

2024 Data Summary

Service Members (2024)

471 Service members died by suicide

302	64	105
Active	Reserve	National Guard

23.2 Rates per 100,000 Service members

23.8	19.5	24.6
Active	Reserve	National Guard

KEY TAKEAWAYS

Fewer Service members died by suicide in 2024 (471) than in 2023 (531). The Total Force suicide rate was lower in 2024 compared to 2023 (23.2 and 26.0, respectively).†

Suicide rates were lower in 2024 for the Active Component (23.8)* and Reserve (19.5)† than in 2023 (28.2 and 22.7, respectively). The National Guard rate was higher in 2024 (24.6) compared to 2023 (21.7).†

Active Component rates increased from 2011 to 2024.* Reserve and National Guard rates remained stable over the same period.†

In 2023, the Active Component rate was higher than the U.S. population rate.*^

Of the Service members who died by suicide in 2024, most were enlisted males under 30 (56% of Total Force suicides).

The use of a firearm was the most common method of death by suicide across the Total Force (66%).

Family Members (2023)^

146 Family members died by suicide

98	48
Spouses	Dependents^^

6.0 Rates per 100,000 Family members

10.1	3.2
Spouses	Dependents^^

KEY TAKEAWAYS

The number of military family members who died by suicide was the same in 2023 as in 2022 (146). The suicide rate was slightly higher in 2023 (6.0) than in 2022 (5.8).†

Suicide rates for Total Force military family members increased from 2011 to 2023.*

Males accounted for 65% of suicides among military spouses and 60% of military dependent suicide deaths.

The use of a firearm was the most common method of death by suicide for military spouses (69%).

Hanging/asphyxiation (44%), followed by firearm (40%), were the most common methods of death by suicide among military dependents.

* Statistically significant — represents a true difference, not likely due to chance ($p < .05$).

† Not statistically significant — the observed difference could likely be explained by chance.

^ 2023 was the most recent year of available U.S. population data; data sourced from the Centers for Disease Control and Prevention (CDC).

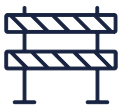
^^ Includes minors (<18 years old) and young adults (18 – 22 years old).

The Department's Suicide Prevention Efforts

The Department remains committed to suicide prevention across the military community. It has developed a number of evidence-informed initiatives meant to increase protective factors and reduce risk factors for suicide. The goal remains one of achieving a long-term, sustained decrease in suicide rates for Service members and their families. The Department's comprehensive suicide prevention program operates across five lines of effort. These lines of effort also guide the implementation of a portfolio of enabling actions, informed by the work of the Suicide Prevention and Response Independent Review Committee (SPRIRC).

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

Aims

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
Improve quality of life for Service members and their families as well as empower leaders to address problems before concerns become challenges and escalate to crises.	Improve access to and the delivery of evidence-based mental health care.	Help Service members overcome stigma and reduce barriers to mental health care, thereby promoting a culture of help-seeking behavior.	Modernize the delivery of suicide prevention and postvention training, with an emphasis on integrating primary prevention principles. See glossary for a detailed definition of "postvention."	Promote lethal means safety and improve the overall safety culture within the Department.

Goals

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
Service members and their families benefit from enhanced support options, ensuring a quality of life that makes life worth living.	Service members and their families receive integrated end-to-end care. The Department is also increasing provider retention to give Service members greater service availability.	Service members seek and receive care via multiple modalities with an increased focus on postvention.	Equip Service members with the skills to handle difficult conversations about suicide and effectively manage any personal challenges.	Service members understand the importance of lethal means safety and have more safe storage options, making lethal means less readily accessible.

Examples

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
▸ The Department's 2025 suicide prevention campaign – *Joining Your Fight: Connect to Protect* – helped foster a supportive environment across the military community. ▸ Supporting families by increasing funding for military spouse career and education programs.	▸ Investing in care to expand evidence-based clinical services. ▸ Allowing longer assignments and extensions for civilian mental health care providers.	▸ *Real Warriors Campaign*: a media campaign that aims to decrease stigma and encourage help-seeking behavior. ▸ Developing and promoting targeted strategies to more efficiently use non-medical counseling programs.	▸ Postvention response: specialized training for those who support individuals affected by a suicide event. ▸ Creating evidence-based core competencies for suicide prevention training across the Department.	▸ Focus on practicality: promoting practical guidance through fact sheets and toolkits on how to implement lethal means safety. ▸ Developing a secure storage voucher program to be piloted at select locations.

IN THIS SECTION

Service Members

The Defense Suicide Prevention Office (DSPO) was established in 2011. This is when the Department first began systematically collecting and recording data on suicides. This section provides an overview of military suicide deaths from 2011 to 2024. It includes short-term and long-term insights, comparisons with the U.S. population, and statistics by demographic group and method of death. Additionally, this section draws on the DoDSER to highlight select contextual characteristics of suicide deaths and attempts.

This year, this section also provides counts and rates by military occupation code as required by the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2025. See Appendix B for detailed information on these requirements.

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 counts, rates, and conducting rate comparisons, understanding variability, volatility, interpretability, and 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 rates in the military to suicide in the U.S. population?

Suicide Counts and Rates for 2024

KEY TAKEAWAYS

The 2024 Total Force suicide rate was lower than in 2023.†

For the Active Component, the 2024 suicide rate was lower than in 2023.*

For the Reserve, the 2024 suicide rate was lower than in 2023.†

For the National Guard, the 2024 suicide rate was higher than in 2023.†

Short-term comparisons only provide a limited snapshot of change over time (see "Understanding Variability in Suicide Rates" in Appendix A).

The lower Active Component suicide rate in 2024 compared to 2023 is an encouraging sign. However, it is too early to say whether this short-term change signals the start of a shift in long-term trends.

The Department remains focused on lasting change. The next section examines long-term trends in military suicide rates, which provide a more robust understanding of rates across time.

Table 1 | Annual Suicide Counts and Unadjusted Rates per 100,000 Service Members by Military Population and Service, 2022 – 2024

Component and Service	2022		2023		2024	
	Rate	Count	Rate	Count	Rate	Count
Total Force	23.7	496	26.0	531	23.2	471
Active Component	25.3	333	28.2	363	23.8	302
Army	28.9	135	35.0	159	29.8	133
Marine Corps	37.2	65	37.1	63	27.3	46
Navy	20.6	71	20.4	68	18.2	60
Air Force	19.0	62	22.2	71	19.0	60
Space Force	--	0	--	2	--	3
Reserve	19.4	65	22.7	75	19.5	64
Army	20.8	37	27.2	48	21.3	37
Marine Corps	--	7	--	10	--	8
Navy	--	7	--	8	--	10
Air Force	--	14	--	9	--	9
National Guard	22.4	98	21.7	93	24.6	105
Army	25.1	83	24.7	80	27.2	88
Air Force	--	15	--	13	--	17

Notes: Data sourced from the Armed Forces Medical Examiner System (AFMES). Table includes both confirmed and suspected suicides as of March 31, 2025, for the listed calendar year. Both confirmed and suspected suicides are included to avoid underestimating counts and rates while cause-of-death investigations are underway. Counts from previous years have been updated since the publication of the CY 2023 ARSM and have been revised for this year's report to reflect the most accurate information to date. Per DoD 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. Numbers in this report only include the Department Services. The U.S. Coast Guard suicide counts and rates are not included in this report because they operate under the U.S. Department of Homeland Security.

* Statistically significant — represents a true difference, not likely due to chance ($p < .05$). † Not statistically significant — the observed difference could likely be explained by chance.

Trends Over Time by Component

Figure 1 | Active Component Adjusted Suicide Rates, 2011 – 2024

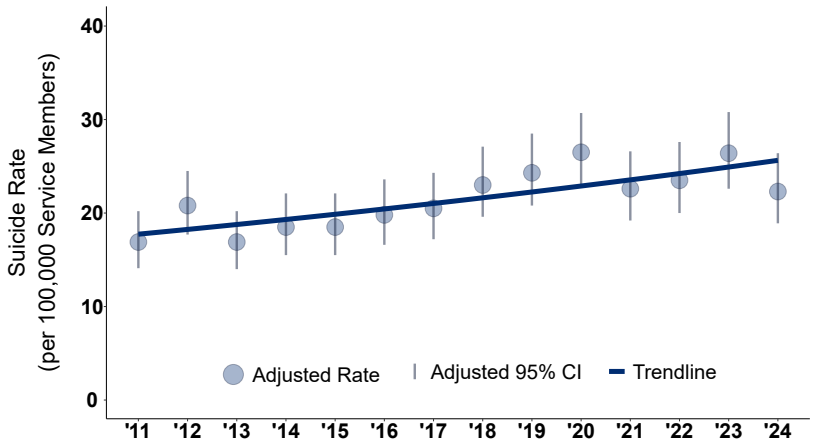


Figure 2 | Reserve Adjusted Suicide Rates, 2011 – 2024

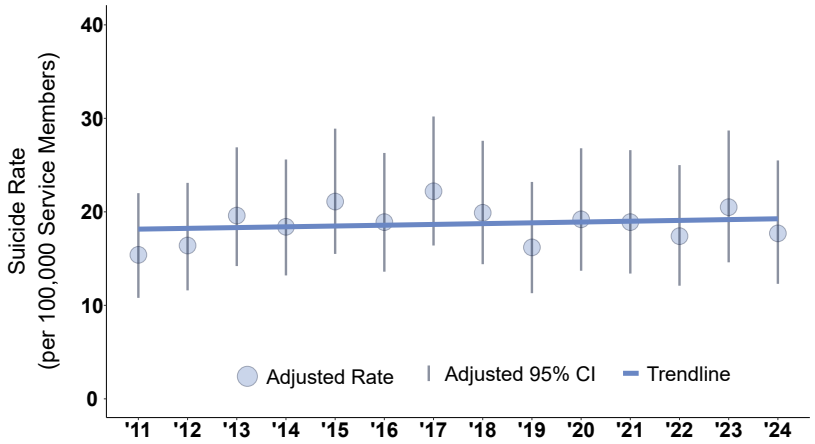
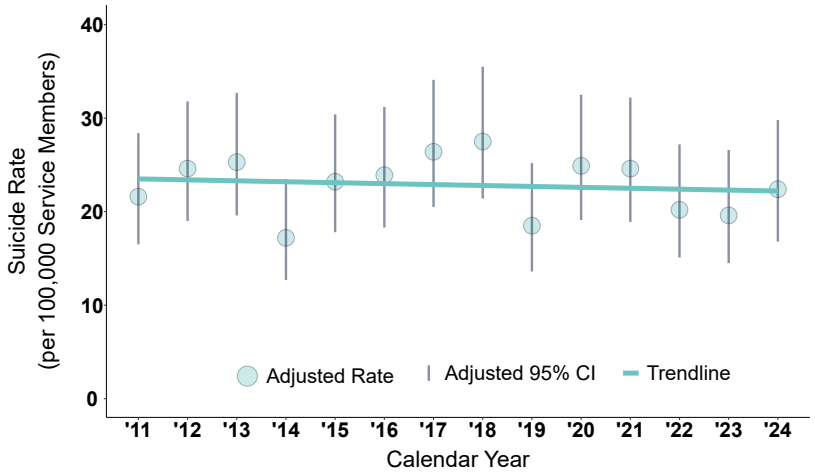


Figure 3 | National Guard Adjusted Suicide Rates, 2011 – 2024



KEY TAKEAWAYS

Despite a lower suicide rate in 2024 compared to 2023,* **Active Component suicide rates increased** from 2011 to 2024.*

The Reserve and National Guard suicide rates remained stable between 2011 and 2024 with no substantive increase or decrease.†

The overall trend from 2011 to 2024 reflects an increase in the Active Component suicide rates, which mirrors the increase in the U.S. population suicide rates over time. Reserve and National Guard rates remain stable.

It remains to be seen whether the short-term decreases observed in 2024 in the Active Component will signal a change in long-term trends. See "Understanding Variability in Suicide Rates" in Appendix A for additional information on interpreting suicide rates over time.

Notes: Data sourced from AFMES. All rates are adjusted for age and sex to account for demographic differences within the military over time. CI = Confidence Interval. Vertical bars around each rate indicate 95% CIs.

* Statistically significant — represents a true difference, not likely due to chance ($p < .05$).

† Not statistically significant — the observed difference could likely be explained by chance.

Trends Over Time for the Active Component

KEY TAKEAWAYS

Active Component suicide rates increased for each Service from 2011 to 2024.*

Army Reserve and Army National Guard rates have remained stable from 2011 to 2024.†‡

Figure 4 | Army Adjusted Suicide Rates, 2011 – 2024

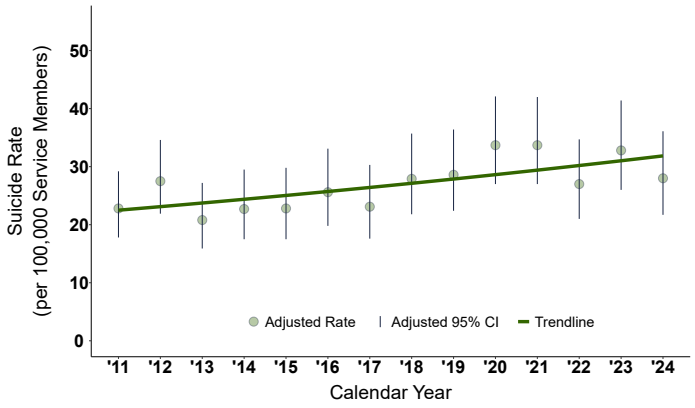


Figure 5 | Marine Corps Adjusted Suicide Rates, 2011 – 2024

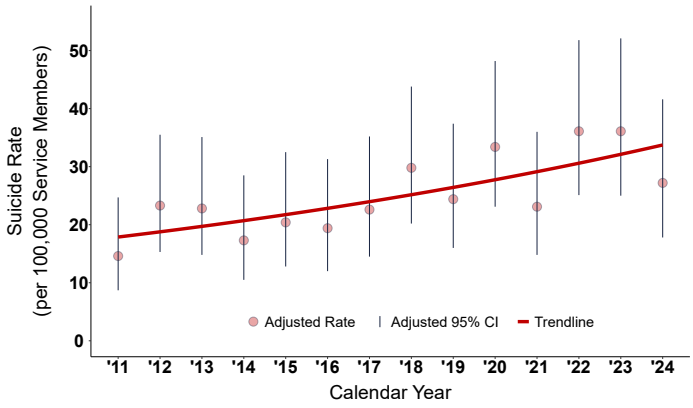


Figure 6 | Navy Adjusted Suicide Rates, 2011 – 2024

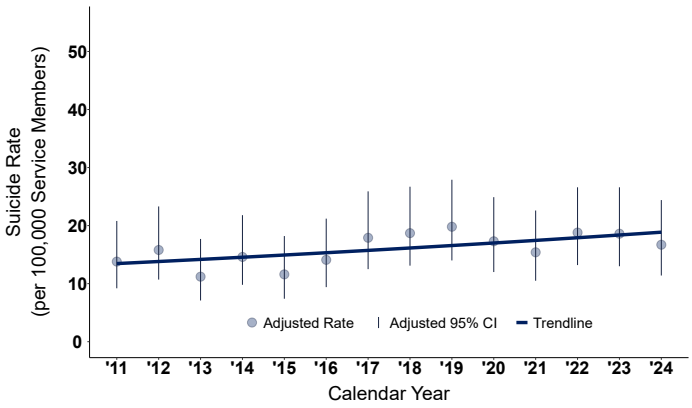
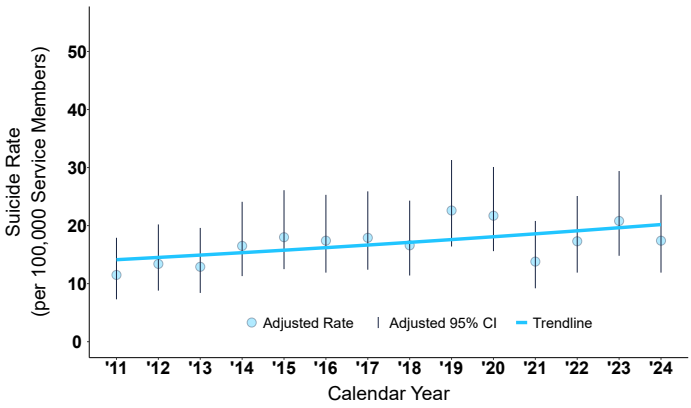


Figure 7 | Air Force Adjusted Suicide Rates, 2011 – 2024



Because the Army is the largest Military Service, changes in its suicide rate can have a larger effect on the overall Active Component rate than changes in any of the other Services.

Like the overall Active Component, suicide rates for each Service in the Active Component also increased from 2011 to 2024.*

Notes: Data sourced from AFMES. All rates are sex and age adjusted to account for population differences over time *within* each respective Service. These adjusted rates should not be used to conduct comparisons *between* Services. Vertical bars around each rate indicate 95% confidence intervals. Trend analysis was not conducted for the Space Force, Marine Corps Reserve, Navy Reserve, Air Force Reserve, and Air Force National Guard due to lacking sufficient data to calculate rates. Per DoDI 6490.16, no rates are calculated when the number of suicide deaths is less than 20.[1]

* Statistically significant — represents a true difference, not likely due to chance ($p < .05$).

† Not statistically significant — the observed difference could likely be explained by chance.

‡ Data not shown.

U.S. Comparisons

Figure 8 | Active Component Adjusted Suicide Rates Compared to the U.S. Population, 2011 – 2024

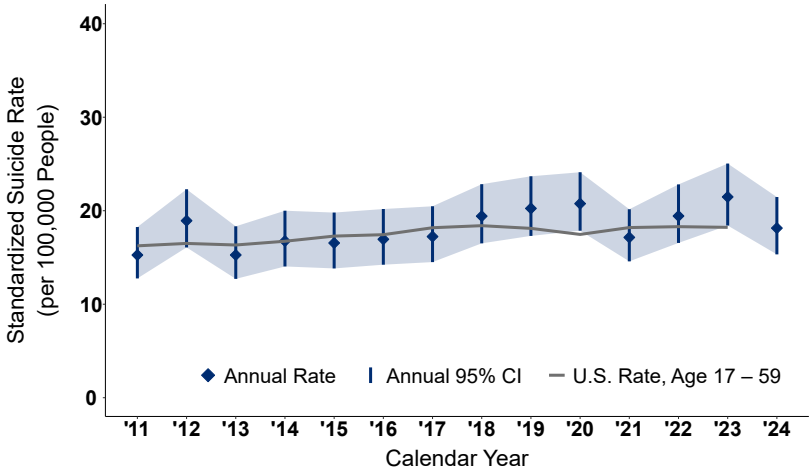


Figure 9 | Reserve Adjusted Suicide Rates Compared to the U.S. Population, 2011 – 2024

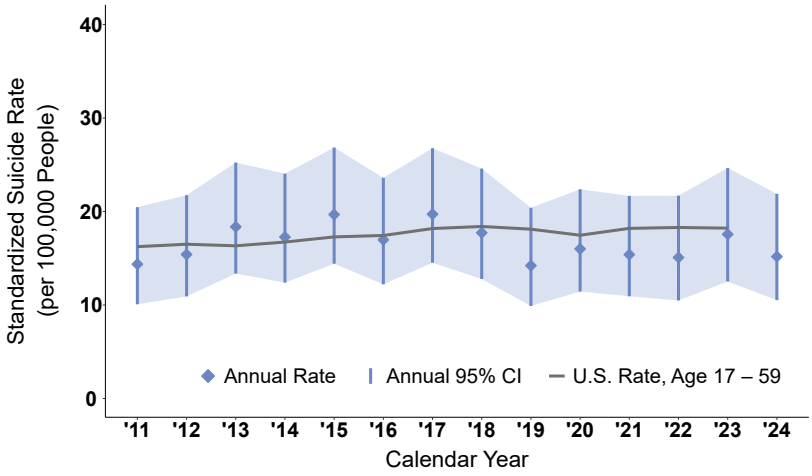
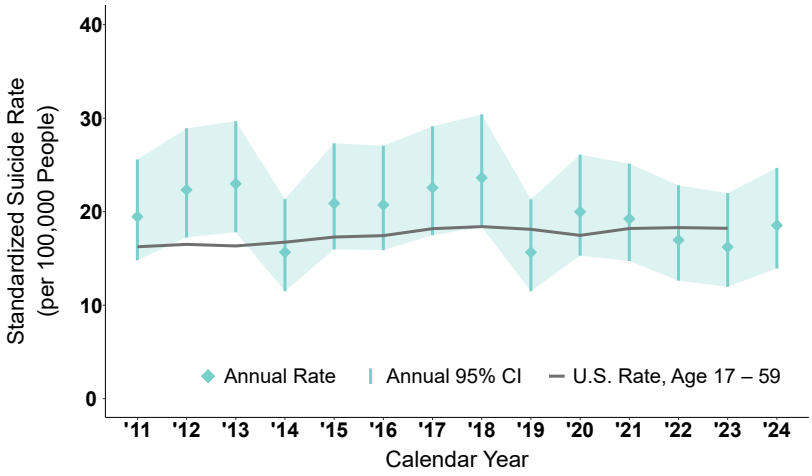


Figure 10 | National Guard Adjusted Suicide Rates Compared to the U.S. Population, 2011 – 2024



KEY TAKEAWAYS

The U.S. suicide rate increased from 2011 to 2023.*^‡

For most years between 2011 and 2023,^ **Active Component suicide rates were similar to U.S. rates,**† except for 2020 and 2023 when Active Component rates were higher.*

Reserve suicide rates were similar to U.S. rates from 2011 to 2023.†^

National Guard suicide rates were similar to U.S. rates from 2011 to 2023,†^ except for 2012 and 2013 when National Guard rates were higher.*

Comparisons with U.S. population rates help contextualize military suicide rates. In these comparisons, military suicide rates are adjusted in order to compare the rates. For additional information, see "Comparing Military Suicide Rates to the U.S. Population" in Appendix A.

In 2023, suicide rates were higher in the Active Component than in the U.S. population.* However, overall military suicide rates have not differed meaningfully from those of the U.S. population for most years since 2011. This result indicates that the military suicide rates resemble trends in the country as a whole.

Notes: Data sourced from AFMES (military) and CDC (U.S.), ages 17 – 59. All rates are adjusted for sex and age to account for population differences over time. The dots represent military rates standardized to the U.S. population and the accompanying shaded vertical bars indicate 95% confidence intervals.

* Statistically significant — represents a true difference, not likely due to chance ($p < .05$).

‡ Data not shown.

† Not statistically significant — the observed difference could likely be explained by chance.

^ 2023 was the most recent year of available U.S. population data; data sourced from the CDC.

Active Component Demographics

Table 2 | Demographic Characteristics of Active Component Service Members Who Died by Suicide, 2024

Demographics	Unadjusted Rate	Count	Percent
Total	23.8	302	100%
Sex			
Male	27.1	283	93.7%
Female	--	19	6.3%
Age Group			
17 – 19	--	12	4.0%
20 – 24	35.2	137	45.4%
25 – 29	22.6	67	22.2%
30 – 34	12.4	26	8.6%
35 – 39	22.4	36	11.9%
40 – 44	--	14	4.6%
45 – 49	--	6	2.0%
50+	--	4	1.3%
Race			
White	24.6	210	69.5%
Black / African American	21.6	49	16.2%
American Indian / Alaska Native	--	3	1.0%
Asian / Pacific Islander	--	19	6.3%
Other	--	13	4.3%
Unknown	--	8	2.6%
Rank			
Enlisted (Total)	26.7	274	90.7%
E1 – E4	28.6	148	49.0%
E5 – E9	24.8	126	41.7%
Commissioned Officer	11.7	25	8.3%
Warrant Officer	--	2	0.7%
Cadet	--	1	0.3%
Marital Status			
Never Married	25.5	143	47.4%
Married	22.1	142	47.0%
Divorced	--	17	5.6%

KEY TAKEAWAYS

Similar to previous years, **most of the Active Component Service members who died by suicide in 2024 were enlisted males under the age of 30**, accounting for about 64% of all decedents.‡

Between 2022 and 2024, compared to the overall Active Component:

- Divorced or separated Service members had higher suicide risk.*‡
- Service members who were female, 30 or older, or a warrant or commissioned officer had a lower suicide risk.*‡

The Department examines metrics across multiple data sources (e.g., administrative data) to better understand suicide risk among Service members. One area of interest is identifying demographic groups at increased risk for suicide.

For example, the Department completed a separate analysis that showed that Active Component Service members under 30 years old – particularly those aged 20 – 24 years old – are at a higher risk of dying by suicide compared to Service members 30 years old or older.*‡

Continued assessment of demographics allows the Department to assess where additional resources may be needed.

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 of suicide deaths is less than 20.[1] When examining suicide risk by demographic group, divorced or separated Service members were combined into a single category. Three years of data were combined to examine suicide risk by demographic group to ensure robust analysis and meaningful findings. The categories used by Army to report racial/ethnic demographics are different from those used by Marine Corps, Navy, Air Force, and Space Force. No decedents were identified for marital status categories Legally Separated, Widowed, and Unknown in CY 2024. Table 16 in Appendix D provides the Total Force demographics.

* Statistically significant — represents a true difference, not likely due to chance ($p < .05$). ‡ Data not shown.

Reserve and National Guard Demographics

KEY TAKEAWAYS

In 2024, **enlisted males under 30 accounted for 33% of Reserve and 46% of National Guard members** who died by suicide.‡

Between 2019 and 2024 among the overall Reserve Component, **marital status was not shown to affect suicide risk.**†‡

However, Service members who were **female or a warrant or commissioned officer had a lower suicide risk** in the overall Reserve Component.*‡

Table 3 | Demographic Characteristics of Reserve and National Guard Service Members Who Died by Suicide, 2024

Demographics	Reserve			National Guard		
	Unadjusted Rate	Count	Percent	Unadjusted Rate	Count	Percent
Total	19.5	64	100%	24.6	105	100%
Sex						
Male	22.6	56	87.5%	27.2	92	87.6%
Female	--	8	12.5%	--	13	12.4%
Age Group						
17 – 19	--	1	1.6%	--	4	3.8%
20 – 24	--	13	20.3%	29.7	31	29.5%
25 – 29	--	12	18.8%	30.0	24	22.9%
30 – 34	--	14	21.9%	--	17	16.2%
35 – 39	--	11	17.2%	--	12	11.4%
40 – 44	--	8	12.5%	--	8	7.6%
45 – 49	--	2	3.1%	--	6	5.7%
50+	--	3	4.7%	--	3	2.9%
Race						
White	19.0	41	64.1%	26.7	87	82.9%
Black / African American	--	11	17.2%	--	8	7.6%
American Indian / Alaska Native	--	1	1.6%	--	0	0.0%
Asian / Pacific Islander	--	2	3.1%	--	5	4.8%
Other	--	4	6.2%	--	4	3.8%
Unknown	--	5	7.8%	--	1	1.0%
Rank						
Enlisted (Total)	21.5	55	85.9%	25.3	92	87.6%
E1 – E4	18.7	20	31.2%	25.1	44	41.9%
E5 – E9	23.6	35	54.7%	25.4	48	45.7%
Commissioned Officer	--	9	14.1%	--	12	11.4%
Warrant Officer	--	0	0.0%	--	1	1.0%
Marital Status						
Never Married	18.3	26	40.6%	24.1	52	49.5%
Married	21.1	34	53.1%	26.9	50	47.6%
Divorced	--	3	4.7%	--	3	2.9%
Unknown	--	1	1.6%	--	0	0.0%

Reserve and National Guard Service members balance the responsibilities of military service with civilian life. Different support options may be available depending on activation status (for examples see "Highlights from Efforts in the Military Services" in the Efforts Section).

Notes: Data sourced from AFMES. Per DoDI 6490.16, rates are not reported ("--") when the number of suicide deaths is less than 20.[1] Percentages may not add up to 100% due to rounding. When examining suicide risk by demographic group, divorced or separated Service members were combined into a single category. Six years of Reserve Component (i.e., Reserve and National Guard) data were combined to examine suicide risk by demographic group. This ensures a robust and meaningful analysis. No decedents were identified for marital status categories Legally Separated and Widowed in CY 2024. Table 16 in Appendix D provides the Total Force demographics.

* Statistically significant — represents a true difference, not likely due to chance ($p < .05$).

† Not statistically significant — the observed difference could likely be explained by chance.

‡ Data not shown.

Method of Death

KEY TAKEAWAYS

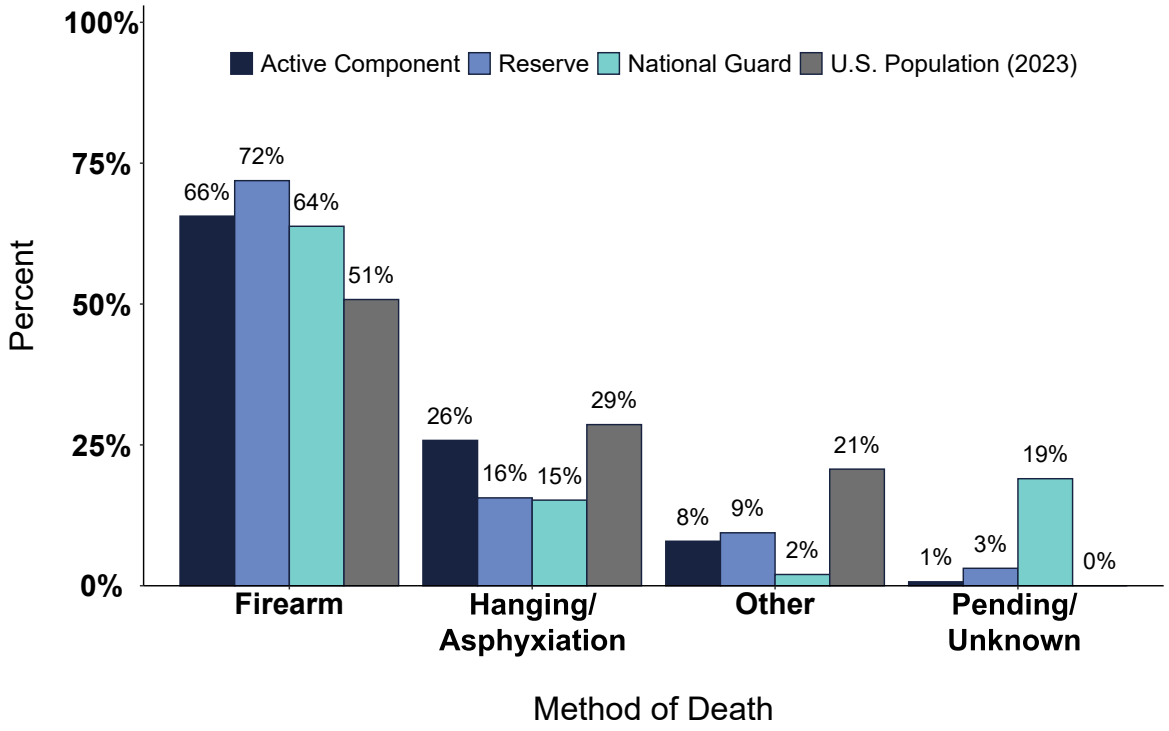
Use of a firearm was the most common method of death by suicide in the Active Component, Reserve, and National Guard in 2024 and in the U.S. population in 2023.^

Total Force Service members had a larger proportion of suicide deaths by firearm than the U.S. population in 2023.*‡^

Consistent with previous years, firearm was the leading method of death by suicide across the Total Force. Most firearm deaths occur with a personally owned firearm.[2] This reinforces the importance of practicing lethal means safety, particularly with firearms.

Safe firearm storage can take many forms. For example, storing the firearm and ammunition separately, using a cable or trigger lock, or storing firearms in a lockbox, gun safe, or off-site, such as at a private gun club. For Service members who reside on installations, it may also be possible to store a personally owned firearm in the installation armory.

Figure 11 | Percentage of Suicide Deaths by Method, 2024



Notes: Data sourced from AFMES. "Other" methods of death include overdose, poisoning, blunt/sharp objects, and falling/jumping. Percentages may not add up to 100% due to rounding.

* Statistically significant — represents a true difference, not likely due to chance ($p < .05$).

^ 2023 was the most recent year of available U.S. population data; data sourced from the CDC.

‡ Data not shown.

Suicide Counts and Rates by Occupation

KEY TAKEAWAYS

Although there were observable unadjusted rate differences between occupation groups, only *Infantry, Gun Crews, and Seamanship Specialists* had a higher-than-average suicide risk at the Total Force level after adjusting for age and sex.*‡

No other occupation group had a substantively higher or lower suicide risk than their respective population average.†‡

Across the Total Force, as well as within the Active Component and overall Reserve Component, no occupation appeared to have a higher risk for suicide compared to the U.S. population.†‡

This is the first year for which suicide counts and rates based on primary DoD occupation code are presented in this report. One year of data is presented and no analyses were done to examine how the rates compare over time.

The "Occupational Conversion Index" per DoDI 1312.01 provides the framework that groups together similar occupations across the Services.[3] This index was used to group the categories of occupations presented here. Additional detail on individual occupation codes is in Appendix E.

Caution should be used when interpreting unadjusted rates, which are not comparable across occupations. Among other limitations, marked differences exist in the size and demographic characteristics of each occupation group. See Appendix A for additional information on unadjusted and adjusted rates and when groups are compared.

Table 4 | Suicide Counts and Unadjusted Rates per 100,000 Service members by Primary DoD Occupation Code, 2024

DoD Primary Occupation Code	Total Force		Active Component		Reserve		National Guard	
	Count	Rate	Count	Rate	Count	Rate	Count	Rate
Enlisted								
Infantry, Gun Crews, and Seamanship Specialists	82	35.7	53	35.3	10	--	19	--
Electronic Equipment Repairers	30	28.0	21	24.7	7	--	2	--
Communications and Intelligence Specialists	52	27.8	40	31.3	5	--	7	--
Health Care Specialists	21	18.9	11	--	4	--	6	--
Other Technical and Allied Specialists	13	--	11	--	0	--	2	--
Functional Support and Administration	46	18.3	32	23.4	8	--	6	--
Electrical/Mechanical Equipment Repairers	74	24.9	47	22.8	7	--	20	37.5
Craftsworkers	26	38.6	10	--	6	--	10	--
Service and Supply Handlers	49	23.3	31	26.9	7	--	11	--
Non-Occupational, Enlisted	22	18.8	14	--	0	--	8	--
Unknown, Enlisted	7	--	4	--	2	--	1	--
Officer								
Tactical Operations Officers	14	--	9	--	2	--	3	--
All Other Officers	34	13.2	18	--	6	--	10	--

Notes: Data sourced from AFMES and the Defense Manpower Data Center (DMDC). Per DoDI 6490.16, rates are not reported ("--") when the number of suicide deaths is less than 20.[1] Duties and responsibilities may vary considerably between Services due to differences in mission, resources, and occupational development. Table 4 provides counts and unadjusted rates for 2-digit occupation codes by rank. Appendix E includes 3-digit occupation code counts by military population. Rate comparisons with the U.S. population were conducted against the Total Force, Active Component, and overall Reserve Component (i.e., Reserve and National Guard) for each 2-digit code occupation group with sufficient data. The Reserve and National Guard data were aggregated for these rate comparisons to have sufficient data to conduct analyses. Cadets are not included in this analysis since they do not have an occupation code. See Appendix A for additional methodological details.

* Statistically significant — represents a true difference, not likely due to chance ($p < .05$).

† Not statistically significant — the observed difference could likely be explained by chance.

‡ Data not shown.

Contextual Data for Active Component Deaths

Within the last year, Active Component Service members who died by suicide in 2024 experienced:

24% Administrative/legal problems

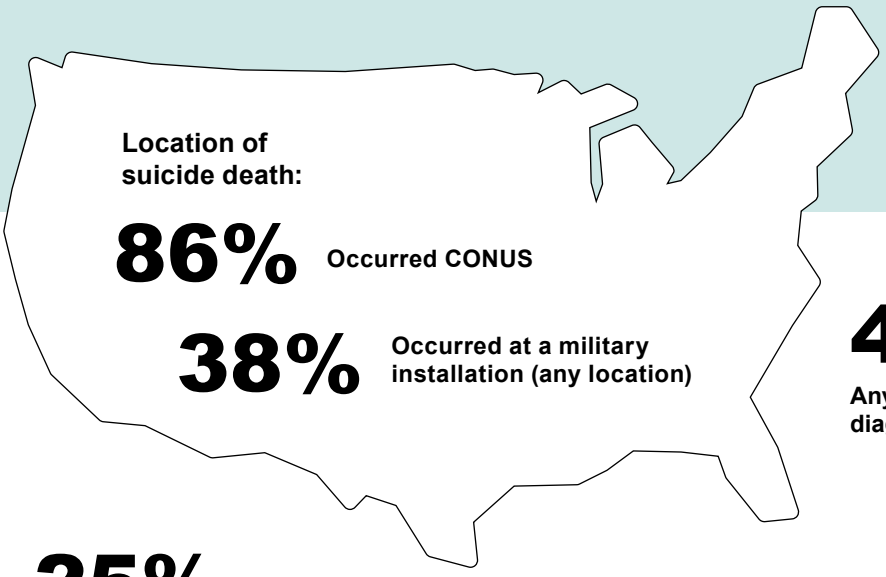
13% Financial difficulties

7% Death by suicide of friend or family member

45% Intimate relationship problems

34% Workplace difficulties

Some Service members experienced assault or harassment, but the percentage is not reported due to small counts.



Location of suicide death:

86% Occurred CONUS

38% Occurred at a military installation (any location)

47% Any mental health diagnosis

Such as alcohol use disorder, substance use disorder, depressive disorder, anxiety disorder, adjustment disorder, posttraumatic stress disorder, or personality disorder.

25%

Communicated intent for self-harm

This intent was communicated to one or more of the following groups (subcategories are not mutually exclusive): mental health staff (7%), friend (8%), spouse/partner (12%), and/or other (10%).

Within the last 90 days:

64% had a primary care encounter

35% had an outpatient mental health encounter

Everyone experiences health and life stressors at some point. For this reason, promoting help-seeking as a sign of strength remains a core part of the Department's strategic messaging. The Department has different support options available to ensure that stressors do not rise to crisis levels.

For those seeking mental health support at a military treatment facility, the Department's policy is to provide screening and comprehensive assessment for suicide risk. The policy also includes training service providers on enhanced suicide risk care procedures aligned with 2024 Department of Veterans Affairs (VA)/DoD Clinical Practice Guidelines

Notes: This page presents contextual information from the DoDSER enclosure. Only Active Component is presented here. See the DoDSER enclosure for information on the Reserve and National Guard. To prevent individual-level identification, DoDSER suppresses data for items or categories with fewer than 10 events or where there are concerns about individual-level identification.

Contextual Data for Active Component Suicide Attempts

In 2024, 1,515 suicide attempts were reported among Active Component Service members.

Army	Marine Corps	Navy	Air Force	Space Force
436	268	356	445	10

Within the last 90 days:

77% had a primary care encounter

56% had an outpatient mental health encounter

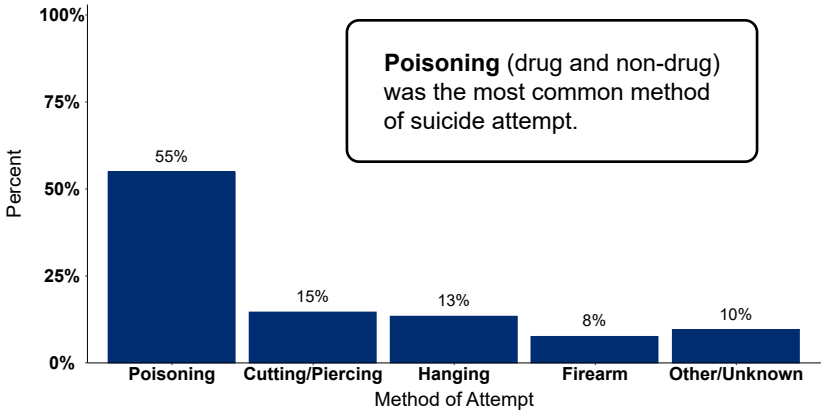
Active Component Service members with a reported suicide attempt in 2024:

30% Female Service members

70% Male Service members

- **65%** Mental health diagnosis
- **38%** Intimate relationship problems
- **38%** Workplace difficulties
- **20%** Administrative/ legal problems
- **13%** Financial difficulties
- **9%** Assault or harassment

Figure 12 | Percentage of Active Component Attempts by Method, 2024



As in previous years, poisoning continues to be the leading method of suicide attempts. It is also the leading method for attempts in the U.S. population.[4]

Lethal means safety strategies to prevent intentional or unintentional overdose include disposing of any unused or expired medications, using lock boxes to dispense misuse-prone medications, asking a trusted individual to manage one's medications, or having one's pharmacy limit the quantity of medication dispensed at once.

Notes: This page presents contextual information from the DoDSER enclosure. Only Active Component is presented here. See the DoDSER enclosure for information on the Reserve and National Guard.

IN THIS SECTION

Family Members

Military families are known for strong family bonds, resilience, and pride in military service. They also face challenges such as the stress of relocations and deployments. These experiences create a unique context that shape many aspects of well-being and suicide risk.

Section 567 of the "Carl Levin and Howard P. 'Buck' McKeon National Defense Authorization Act for Fiscal Year 2015" (Public Law 113–291), requires the Department to 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). The Department acquired additional years of data 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 2023 (i.e., lagging one year relative to military data sources).

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 additional information on how suicide deaths of military family members are reported.

MILITARY FAMILY MEMBERS

Suicide Counts and Rates for 2023

KEY TAKEAWAYS

Across the Total Force, counts for **family member suicide deaths were the same in 2023 and 2022.** However, the **2023 suicide rate was slightly higher than in 2022.**†

For spouses, the 2023 suicide rate was higher than in 2022.† For dependents, the 2023 suicide rate was lower than in 2022.†

Suicide rates for Total Force military family members increased between 2011 and 2023.*‡

In 2023, family member suicide rates increased compared to the previous year despite suicide counts staying the same. The rate depends on both the count *and* the size of the population being examined, which was lower in 2023 than in 2022, resulting in a change in rate over this period. As with Service members, examining short-term differences provides only a limited snapshot. The long-term trend indicates that overall family member suicide rates have increased since 2011.

Table 5 | Military Family Member Suicide Unadjusted Rates per 100,000 Individuals by Service Member's Military Population, 2021 – 2023

Military Population	2021		2022		2023	
	Rate	Count	Rate	Count	Rate	Count
Total Force	6.4	165	5.8	146	6.0	146
Spouse	11.0	112	9.3	93	10.1	98
Dependent	3.4	53	3.5	53	3.2	48
Active Component	6.2	101	6.0	95	6.0	91
Spouse	11.4	76	9.7	63	10.6	67
Dependent	2.6	25	3.4	32	2.7	24
Reserve	8.1	36	6.0	26	7.1	30
Spouse	12.3	20	--	--	--	18
Dependent	--	16	--	--	--	12
National Guard	5.4	28	4.9	25	5.0	25
Spouse	--	16	--	13	--	13
Dependent	--	12	--	12	--	12

Notes: Data sourced from NDI (suicide counts) and DMDC (denominators only). Per 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. 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 Department Services are reported here (i.e., Coast Guard family member suicide rates are not included in this report). Due to missing population data, the sponsor status of Army Service members could not be verified from November 2022 to June 2023. Additional data sources were used to best approximate the population of military family members sponsored by an Army Service member. The data reported in this section includes family members who were themselves Service members. This is done for completeness of data reporting and to fully capture the extent of suicide among military family members.

* Statistically significant — represents a true difference, not likely due to chance ($p < .05$).

† Not statistically significant — the observed difference could likely be explained by chance.

‡ Data not shown.

MILITARY FAMILY MEMBERS

Spouse Demographics and Method of Death

KEY TAKEAWAYS

Male spouses accounted for 65% of suicides among military spouses.

From 2022 to 2023, the male spouse suicide rate increased,* while the female spouse rate decreased.†

About 81% of spouses who died by suicide were under the age of 40. Spouses under 40 account for a similar percentage of the total military spouse population.‡

Firearm was the most common method of death among military spouses (69%).

Table 6 | Military Spouse Suicide Counts and Percentages by Demographics, 2023

Demographics	Count	Percent
Sex		
Male	64	65.3%
Female	34	34.7%
Age Group		
< 40	79	80.6%
≥ 40	19	19.4%
Service History		
Any Service History	58	59.2%
Prior Service	24	24.5%
Currently Serving	34	34.7%
No Service History	40	40.8%

Table 7 | Military Spouse Suicide Unadjusted Rates per 100,000 Individuals by Sex, 2021 – 2023

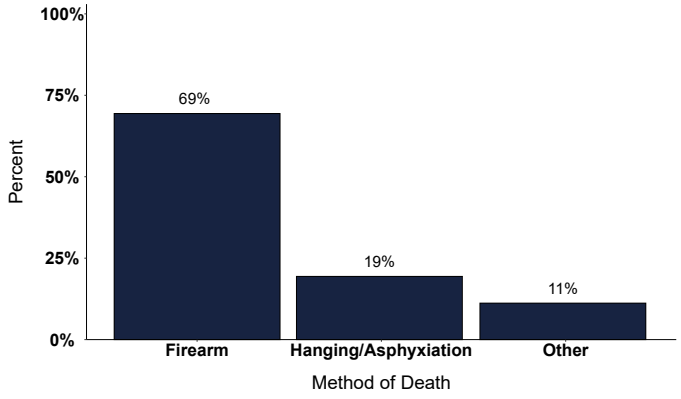
Component	2021		2022		2023	
	Male	Female	Male	Female	Male	Female
Total Force	40.3	6.4	31.8	5.7	46.8	4.1
Active Component	43.3	6.6	34.3	5.9	51.1	4.2
Reserve	--	--	--	--	--	--
National Guard	--	--	--	--	--	--

Male spouses accounted for nearly two-thirds of suicides among military spouses despite representing a much smaller share of the overall military spouse population (14%). These findings are similar to the U.S. population, which consistently shows males are more likely to die by suicide than females.[5]

Given differences in population size and demographics, comparing Service member and military spouse suicide rates may be misleading. For example, a majority of male military spouses who died by suicide (78%) had a history of military service.‡ Conversely, more than 75% of female spouses who died by suicide had no history of military service.‡

The Department recognizes that some military spouses may struggle with experiences related to their own military service. The Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 now ensures that transitioning Service members receive at least a full year of supportive services from the VA following discharge. The Department also continues to expand the supportive options available to military spouses.

Figure 13 | Percentage of Spouse Suicide Deaths by Method, 2023



Notes: Data sourced from NDI (suicide counts) and DMDC (denominators only). Per 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. The data reported in this section includes family members who were themselves Service members. This is done for completeness of data reporting and to fully capture the extent of suicide among military family members. Only Department Services are reported here (i.e., Coast Guard family member suicide rates are not included in this report). Percentages may not add up to 100% due to rounding.

* Statistically significant — represents a true difference, not likely due to chance ($p < .05$).

† Not statistically significant — the observed difference could likely be explained by chance.

‡ Data not shown.

Dependent Demographics and Method of Death

KEY TAKEAWAYS

Males accounted for 60% of military dependent suicide deaths in 2023.

About 35% of military dependent deaths occurred among those who were between the ages of 18 and 22. Dependents in this age group account for 7% of the total military dependent population.‡

Hanging or asphyxiation (44%) followed by use of firearm (40%) were the most common methods of death by suicide among dependents.

Table 8 | Military Dependent Suicide Counts and Percentages by Demographics, 2023

Demographics	Count	Percent
Sex		
Male	29	60.4%
Female	19	39.6%
Age Group		
< 18	31	64.6%
18 – 22	17	35.4%
Service History		
No Service	45	93.8%
History of Service	--	< 7.0%
Currently Serving	--	< 5.0%

Table 9 | Military Dependent Suicide Unadjusted Rates per 100,000 Individuals by Sex, 2021 – 2023

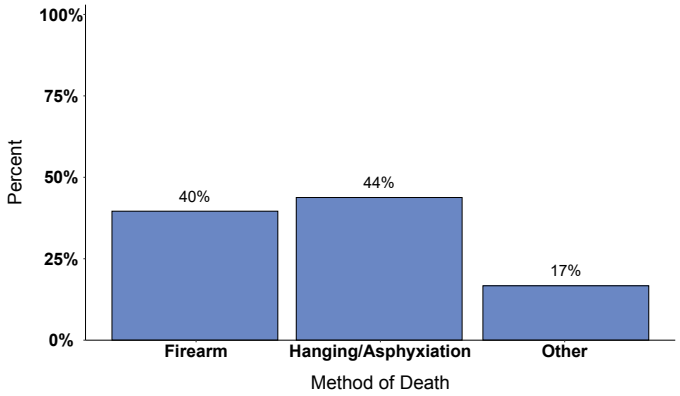
Component	2021		2022		2023	
	Male	Female	Male	Female	Male	Female
Total Force	4.6	--	4.9	--	3.8	--
Active Component	4.3	--	4.9	--	--	--
Reserve	--	--	--	--	--	--
National Guard	--	--	--	--	--	--

Military dependents face their own unique life experiences such as the stress of having to change schools every few years or the worry that comes with a parent being deployed. The impact of these stressors may vary with age.

Older dependents (18 to 22 years old) made up only 7% of the dependent population but account for 35% of suicide deaths among dependents. This finding aligns with U.S. population trends, as suicide rates are typically higher among young adults.[5]

Firearm and hanging/asphyxiation dominate as the leading methods of death for dependents. The Department will continue to promote lethal means safety strategies as one way to reduce hazards for self-harm.

Figure 14 | Percentage of Dependent Suicide Deaths by Method, 2023



Notes: Data sourced from NDI (suicide counts) and DMDC (denominators only). Per 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 Department Services are reported here (i.e., Coast Guard family member suicide rates are not included in this report). Percentages may not add up to 100% due to rounding.

‡ Data not shown.

IN THIS SECTION

Current and Ongoing Department Efforts

This section highlights examples of suicide prevention efforts being implemented across the Department, provides updates on the implementation of SPRIRC-enabling actions, and includes examples of initiatives unique to a given Service. Each of these efforts supports one or more lines of effort. A detailed description of each line of effort can be found on page 6.

The Department's suicide prevention lines of effort

- 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

Efforts in Preventing Suicide

The Department is committed to preventing suicide in support of a mission-ready and lethal Total Force. In keeping with the warrior ethos, the Department is invested in ensuring Service members are fit and ready to deploy. This includes equipping them and their families with the resources and support they need to thrive. This section highlights some of the Department's efforts from across the five lines of effort.

Foster a Supportive Environment

Annual Suicide Prevention Recognition Ceremony

- Each September, for Suicide Prevention Month, the Department recognizes installations and commands that implemented innovative suicide prevention programs and initiatives that foster a supportive environment. This increases awareness of these efforts and better encourages implementation in the Military Services. In 2024, the Department recognized 11 installations in an event held in the Pentagon's Hall of Heroes.
- More information can be found here: https://www.war.gov/News/News-Stories/Article/Article/3911824/dod-recognizes-eleven-installations-commands-for-suicide-prevention-success/

The Department's 2025 Suicide Prevention Campaign

- The theme of this campaign was "Joining Your Fight: Connect to Protect." It focused on promoting help-seeking behavior, reducing stigma, encouraging lethal means safety, and building connections and collaboration across the military community. As part of this campaign, DSPO attended nine in-person events and increased its number of followers on social media by over 250 people.
- More information can be found here: https://www.dspo.mil/Portals/113/Images/SPM%20Toolkit%202024/20240708-DSPO-CampaignFactSheet-SPAM-508c.pdf?ver=7aA5LlICV6zRwoab56UMTw%3d%3d

Interagency Collaboration

- The Department continued its collaboration with the VA and other Federal agencies to provide Service members diverse supportive resources. For example, the Department and VA worked together to increase use of publicly accessible mobile apps that have been shown to support mental health, such as Virtual Hope Box, Breathe2Relax, Insomnia Coach, and Mindfulness Coach.
- More information can be found here: https://health.mil/About-MHS/MHS-Elements/DVPO

Spotlight on the Brandon Act

The Brandon Act honors U.S. Navy Petty Officer 3rd Class Brandon Caserta, who died by suicide in 2018. It was enacted into law as part of the NDAA for FY 2022. This Act allows Service members to seek help confidentially, for any reason, at any time, and in any environment. It empowers Service members to seek support by requesting a referral for a mental health evaluation from a commanding officer or supervisor who is in a grade E-6 or above.

The Department continues to actively promote awareness and use of the Brandon Act across social media and other outlets. Examples include:

- Military Mental Health and Building Resilience in 2023: https://health.mil/News/Dvids-Articles/2024/01/08/news459748
- For Service Members, Access to Mental Health Care Streamlined Under Brandon Act: https://www.war.gov/News/News-Stories/Article/Article/3651970/for-service-members-access-to-mental-health-care-streamlined-under-brandon-act/
- Q&A on the Brandon Act: https://health.mil/Reference-Center/Frequently-Asked-Questions/Brandon-Act
- Brandon Act Fact Sheet: https://www.health.mil/Reference-Center/Fact-Sheets/2025/11/13/Brandon-Act-Fact-Sheet

Efforts in Preventing Suicide

Improve the Delivery of Mental Health Care

Military Health System Mental Health Hub

- A variety of mental health programs and services are available through the Military Health System. The Mental Health Hub was created as a resource for Service members and their families to navigate these options and readily access support when it is needed.
- More information can be found here: https://www.health.mil/Military-Health-Topics/Mental-Health

Targeted Care

- The targeted care approach connects Active Duty Service members with specialized mental health support matched to their needs. The Defense Health Agency (DHA) implemented this approach across all military medical treatment facilities.
- More information can be found here: https://health.mil/Military-Health-Topics/Mental-Health/Targeted-Care

Enhancing Care Options

- The Department continues to invest in expanding evidence-based clinical mental health programs, treatment, case management, and crisis management initiatives for Active Duty Service members.
- More information can be found here: https://health.mil/News/Dvids-Articles/2025/04/30/news496580

Address Stigma and Other Barriers to Care

National Strategy for Suicide Prevention (NSSP) Interagency Task Force (ITF)

- As part of the ITF, the Department is working to achieve the goals of the NSSP across the military community. These goals include addressing barriers to care and reducing stigma related to help-seeking. The Department actively engages in education and messaging efforts to achieve these goals.
- More information can be found here: https://www.hhs.gov/programs/prevention-and-wellness/mental-health-substance-use-disorder/national-strategy-suicide-prevention/index.html

Real Warriors Campaign

- This public health campaign focuses on encouraging help-seeking behavior for psychological health among Active Duty Service members, Veterans, and their families. This is done by decreasing stigma, increasing psychological health literacy, and improving access to care. The campaign amplifies existing suicide prevention initiatives through in-person events, webinars, and dissemination of articles, infographics, toolkits, videos, and social media posts.
- More information can be found here: https://health.mil/Military-Health-Topics/Centers-of-Excellence/Psychological-Health-Center-of-Excellence/Real-Warriors-Campaign

Enhancing Department Policy

- The Assistant Secretary of War for Health Affairs issued a memorandum clarifying policy established in DoDI 6490.08 that promotes help-seeking behavior and stigma reduction.[6] The memorandum clarified that health care providers will notify command of mental health service use by a Service member only in certain urgent circumstances (e.g., threat of harm to self or others).
- More information can be found here: https://www.arngbhreadiness.cstsonline.org/assets/media/documents/arngbh/(HQDA)%20Clarification%20of%20DoDI%206490.08%20Section%203.1.b.(1)(b)%20and%203.1.b.(2)(b)%20-%20UPR003336-23.pdf

Efforts in Preventing Suicide

Revise Suicide Prevention Training

Resources Exist, Asking Can Help (REACH)

- This training aims to normalize help-seeking by reducing barriers to care and increasing knowledge of available supportive resources. Specialized versions of REACH are available for Service members and military spouses. Most recently, a new version was also developed for Federal employees.
- More information can be found here: https://www.opa.mil/research-analysis/health-well-being/mental-health/resources-exist-asking-can-help-civilian-reach-c/

Postvention Response

- The Department continues to develop and refine postvention support for those affected by a suicide event. Examples include updating the postvention toolkit following a death by suicide and Service-specific guidelines for unit reintegration of a Service member following a suicide attempt or crisis.
- More information can be found here: https://www.dspo.mil/Portals/113/Documents/20250304-PostventionToolkit-Update.pdf

Expanding Treatment Options

- The Department continues to sponsor research into interventions that are effective at reducing suicide risk (e.g., crisis response planning). The results of this research inform training options for frontline service providers. Such research also serves to enhance support options for the military community.
- More information can be found here: https://www.msrc.fsu.edu/blog/msrc-common-data-elements-cde/

Promote a Culture of Lethal Means Safety

Tools to Promote Lethal Means Safety

- The Department continues to promote practical guidance on how to implement lethal means safety. This includes creating a suite of tools, such as a fact sheet on lethal means safety during the holidays, a toolkit for firearm retailers, and lethal means safety counseling recommendations for service providers.
- More information can be found here: https://www.dspo.mil/Portals/113/2024/documents/20241126-DSPO-Holiday-LMS-flyer-Final.pdf

Lethal Means Safety Public Service Announcements (PSAs)

- DOW and VA co-produced a multimedia public education campaign with the tagline “Keep It Secure.” These PSAs reinforce the importance of secure storage and that no one is alone in their personal battles.
- More information can be found here: https://keepitsecure.net

Pause to Protect

- This is a community-driven initiative for firearm businesses and owners to promote firearm safety and prevent suicide. Funded in part by the Department, firearm businesses near military installations receive a monetary stipend to accept firearms for secure, off-site storage. Businesses, Service members, Veterans, and the public can access educational materials on firearm safety.
- More information can be found here: https://pausetoprotect.org

EFFORTS

Implementation of the SPRIRC Portfolio

The Office of the Secretary of War and each of the Military Services are collaborating to implement and evaluate the efficacy of actions that are spread across the five lines of effort. These enabling actions are meant to improve readiness and enhance suicide prevention, intervention, and postvention. This section highlights some of the key efforts supporting implementation of these enabling actions. This section also presents how many enabling actions have been implemented and closed out for each line of effort. As of November 2025, the Department has implemented and closed out a total of 27 enabling actions.

Foster a Supportive Environment

16 out of 19 enabling actions closed to date

- Codifying involvement of mental health care providers in warm hand-offs of Service members under investigation.
- Increasing funding for military spouse career and education programs via enhancements to the My Career Advancement Account and the Military Spouse Career Accelerator Pilot.

Improve the Delivery of Mental Health Care

6 out of 20 enabling actions closed to date

- Implementing a behavioral health case management workforce.
- Expanding availability of mental health professionals.
- Continuing phased rollout of verification services.
- Expanding the Behavioral Health Resources and Virtual Experience Program to serve Active Duty family members and pediatric patients. This includes increasing the number of OCONUS sites supporting telehealth.

Address Stigma and Other Barriers to Care

2 out of 17 enabling actions closed to date

- Developing and promoting targeted strategies to more efficiently use non-medical counseling programs to meet the current demand for mental health care services.
- Creating a postvention response system to share resources with and provide guidance to Service members, Commanders, Chaplains, and other stakeholders at installations or units following a suicide death.

Revise Suicide Prevention Training

1 out of 19 enabling actions closed to date

- Creating evidence-based core competencies for suicide prevention training across the Department.
- Launching Service Postvention Response Teams and developing corresponding tools and programming.

Promote a Culture of Lethal Means Safety

2 out of 8 enabling actions closed to date

- Developing a secure storage voucher program to be piloted at select locations.
- Creating a multimedia public education campaign on secure firearm storage.

Highlights from Efforts in the Military Services

Each Military Service has its own suicide prevention program that complements and supports the Department's suicide prevention efforts. Service members can access support options unique to their Military Service through these programs. This section highlights examples of Service-specific efforts. Of note, some of these efforts are also shared across Services (e.g., Air Force and Space Force, Navy and Marine Corps).

Army	
Ask, Care, Escort (ACE) Lethal Means Safety Training Module Available Service-wide to Soldiers, Army Civilians, and Army families.	This module provides users with an opportunity to explore and discuss ways to practice and promote lethal means safety, support themselves and others, and help prevent suicide within their unit and support group. This module also enables Commanders to better tailor annual training to their unit's needs.
ACE Rap Videos Publicly accessible across Army's social media; YouTube; Directorate of Prevention, Resilience and Readiness Website; and ACE annual training.	Three rap videos showing a Soldier practicing ACE were produced to complement year-round prevention activities. Army leaders commended the initiative and expressed enthusiasm for the modernization of training to effectively engage younger Soldiers. Following widespread interest, additional videos are being produced across different musical genres.
Critical Assistance with Resources for Environmental Stressors Currently available to Soldiers at Joint Base Lewis-McChord.	This program aims to enhance Soldiers' resilience through proactive care, minimizing reliance on mental health care services. Soldiers can download an app with risk mitigation tools.
Department of the Navy (DON)	
Integrated Resilience and Mental Health Forums Open Department-wide to Navy and Marine Corps Senior Leaders.	In 2024, the Secretary of the Navy hosted two forums on critical topics of resilience, mental health, and suicide prevention. Senior leaders shared best practices, barriers to optimization, and encouraged cross-collaboration. The forum also engaged subject matter experts to inform further efforts, innovation, and strategy to reduce suicides.
Integrated Primary Prevention Workforce Symposium Open Department-wide to Integrated Primary Prevention Workforce personnel from the DON, Navy, and Marine Corps.	The symposium provides training, opportunities for collaboration, and shared learning related to the prevention of harmful behaviors, including suicide. Participants learn how to implement primary prevention measures and strategies, instruct others in best practices, enhance protective factors, and implement strategies for data collection and interpretation.

Highlights from Efforts in the Military Services

Department of the Navy (DON) (Continued)	
Evaluate and Update Suicide Prevention Training Open Department-wide for personnel from the DON, including Navy and Marine Corps Active Duty personnel.	DON suicide prevention policies and programs must be effective and impactful, increasing the readiness and lethality of the warfighter. DON evaluated existing trainings to ensure they reinforce the warrior ethos and enhance the well-being of Sailors and Marines. Strategies were also identified to address any gaps.
Marine Corps	
Marine Corps Total Fitness (MCTF) Strategy Implementation and *Warfighter Mental Readiness Playbook* (WMRP) Open Service-wide to all Marines, assigned Sailors, and family members.	MCTF is a strength-based approach for Marines and their families to ensure readiness and success in all domains of life. It is an investment in Marine well-being and lethality, increasing total fitness, and ensuring Marines know theirs is a life worth living. The Marine Corps WMRP released in 2024 arms all Marines with tools to enhance well-being and unit mental readiness.
Prioritization of Skills-Based Education and Peer Support Open Service-wide to all stakeholders operating within the Marine Corps.	The Marine Corps prioritizes education and peer support across various fields, imprinting lifesaving skills through repetition. This is how lethal means safety has become a permanent part of Marine Corps culture. Additionally, modernized suicide prevention education is done through experiential learning and educational wargaming. The Marine Intercept Program, the first of its kind in the Department, supports Marines who experienced suicide ideation or an attempt.
Annual Wellness Symposium Open Service-wide to all suicide prevention stakeholders.	This annual symposium allows stakeholders at all levels to align their prevention efforts with best practices. It serves as a venue to better operationalize MCTF, integrating multiple capabilities and leveraging existing resources to achieve a healthier and more ready force. Local suicide prevention initiatives are also recognized during the symposium.
Navy	
Suicide-Related Behavior and Response Postvention Guide Open Service-wide to all Commanders.	This guide prepares Commanders to respond to suicide events. This includes facilitating unit reintegration following a suicide attempt or crisis as well as suicide postvention following a death. No less than annually, Commanders conduct drills to ensure suicide crisis response plans are up-to-date and actionable.

Highlights from Efforts in the Military Services

Navy (Continued)	
Sailor Assistance and Intercept for Life (SAIL) Program Open Service-wide to all Sailors.	The SAIL program provides non-clinical support facilitating unit reintegration for Sailors following suicide ideation or an attempt. This is done through caring contacts, ongoing risk assessment, and care coordination. SAIL case managers maintain contact with Sailors, health care providers, and command leadership. Participation is entirely voluntary.
Navy Culture of Excellence Implemented Service-wide for all Sailors.	This initiative gives Navy leaders the resources to support Sailors in times of need, hold conversations that matter, implement the Brandon Act, and identify and respond to mental health concerns. This includes guidelines to ensure a positive, warm hand-off before a Sailor with known challenges or issues is transferred.
Air Force and Space Force	
Wingman Guardian Connect (WGC) Presently offered at the First Term Enlisted Course at nine bases. By close of FY 2026, this will expand to 16 additional bases, and all remaining bases by close of FY 2028.	A program where participants learn and model skills supportive of mental health and job success. WGC was validated at Sheppard Air Force Base in a randomized controlled trial. It supports mission readiness by helping Airmen and Guardians enhance social connections and develop peer-to-peer support, improving unit morale.
Airman and Guardian's Edge (AGE) Operational tests planned at five bases beginning in 2026.	AGE fills the need for an evidence-based, peer-to-peer suicide prevention strategy that does not require new unit-wide training. Peer-mentors teach skills around stress management, sleep hygiene, resilience, motivation, suicide prevention, and other factors directly related to remaining combat effective in times of increased stress. Operational tests will evaluate scalability and suicide prevention effectiveness.
Suicide Postvention Command Support Team (SPCST) Intended for Department of Air Force leadership.	SPCSTs provide support to installation leaders when more than one suicide has occurred and prior to an identified suicide cluster. SPCSTs help enhance postvention response and reduce risk of a suicide contagion effect. SPCSTs also provide long-term recommendations for suicide prevention, intervention, and postvention at multiple levels of responsibility.

Highlights from Efforts in the Military Services

National Guard Bureau	
Connectedness and Relationship Education System (CARES) This program is available in all 50 states, three territories, and the District of Columbia.	CARES helps maintain mission readiness by providing information on available supportive resources to Service members and their families. This program supports a broad range of outcomes, such as developing leadership skills, healthy relationships, enhanced self-awareness, coping skills, and building skills necessary for success outside the military.
Star Behavioral Health Providers (SBHP) This program is available in all 50 states, three territories, and the District of Columbia.	SBHP is a training program for civilian mental health providers, educating them on military culture, the deployment cycle, and treatment options for military personnel and their families. Multiple levels of online training are offered. SBHP maintains a registry of providers who have completed this training.
Project SafeGuard (PSG) This program is available across five states, with recruitment open to all interested states.	PSG provides training and counseling on lethal means safety. Participants are encouraged to spread their knowledge of safe storage practices to foster the development of protective environments. Participants also receive training in peer counseling techniques to normalize discussion on safe storage and address misconceptions related to lethal means safety.
Army Reserve Command	
Encouraging Help-Seeking Behaviors Through Music Open Service-wide to all Soldiers, Army Civilians, and family members.	This initiative strategically uses music to raise awareness and encourage meaningful conversations about mental health. It is meant to improve the effectiveness of prevention messaging, decrease stigma, and foster a culture of help-seeking. Seven original songs were produced, delivering a message of resilience and unity.
U.S. Army Reserve Deputy Commanding General's "Connect to Protect" Stand-Up Initiative Open Service-wide to all Army Reserve Soldiers.	This initiative aims to mitigate high-risk behaviors within the Army Reserve by promoting care and communication during periods of heightened stress (e.g., holiday season). This initiative uses proactive engagement, Suicide Prevention Liaisons, and suicide prevention training to reduce suicidal behavior in the Army Reserve.

Appendix

APPENDIX A: METHODOLOGICAL APPROACH

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

Suicide Data and Interpretation

Reporting Suicide Deaths for Service Members

By Department policy, AFMES determines the counts and rates for Service member suicide deaths, including those of cadets and midshipmen. All suicide deaths are reported to AFMES by the individual Service branch. AFMES reviews and verifies any cause-of-death determination in the case of Active Component Service members as well as Reserve and National Guard Service members on Active Duty at the time of death.[a] For Reserve and National Guard 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 in both Active Duty and non-duty status.

Defining Military Family Members

For the purposes of this report, a "military family member" is a person who is sponsored by the Service member, enrolled in DEERS, and eligible for benefits under Section 1072 of Title 10, U.S. Code. This includes family members of Reserve and National Guard Service members, including those in the Selected Reserve, in both Active Duty and non-duty status. "Dependent spouses" are referred to in this report as "spouses" and "dependent children" are referred to as "dependents." When comparing suicide rates between military family members and the U.S. population, the present analysis only considers suicide deaths among military dependents aged 10 years or older. This is done to align with CDC standards on reporting suicide deaths.

Reporting Suicide Deaths for Military Family Members

Suicide counts and rates reported for military family members may be underestimated and should be interpreted with caution. The Department uses data from the CDC National Center for Health Statistics NDI to determine suicide counts and rates for military family members. The NDI is a national database of death record information compiled from state offices. NDI data lag one year relative to Service member data due to the time it takes to collect and process state-level data.

No single data source can fully capture all suicide deaths among military spouses and dependents, most of whom are civilians. In 2023, DSPO reviewed different data sources and found that the NDI is the most reliable data source for identifying civilian deaths. This is important because military family member deaths seldom occur on military installations and the Department does not have visibility of or jurisdiction over these death investigations.

Due to missing population data, the sponsor status of Army Service members could not be verified from November 2022 to June 2023. Additional data sources were used to best approximate the population of military family members sponsored by an Army Service member.

Counts Versus Rates

Suicide death counts are the number of people who died by suicide in one year. Counts on their own can be misleading when comparing them between groups or assessing changes over time because they do not account for differences in the size of the group. For a more accurate comparison, we calculate the suicide rate. To calculate a crude or unadjusted suicide rate in this report, the number of deaths each year is divided by the size of the group, then multiplied by 100,000. Based on this formula, crude rates may increase year-to-year due to a larger number of deaths or a smaller population size.

Although rates reflect differences in the size of a population, 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 with different demographic compositions, such as a group consisting mostly of males versus a group consisting mostly of females. When comparing different groups, suicide rates are statistically adjusted for such differences. This is called an adjusted rate. Adjusting ensures the groups are more like each other (i.e., based on chosen characteristics). This ensures reliable comparative analyses. In the case of this report, rates are adjusted for the age and sex composition of each group.

In practical terms, rates are an important measure for monitoring the prevalence of suicide in the military. Rates serve as a standardized metric to monitor change over time. This is especially important considering that suicide counts in the military are considered mathematically small compared to the size of the Total Force.

Calculating the size of a given Service is a necessary part of calculating Service-specific suicide rates. Army population data were unavailable from November 2022 to June 2023.

[a] Service member deaths can 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.

For this reason, statistical imputation was used to determine the total size of the Army for CY 2022 and CY 2023. Statistical imputation is a process used to account for missing data. Use of statistical imputation can raise the possibility that rates may be over- or under-estimated. For this reason, Army suicide rates for CY 2022 and CY 2023 should be interpreted with caution.

Understanding Variability in Suicide Rates

All data are subject to natural variability. This refers to data changes that may happen by chance or without any external intervention. Examples include a basic change in the frequency of a behavior or outcome (e.g., decrease in suicide deaths in a given year) or variability in how standardized criteria are applied in examining a behavior (e.g., how medical examiners determine suicide as the cause of death). As a result of natural variability, the number of recorded suicide deaths may increase or decrease in a given year.

In the military, the overall number of suicide deaths is mathematically small compared to the size of the entire military population. For this reason, military suicide rates are considered volatile. Rates are considered volatile when even a small change in the number of deaths leads to a noticeable shift in the suicide rate, such as when a difference of two or three suicide deaths can change a rate by one decimal place.

The possibility of natural variability and volatility should be considered whenever trying to understand any observed differences between groups or over time. This does not mean that suicide rate data are somehow unreliable or unusable. It means that interpretation of these data, especially across short time frames or between smaller groups, should be done with caution and with as much context as possible to reliably inform policy, programs, and decision-making.

Understanding Statistical Significance

"Statistical significance" is a scientific term used to describe confidence 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, we cannot determine whether the observed difference is due to a true difference or due to natural variability. In such cases, more data or observations may be required to confirm any findings.

What are *p* values?

A *p* value represents the probability that the result could have occurred due to chance or natural variability. A common threshold for determining statistical significance is $p < .05$ and this is the threshold used throughout this report. This means that if a result is statistically significant ($p < .05$), then the likelihood that the observed difference is due to chance rather than a real difference is less than 5%.

What are 95% confidence intervals?

A level of uncertainty is associated with suicide rates due to random error and/or data volatility. 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.

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 determine whether one year's adjusted rate is statistically different from another year's adjusted rate. Some statistical tests can also indicate the strength of a relationship, such as by measuring effect size.

In this report, *p* values are used to interpret results and determine statistical significance. Statistically significant findings are identified in this report with an asterisk (*). Findings that are not statistically significant (i.e., null results), are identified with an obelus (†).

Analysis

The methods below outline the analytic approach used since CY 2019 to prepare the ARSM and DoDSER. For more details, see the CY 2019 DoDSER Appendix D.

Calculating Unadjusted and Adjusted Suicide Rates

Unadjusted suicide rates represent the number of people who died for every 100,000 people in that group or population in a given year.

Adjusted rates are estimated using a generalized log-linear regression model 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).

This type of model is achieved using a generalized linear model with a log-link function and based on the Poisson distribution, which is well suited to describing counts or rates for rare events. When adjusting for age and sex, the model also uses weighted effects coding to account for large differences in the size of demographic groups.[b] Adjusted rates in this report account for changes in age and sex demographics for a single population across time. Therefore, they are used to evaluate changes within a group across years, not to compare rates between different groups.

Statistical comparisons of suicide rates (e.g., between groups, over time) in this report are done using adjusted rates. When several statistical comparisons are done at once, we do a multiple comparisons correction using the multcomp package in R. This adds confidence to our findings by ensuring the *p* values reflect the increased likelihood of false positive test results. See Figure 1 for an example showing age and sex-adjusted rates for each year.

Estimating Change Over Time in Suicide Rates

To estimate long-term trends, this report uses a generalized log-linear regression model, similar to that used to determine the adjusted rates. Rather than using this model to calculate adjusted rates for each year individually, a line of best fit is estimated instead, adjusted for age and sex, to determine a rate of change over time from CY 2011 to CY 2024.

To describe short-term changes, this report uses the same trend analysis method to compare the rate for a given year to the rate for the previous year. For both near- and long-term analyses, the result of the trend analysis was a single estimated rate of change for the period. A statistical test was then performed to determine whether the trend direction (i.e., increasing or decreasing) was statistically significant for the period of interest.

Assessing Risk for Death by Suicide Among Specific Groups

Rate ratios are used to estimate suicide risk among demographic groups. This is the ratio of the adjusted suicide rate for a given demographic group to the average adjusted rate for the Component as a whole. When the rate ratio value is significantly higher than 1, the demographic group has a higher suicide risk. Conversely, a value that is lower – with statistical significance – than 1 implies lower suicide risk. Adjusted rates are estimated with a generalized log-linear regression model. Besides age and sex, rates are additionally adjusted for race, rank, and marital status. Weighted effects coding was applied so that each group was compared against the weighted average of all demographic groups in the Component.

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

Rate ratios were calculated for the overall Reserve Component (i.e., Reserve and National Guard) to ensure meaningful interpretation of findings. This is due to the relatively small number of decedents in the Reserve and National Guard, respectively. To reduce the volatility of the results, decedent and population counts were aggregated over three years for the Active Component. To reduce volatility in the overall Reserve Component, counts were aggregated over six years.

We also use rate ratio analysis to assess suicide risk between different military occupation codes. Cadets were excluded from occupational code analyses owing to their lack of an assigned occupation. We use six-digit occupation codes that are standardized across the Services and grouped such that the first two digits of each code represent broader categorizations. We further group the officer categories into Tactical Operations Officers and all other officers to ensure sufficient sample sizes to get statistically meaningful results. We adjust for age, sex, and these two-digit occupation codes for the most recent year of data and compare the adjusted rate of each group to the average adjusted rate for the whole population.

Comparing Military Suicide Rates to the U.S. Population

Comparing suicide rates between the military and the U.S. population requires accounting for age and sex differences. This is because the military has proportionally more men and more young people (i.e., under 30) than the U.S. population. Using unadjusted or crude rates to conduct such comparisons would give misleading results.

Accounting for these differences is done by first standardizing for age and sex differences between the military and U.S. population. Next, suicide rates within the military are adjusted for these age and sex differences.

To compare the military with the U.S. population, indirect standardization is used to account for differences in the demographic makeup of decedents. This was done because the number of suicide deaths within subsets of the military population are very small. A generalized log-linear regression model was used to estimate the standardized mortality ratio between the military and U.S. populations. Next, this ratio is multiplied by the U.S. population rate to get the standardized rate for the military. Statistical tests are then used to identify any significant differences between this standardized rate and the rate in the U.S. population.

In this report, military suicide rates are specifically standardized and adjusted for comparisons with U.S. population suicide rates. They should not be compared with rates for other populations or groups. U.S. population data were obtained using CDC Wide-ranging Online Data for Epidemiologic Research (https://wonder.cdc.gov/).

APPENDIX B: REPORTING REQUIREMENTS FOR SUICIDE IN THE MILITARY

Section 736 of the "Servicemember Quality of Life Improvement and National Defense Authorization Act for Fiscal Year 2025" (Public Law 118–159), requires DOW to submit to the Committee on Armed Services of the Senate and House of Representatives an annual report on suicide among members of the Armed Forces. This appendix lists each requirement and where they are addressed in the ARSM and/or DoDSER.

Requirement	Location
(A) The number of suicides, attempted suicides, and known cases of suicidal ideation involving a member of the Armed Forces, including the reserve components thereof, listed by Armed Force.	ARSM: p. 8 DoDSER: p. 77
(B) The number of suicides, attempted suicides, or known cases of suicidal ideation identified in (A) that occurred during each of the following periods: **(i)** The first 180 days of the member serving in the Armed Forces. **(ii)** The period in which the member is deployed in support of a contingency operation. **(iii)** The one-year period following the date on which the member returns from such a deployment.	DoDSER: p. 77
(C) With respect to the number of suicides, attempted suicides, or known cases of suicidal ideation identified in (B)(i), the initial recruit training location of the member.	DoDSER: p. 77
(D) The number of suicides involving a member who was prescribed a medication to treat a mental health or behavioral health diagnosis during the one-year period preceding the death.	DoDSER: p. 69
(E) The number of suicides involving a dependent of a member.	ARSM: pp. 19 – 21
(F) The number of suicides identified under (A) disaggregated by the military occupational specialty (or other similar classification, rating, or specialty code) of the member, excluding such specialties that the Secretary determines would not provide statistically valid data.	ARSM: p. 15
(G) A compilation of suicide data by military occupational specialty covered under subparagraph (F) to determine which military career fields have a higher per capita suicide rate compared to — **(i)** other military career fields for the same time period; **(ii)** the overall suicide rate for each Armed Force for the same time period; **(iii)** the overall suicide rate for the Department of Defense for the same time period; and **(iv)** the national suicide rate for the same time period.	ARSM: p. 15, Appendix E

APPENDIX B: REPORTING REQUIREMENTS FOR SUICIDE IN THE MILITARY

Requirement	Location
(H) The number of suicides identified under subparagraph (A) disaggregated by the age of the member.	ARSM: pp. 12 – 13 DoDSER: pp. 68, 71, 74
(I) A description of any research collaborations and data sharing by the Department of Defense with the Department of Veterans Affairs, other departments or agencies of the Federal Government, academic institutions, or nongovernmental organizations.	ARSM: Appendix F
(J) Identification of a research agenda for the Department of Defense to improve the evidence base on effective suicide prevention treatment and risk communication.	ARSM: Appendix G
(K) The availability and usage of the assistance of chaplains, houses of worship, and other spiritual resources for members of the Armed Forces who identify as religiously affiliated and have attempted suicide, have experienced suicidal ideation, or are at risk of suicide, and metrics on the impact these resources have in assisting religiously affiliated members who have access to and utilize them compared to religiously affiliated members who do not.	ARSM: Appendix H
(L) A description of the effectiveness of the policies developed pursuant to section 567 of the Carl Levin and Howard P. ‘‘Buck’’ McKeon National Defense Authorization Act for Fiscal Year 2015 (Public Law 113–291; 10 U.S.C. 1071 note) and section 582 of the National Defense Authorization Act for Fiscal Year 2013 (Public Law 112–239; 10 U.S.C. 1071 note), including with respect to— **(i)** metrics identifying effective treatment modalities for members of the Armed Forces who are at risk for suicide (including any clinical interventions involving early identification and treatment of such members); **(ii)** metrics for the rate of integration of mental health screenings and suicide risk and prevention for members during the delivery of primary care for such members; **(iii)** metrics relating to the effectiveness of suicide prevention and resilience programs and preventative behavioral health programs of the Department of Defense (including those of the military departments and the Armed Forces); and **(iv)** metrics evaluating the training standards for behavioral health care providers to ensure that such providers have received training on clinical best practices and evidence-based treatments.	ARSM: Appendix I
(M) A description of the programs carried out by the military departments to address and reduce the stigma associated with seeking assistance for mental health or suicidal thoughts.	ARSM: pp. 22 – 30

APPENDIX C: UNADJUSTED AND ADJUSTED SERVICE MEMBER SUICIDE RATES

Tables 10 – 12 present unadjusted and adjusted rates for the 2011 – 2024 trend analyses in the Service Member Key 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. Because 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 2024 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 2024 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 2024), 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 10 | Suicide Rates per 100,000 Service Members by Component, 2011 – 2024

Year	Active Component		Reserve		National Guard	
	Unadjusted	Adjusted	Unadjusted	Adjusted	Unadjusted	Adjusted
2011	18.7	16.9	18.1	15.4	24.9	21.6
2012	22.9	20.8	19.3	16.4	28.2	24.6
2013	18.4	16.9	23.1	19.6	28.9	25.3
2014	20.2	18.5	21.6	18.4	19.6	17.2
2015	20.2	18.5	24.8	21.1	26.4	23.2
2016	21.5	19.8	22.0	18.9	27.1	23.9
2017	22.2	20.5	25.8	22.2	29.8	26.4
2018	24.9	23.0	22.9	19.9	30.8	27.5
2019	26.3	24.3	18.5	16.2	20.5	18.5
2020	28.5	26.5	21.7	19.2	27.5	24.9
2021	24.4	22.6	21.3	18.9	27.3	24.6
2022	25.3	23.5	19.4	17.4	22.5	20.2
2023	28.3	26.4	22.7	20.5	21.7	19.6
2024	23.8	22.3	19.6	17.7	24.6	22.4

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.

APPENDIX C: UNADJUSTED AND ADJUSTED SERVICE MEMBER SUICIDE RATES

Table 11 | Active Component Suicide Rates per 100,000 Service Members by Service, 2011 – 2024

Year	Army		Marine Corps		Navy		Air Force	
	Unadjusted	Adjusted	Unadjusted	Adjusted	Unadjusted	Adjusted	Unadjusted	Adjusted
2011	24.8	22.8	15.4	14.7	16.0	13.8	12.9	11.5
2012	29.9	27.5	24.3	23.3	18.1	15.8	15.0	13.4
2013	22.5	20.8	23.6	22.8	12.8	11.2	14.4	12.9
2014	24.4	22.7	17.9	17.3	16.6	14.6	18.5	16.5
2015	24.4	22.8	21.2	20.4	13.1	11.6	20.2	18.0
2016	27.4	25.6	20.1	19.4	15.9	14.1	19.4	17.4
2017	24.7	23.1	23.4	22.6	20.1	17.9	19.9	17.9
2018	29.9	27.9	30.8	29.8	20.7	18.6	18.5	16.6
2019	30.7	28.6	25.3	24.5	21.8	19.7	25.1	22.6
2020	36.2	33.7	34.5	33.4	19.0	17.3	24.0	21.7
2021	36.1	33.6	23.9	23.1	17.0	15.4	15.3	13.8
2022	28.9	27.0	37.2	36.1	20.7	18.7	19.0	17.3
2023	35.0	32.8	37.1	36.1	20.4	18.6	22.2	20.3
2024	29.8	28.0	27.3	26.6	18.2	16.7	19.0	17.4

Table 12 | Army Reserve and Army National Guard Suicide Rates per 100,000 Service Members, 2011 – 2024

Year	Army Reserve		Army National Guard	
	Unadjusted	Adjusted	Unadjusted	Adjusted
2011	21.4	18.8	27.4	23.9
2012	24.7	21.5	30.8	26.9
2013	29.6	25.8	33.7	29.6
2014	21.4	18.7	21.5	18.9
2015	27.2	23.9	28.7	25.2
2016	20.6	18.2	31.3	27.6
2017	32.1	28.5	35.5	31.4
2018	25.3	22.7	35.6	31.8
2019	19.4	17.5	22.9	20.7
2020	22.2	20.1	31.5	28.5
2021	24.8	22.6	31.3	28.3
2022	20.8	19.0	25.1	22.6
2023	27.2	24.9	24.7	22.3
2024	21.3	19.6	27.2	24.8

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 D: DEMOGRAPHICS OF SUICIDE DECEDENTS BY SERVICE OR COMPONENT

Tables 13 – 15 present the unadjusted rates, counts, and percentages of suicide decedents by demographic subgroups for each Service and Component.

Table 13 | Active Component Suicide Counts, Rates per 100,000 Service Members, and Percentages by Service, 2024

Demographics	Army			Marine Corps			Navy			Air Force		
	Rate	Count	Percent	Rate	Count	Percent	Rate	Count	Percent	Rate	Count	Percent
Total	29.8	133	100%	27.3	46	100%	18.2	60	100%	19.0	60	100%
Sex												
Male	33.8	127	95.5%	30.3	46	100.0%	21.5	56	93.3%	20.6	51	85.0%
Female	--	6	4.5%	--	0	0.0%	--	4	6.7%	--	9	15.0%
Age Group												
17 – 19	--	4	3.0%	--	8	17.4%	--	0	0.0%	--	0	0.0%
20 – 24	48.8	63	47.4%	32.2	25	54.3%	25.1	24	40.0%	29.3	25	41.7%
25 – 29	24.1	26	19.5%	--	8	17.4%	--	14	23.3%	--	18	30.0%
30 – 34	--	7	5.3%	--	1	2.2%	--	8	13.3%	--	10	16.7%
35 – 39	--	19	14.3%	--	3	6.5%	--	8	13.3%	--	5	8.3%
40 – 44	--	7	5.3%	--	1	2.2%	--	4	6.7%	--	2	3.3%
45 – 49	--	5	3.8%	--	0	0.0%	--	1	1.7%	--	0	0.0%
50+	--	2	1.5%	--	0	0.0%	--	1	1.7%	--	0	0.0%
Race												
White	32.1	95	71.4%	26.1	35	76.1%	21.7	44	73.3%	16.3	35	58.3%
Black / African American	28.2	27	20.3%	--	5	10.9%	--	4	6.7%	--	11	18.3%
American Indian / Alaska Native	--	1	0.8%	--	0	0.0%	--	1	1.7%	--	1	1.7%
Asian / Pacific Islander	--	5	3.8%	--	4	8.7%	--	3	5.0%	--	7	11.7%
Other	--	4	3.0%	--	1	2.2%	--	5	8.3%	--	3	5.0%
Unknown	--	1	0.8%	--	1	2.2%	--	3	5.0%	--	3	5.0%
Rank												
Enlisted (Total)	35.4	124	93.2%	29.9	44	95.7%	17.4	47	78.3%	22.6	57	95.0%
E1 – E4	35.0	62	46.6%	33.5	32	69.6%	18.6	21	35.0%	25.5	33	55.0%
E5 – E9	35.8	62	46.6%	--	12	26.1%	16.5	26	43.3%	19.6	24	40.0%
Commissioned Officer	--	8	6.0%	--	2	4.3%	--	11	18.3%	--	3	5.0%
Warrant Officer	--	1	0.8%	--	0	0.0%	--	1	1.7%	--	0	0.0%
Cadet	--	0	0.0%	--	0	0.0%	--	1	1.7%	--	0	0.0%
Marital Status												
Never Married	32.3	56	42.1%	29.3	28	60.9%	19.9	31	51.7%	21.3	28	46.7%
Married	29.2	72	54.1%	--	17	37.0%	14.6	23	38.3%	16.4	27	45.0%
Divorced	--	5	3.8%	--	1	2.2%	--	6	10.0%	--	5	8.3%
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	--	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%

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 of suicide deaths is less than 20.[1] The categories used by Army to report racial/ethnic demographics are different from those used by Marine Corps, Navy, Air Force, and Space Force. No demographic information is presented for Space Force due to low counts. Established in 2019, the Space Force had no suicides from 2020 to 2022, two in 2023, and three in 2024. Only Department Services are reported here. Suicide rates for the Coast Guard are not normally included in this report because the Service operates under the U.S. Department of Homeland Security. Coast Guard cases are only included when operating under the Department of the Navy.

APPENDIX D: DEMOGRAPHICS OF SUICIDE DECEDENTS BY SERVICE OR COMPONENT

Table 14 | Reserve Suicide Counts, Rates per 100,000 Service Members, and Percentages by Service, 2024

Demographics	Army Reserve			Marine Corps Reserve			Navy Reserve			Air Force Reserve		
	Rate	Count	Percent	Rate	Count	Percent	Rate	Count	Percent	Rate	Count	Percent
Total	21.3	37	100%	--	8	100%	--	10	100%	--	9	100%
Sex												
Male	23.3	30	81.1%	--	8	100%	--	9	90.0%	--	9	100.0%
Female	--	7	18.9%	--	0	0.0%	--	1	10.0%	--	0	0.0%
Age Group												
17 – 19	--	0	0.0%	--	1	12.5%	--	0	0.0%	--	0	0.0%
20 – 24	--	7	18.9%	--	4	50.0%	--	2	20.0%	--	0	0.0%
25 – 29	--	6	16.2%	--	3	37.5%	--	1	10.0%	--	2	22.2%
30 – 34	--	9	24.3%	--	0	0.0%	--	2	20.0%	--	3	33.3%
35 – 39	--	5	13.5%	--	0	0.0%	--	4	40.0%	--	2	22.2%
40 – 44	--	5	13.5%	--	0	0.0%	--	1	10.0%	--	2	22.2%
45 – 49	--	2	5.4%	--	0	0.0%	--	0	0.0%	--	0	0.0%
50+	--	3	8.1%	--	0	0.0%	--	0	0.0%	--	0	0.0%
Race												
White	19.8	22	59.5%	--	7	87.5%	--	6	60.0%	--	6	66.7%
Black / African American	--	8	21.6%	--	0	0.0%	--	1	10.0%	--	2	22.2%
American Indian / Alaska Native	--	1	2.7%	--	0	0.0%	--	0	0.0%	--	0	0.0%
Asian / Pacific Islander	--	1	2.7%	--	0	0.0%	--	1	10.0%	--	0	0.0%
Other	--	1	2.7%	--	1	12.5%	--	1	10.0%	--	1	11.1%
Unknown	--	4	10.8%	--	0	0.0%	--	1	10.0%	--	0	0.0%
Rank												
Enlisted (Total)	22.9	31	83.8%	--	8	100.0%	--	10	100.0%	--	6	66.6%
E1 – E4	--	10	27.0%	--	5	62.5%	--	2	20.0%	--	3	33.3%
E5 – E9	28.8	21	56.8%	--	3	37.5%	--	8	80.0%	--	3	33.3%
Commissioned Officer	--	6	16.2%	--	0	0.0%	--	0	0.0%	--	3	33.3%
Warrant Officer	--	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%
Marital Status												
Never Married	--	14	37.8%	--	4	50.0%	--	5	50.0%	--	3	33.3%
Married	25.6	21	56.8%	--	4	50.0%	--	3	30.0%	--	6	66.7%
Divorced	--	2	5.4%	--	0	0.0%	--	1	10.0%	--	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	--	0	0.0%	--	0	0.0%	--	1	10.0%	--	0	0.0%

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 of suicide deaths is less than 20.[1] The categories used by Army to report racial/ethnic demographics are different from those used by Marine Corps, Navy, Air Force, and Space Force.

APPENDIX D: DEMOGRAPHICS OF SUICIDE DECEDENTS BY SERVICE OR COMPONENT

Table 15 | National Guard Suicide Counts, Rates per 100,000 Service Members, and Percentages by Service, 2024

Demographics	Army National Guard			Air National Guard		
	Rate	Count	Percent	Rate	Count	Percent
Total	27.2	88	100%	--	17	100%
Sex						
Male	29.4	76	86.4%	--	16	94.0%
Female	--	12	13.6%	--	1	5.9%
Age Group						
17 – 19	--	4	4.5%	--	0	0.0%
20 – 24	32.3	29	33.0%	--	2	11.8%
25 – 29	36.3	23	26.1%	--	1	5.9%
30 – 34	--	15	17.0%	--	2	11.8%
35 – 39	--	8	9.1%	--	4	23.5%
40 – 44	--	6	6.8%	--	2	11.8%
45 – 49	--	3	3.4%	--	3	17.6%
50+	--	0	0.0%	--	3	17.6%
Race						
White	29.9	73	83.0%	--	14	82.4%
Black / African American	--	7	8.0%	--	1	5.9%
American Indian / Alaska Native	--	0	0.0%	--	0	0.0%
Asian / Pacific Islander	--	5	5.7%	--	0	0.0%
Other	--	2	2.3%	--	2	11.8%
Unknown	--	1	1.1%	--	0	0.0%
Rank						
Enlisted (Total)	29.3	81	92.0%	--	11	64.7%
E1 – E4	29.3	44	50.0%	--	0	0.0%
E5 – E9	29.2	37	42.0%	--	11	64.7%
Commissioned Officer	--	6	6.8%	--	6	35.3%
Warrant Officer	--	1	1.1%	--	0	0.0%
Marital Status						
Never Married	26.8	48	54.5%	--	4	23.5%
Married	29.9	38	43.2%	--	12	70.6%
Divorced	--	2	2.3%	--	1	5.9%
Legally Separated	--	0	0.0%	--	0	0.0%
Widowed	--	0	0.0%	--	0	0.0%
Unknown	--	0	0.0%	--	0	0.0%

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 of suicide deaths is less than 20.[1] The categories used by Army to report racial/ethnic demographics are different from those used by Marine Corps, Navy, Air Force, and Space Force.

APPENDIX D: DEMOGRAPHICS OF SUICIDE DECEDENTS BY SERVICE OR COMPONENT

Table 16 shows the unadjusted rates, counts, and percentages of Active Component, Reserve, and National Guard Service members who died by suicide by demographic subgroups. The table also includes the Total Force count and percentages for these military populations.

Table 16 | Suicide Rates per 100,000 Service Members, Counts, and Percentages by Demographic Characteristic, 2024

Demographics	Active Component					Reserve					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	23.8	302	100%	1,270,974	100%	19.5	64	100%	327,921	100%	24.6	105	100%	427,030	100%
Sex															
Male	27.1	283	93.7%	1,042,753	82.0%	22.6	56	87.5%	248,073	75.7%	27.2	92	87.6%	338,806	79.3%
Female	--	19	6.3%	228,220	18.0%	--	8	12.5%	79,848	24.3%	--	13	12.4%	88,224	20.7%
Age Group															
17 – 19	--	12	4.0%	86,198	6.8%	--	1	1.6%	11,452	3.5%	--	4	3.8%	34,629	8.1%
20 – 24	35.2	137	45.4%	389,176	30.6%	--	13	20.3%	59,963	18.3%	29.7	31	29.5%	104,534	24.5%
25 – 29	22.6	67	22.2%	296,817	23.4%	--	12	18.8%	62,438	19.0%	30.0	24	22.9%	80,059	18.7%
30 – 34	12.4	26	8.6%	209,556	16.5%	--	14	21.9%	56,036	17.1%	--	17	16.2%	67,786	15.9%
35 – 39	22.4	36	11.9%	160,433	12.6%	--	11	17.2%	53,440	16.3%	--	12	11.4%	58,192	13.6%
40 – 44	--	14	4.6%	84,435	6.6%	--	8	12.5%	40,766	12.4%	--	8	7.6%	40,145	9.4%
45 – 49	--	6	2.0%	30,072	2.4%	--	2	3.1%	21,393	6.5%	--	6	5.7%	20,320	4.8%
50+	--	4	1.3%	14,286	1.1%	--	3	4.7%	22,433	6.8%	--	3	2.9%	21,365	5.0%
Race															
White	24.6	210	69.5%	853,703	67.2%	19.0	41	64.1%	215,416	65.7%	26.7	87	82.9%	325,770	76.3%
Black / African American	21.6	49	16.2%	227,236	17.9%	--	11	17.2%	63,856	19.5%	--	8	7.6%	63,183	14.8%
American Indian / Alaska Native	--	3	1.0%	13,808	1.1%	--	1	1.6%	2,933	0.9%	--	0	0.0%	2,950	0.7%
Asian / Pacific Islander	--	19	6.3%	86,743	6.8%	--	2	3.1%	19,550	6.0%	--	5	4.8%	21,589	5.1%
Other	--	13	4.3%	57,813	4.5%	--	4	6.2%	10,040	3.1%	--	4	3.8%	10,751	2.5%
Unknown	--	8	2.6%	31,670	2.5%	--	5	7.8%	16,125	4.9%	--	1	1.0%	2,787	0.7%
Rank															
Enlisted (Total)	26.7	274	90.7%	1,024,509	80.6%	21.5	55	85.9%	255,667	78.0%	25.3	92	87.6%	364,173	85.3%
E1 – E4	28.6	148	49.0%	517,153	40.7%	18.7	20	31.2%	107,186	32.7%	25.1	44	41.9%	174,993	41.0%
E5 – E9	24.8	126	41.7%	507,357	39.9%	23.6	35	54.7%	148,480	45.3%	25.4	48	45.7%	189,180	44.3%
Commissioned Officer	11.7	25	8.3%	213,415	16.8%	--	9	14.1%	68,274	20.8%	--	12	11.4%	53,896	12.6%
Warrant Officer	--	2	0.7%	19,984	1.6%	--	0	0.0%	3,980	1.2%	--	1	1.0%	8,961	2.1%
Cadet	--	1	0.3%	13,065	1.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Marital Status															
Never Married	25.5	143	47.4%	560,142	44.1%	18.3	26	40.6%	142,064	43.3%	24.1	52	49.5%	216,181	50.6%
Married	22.1	142	47.0%	641,982	50.5%	21.1	34	53.1%	160,801	49.0%	26.9	50	47.6%	185,701	43.5%
Divorced	--	17	5.6%	63,951	5.0%	--	3	4.7%	24,198	7.4%	--	3	2.9%	24,629	5.8%
Legally Separated	--	0	0.0%	616	0.0%	--	0	0.0%	172	0.1%	--	0	0.0%	145	0.0%
Widowed	--	0	0.0%	808	0.1%	--	0	0.0%	447	0.1%	--	0	0.0%	371	0.1%
Unknown	--	0	0.0%	3,474	0.3%	--	1	1.6%	237	0.1%	--	0	0.0%	3	0.0%

Notes: Data sourced from AFMES and DMDC. Percentages may not add up to 100% due to rounding. Per DoDI 6490.16, rates are not reported ("--") when the number of suicide deaths is less than 20.[1]

APPENDIX E: OCCUPATION CODE

Tables 17 and 18 show the counts of Service members who died by suicide by DoD primary occupation code. Table 17 shows these counts by Total Force, Active Component, Reserve, and National Guard. Table 18 displays these counts by Service. Only occupations that had a Service member who died by suicide are shown in the tables. Cadets were excluded from occupational code analyses owing to their lack of an assigned occupation. For this reason, counts presented in these tables may not align with that of the general Service member population.

Table 17 | Counts of Service Members Who Died by Suicide by 3-digit Primary Occupation Code and Component, 2024

Code	DoD Primary Occupation	Total Force	Active Component	Reserve	National Guard
	Total	470	301	64	105
	Enlisted				
10	**Infantry, Gun Crews, and Seamanship Specialists**				
101	Infantry	49	33	2	14
102	Armor and Amphibious	3	3	0	0
103	Combat Engineering	13	5	4	4
104	Artillery/Gunnery, Rockets, and Missiles	9	7	2	0
105	Air Crew	7	4	2	1
106	Seamanship	1	1	0	0
11	**Electronic Equipment Repairers**				
110	Radio/Radar	18	11	5	2
112	Missile Guidance, Control and Checkout	1	0	1	0
113	Sonar Equipment	1	1	0	0
115	Automated Data Processing Computers	6	5	1	0
119	Other Electronic Equipment	4	4	0	0
12	**Communications and Intelligence Specialists**				
120	Radio and Radio Code	1	0	1	0
122	Radar and Air Traffic Control	5	4	0	1
123	Signal Intelligence/Electronic Warfare	14	13	0	1
124	Intelligence	13	8	3	2
125	Combat Operations Control	12	10	0	2
126	Communications Center Operations	3	2	1	0
127	Cyberspace Operations	4	3	0	1
13	**Health Care Specialists**				
130	Medical Care	16	7	4	5
132	Biomedical Sciences and Allied Health	2	2	0	0
133	Dental Care	2	2	0	0
134	Medical Administration and Logistics	1	0	0	1

Table 17 | Counts of Service Members Who Died by Suicide by 3-digit Primary Occupation Code and Component, 2024 CONTINUED

Code	DoD Primary Occupation	Total Force	Active Component	Reserve	National Guard
	Enlisted				
14	**Other Technical and Allied Specialists**				
140	Photography	1	1	0	0
142	Weather	2	2	0	0
143	Ordnance Disposal and Diving	3	3	0	0
145	Musicians	1	0	0	1
149	Technical Specialists, Not Elsewhere Classified	6	5	0	1
15	**Functional Support and Administration**				
150	Personnel	4	3	1	0
151	Administration	5	3	2	0
152	Clerical/Personnel	5	3	1	1
153	Data Processing	7	4	1	2
154	Accounting, Finance and Disbursing	1	1	0	0
155	Other Functional Support	22	17	2	3
157	Information and Education	2	1	1	0
16	**Electrical/Mechanical Equipment Repairers**				
160	Aircraft and Aircraft Related	27	20	1	6
161	Automotive	24	12	2	10
162	Wire Communications	2	2	0	0
164	Armament and Munitions	13	7	4	2
165	Shipboard Propulsion	3	3	0	0
166	Power Generating Equipment	4	2	0	2
167	Precision Equipment	1	1	0	0
17	**Craftsworkers**				
170	Metalworking	4	2	0	2
171	Construction	10	2	5	3
172	Utilities	10	4	1	5
179	Other Craftworkers, Not Elsewhere Classified	2	2	0	0

APPENDIX E: OCCUPATION CODE

Table 17 | Counts of Service Members Who Died by Suicide by 3-digit Primary Occupation Code and Component, 2024 CONTINUED

Code	DoD Primary Occupation	Total Force	Active Component	Reserve	National Guard
	Enlisted				
18	**Service and Supply Handlers**				
180	Food Service	4	4	0	0
181	Motor Transport	19	10	3	6
182	Materiel Receipt, Storage and Issue	10	6	3	1
183	Law Enforcement	16	11	1	4
19	**Non-Occupational, Enlisted**				
191	Officer Candidates and Students	9	2	0	7
195	Not Occupationally Qualified	13	12	0	1
--	**Unknown, Enlisted**	**7**	**4**	**2**	**1**
	Officers				
220	Tactical Operations Officers	14	9	2	3
230	Intelligence Officers	3	1	1	1
240	Engineering and Maintenance Officers	10	8	0	2
250	Scientists and Professionals	1	1	0	0
260	Health Care Officers	9	2	4	3
270	Administrators	3	2	1	0
280	Supply, Procurement and Allied Officers	4	1	0	3
290	Non-Occupational, Officer	4	3	0	1

APPENDIX E: OCCUPATION CODE

Table 18 | Counts of Service Members Who Died by Suicide by 3-digit Primary Occupation Code and Service, 2024

Code	DoD Primary Occupation	Army	Marine Corps	Navy	Air Force	Space Force
	Total	258	54	69	86	3
	Enlisted					
10	**Infantry, Gun Crews, and Seamanship Specialists**					
101	Infantry	41	7	0	1	0
102	Armor and Amphibious	2	1	0	0	0
103	Combat Engineering	12	1	0	0	0
104	Artillery/Gunnery, Rockets, and Missiles	5	0	4	0	0
105	Air Crew	0	3	0	4	0
106	Seamanship	0	0	1	0	0
11	**Electronic Equipment Repairers**					
110	Radio/Radar	6	2	10	0	0
112	Missile Guidance, Control and Checkout	0	0	1	0	0
113	Sonar Equipment	0	0	1	0	0
115	Automated Data Processing Computers	0	0	6	0	0
119	Other Electronic Equipment	1	0	2	1	0
12	**Communications and Intelligence Specialists**					
120	Radio and Radio Code	0	1	0	0	0
122	Radar and Air Traffic Control	1	0	4	0	0
123	Signal Intelligence/Electronic Warfare	7	2	1	4	0
124	Intelligence	8	0	4	1	0
125	Combat Operations Control	10	0	0	2	0
126	Communications Center Operations	3	0	0	0	0
127	Cyberspace Operations	0	0	0	4	0
13	**Health Care Specialists**					
130	Medical Care	11	0	3	2	0
132	Biomedical Sciences and Allied Health	2	0	0	0	0
133	Dental Care	1	0	0	1	0
134	Medical Administration and Logistics	1	0	0	0	0
14	**Other Technical and Allied Specialists**					
140	Photography	0	1	0	0	0
142	Weather	0	0	0	2	0
143	Ordnance Disposal and Diving	1	0	0	2	0
145	Musicians	1	0	0	0	0
149	Technical Specialists, Not Elsewhere Classified	3	1	0	2	0

APPENDIX E: OCCUPATION CODE

Table 18 | Counts of Service Members Who Died by Suicide by 3-digit Primary Occupation Code and Service, 2024 CONTINUED

Code	DoD Primary Occupation	Army	Marine Corps	Navy	Air Force	Space Force
	Enlisted					
15	**Functional Support and Administration**					
150	Personnel	3	0	0	1	0
151	Administration	4	0	0	1	0
152	Clerical/Personnel	3	2	0	0	0
153	Data Processing	6	1	0	0	0
154	Accounting, Finance and Disbursing	1	0	0	0	0
155	Other Functional Support	9	4	1	8	0
157	Information and Education	2	0	0	0	0
16	**Electrical/Mechanical Equipment Repairers**					
160	Aircraft and Aircraft Related	6	3	4	14	0
161	Automotive	19	3	1	1	0
162	Wire Communications	0	0	2	0	0
164	Armament and Munitions	5	4	0	4	0
165	Shipboard Propulsion	0	0	3	0	0
166	Power Generating Equipment	1	0	2	1	0
167	Precision Equipment	0	1	0	0	0
17	**Craftsworkers**					
170	Metalworking	1	0	0	3	0
171	Construction	8	1	0	1	0
172	Utilities	6	0	0	4	0
179	Other Craftworkers, Not Elsewhere Classified	0	0	2	0	0

APPENDIX E: OCCUPATION CODE

Table 18 | Counts of Service Members Who Died by Suicide by 3-digit Primary Occupation Code and Service, 2024 CONTINUED

Code	DoD Primary Occupation	Army	Marine Corps	Navy	Air Force	Space Force
	Enlisted					
18	**Service and Supply Handlers**					
180	Food Service	2	0	2	0	0
181	Motor Transport	15	2	0	2	0
182	Materiel Receipt, Storage and Issue	8	2	0	0	0
183	Law Enforcement	6	2	3	5	0
19	**Non-Occupational, Enlisted**					
191	Officer Candidates and Students	9	0	0	0	0
195	Not Occupationally Qualified	5	6	0	2	0
--	**Unknown, Enlisted**	**2**	**2**	**0**	**1**	**2**
	Officers					
220	Tactical Operations Officers	3	1	7	3	0
230	Intelligence Officers	1	0	0	2	0
240	Engineering and Maintenance Officers	7	0	3	0	0
250	Scientists and Professionals	0	0	0	0	1
260	Health Care Officers	5	0	0	4	0
270	Administrators	3	0	0	0	0
280	Supply, Procurement and Allied Officers	1	1	0	2	0
290	Non-Occupational, Officer	1	0	2	1	0

APPENDIX F: RESEARCH, PROGRAM EVALUATION, AND DATA SHARING COLLABORATIONS

The Department routinely engages in collaborations both within the organization and with external partners. These collaborations serve to enhance understanding of suicide and to strengthen the scientific evidence base for developing effective suicide prevention policies and programs. External partners include other Federal agencies, academic institutions, and non-governmental organizations (e.g., private sector). This appendix highlights selected examples of the Department's current and ongoing collaborations that contribute to suicide prevention, intervention, and postvention efforts.

Research Collaborations

The Department collaborates internally, as well as funds and works with academic institutions and non-governmental organizations, to conduct research. This table includes examples and program overviews of select research studies. This table is not intended to be an exhaustive list of all research collaborations across the Department.

Collaboration Example	Program Overview
Augmenting Suicide Prevention Interventions for Service Members (ASPIS) Collaboration with the Military Services and academic institutions	ASPIS is a collection of five studies funded by the Department and conducted by Ohio State University in collaboration with Rutgers University and the Medical University of South Carolina. ASPIS studies are meant to identify the most effective suicide prevention strategies for specific Service member subgroups.
Congressionally Directed Medical Research Program (CDMRP) Collaboration with the Military Services and academic institutions	The CDMRP is developing its psychological health and traumatic brain injury research portfolio, supported by a recent $175 million Congressional allocation. Research is being conducted in collaboration with the Military Suicide Research Consortium (MSRC) and components of the Psychological Health Center of Excellence (PHCoE) and the Traumatic Brain Injury Center of Excellence.
Military Family Lifestyle Survey Collaboration with the Military Services, VA, non-governmental organizations, and academic institutions	Blue Star Families' Annual Military Family Lifestyle Survey provides a comprehensive review of military life, highlighting economic pressures, health access gaps, and family readiness. The results of the survey shape policy to better support military and Veteran families. The survey is conducted in collaboration with the D'Aniello Institute for Veterans and Military Families at Syracuse University.
Military Operational Medicine Research Program's (MOMRP) Psychological Health Post-Traumatic Stress Disorder (PTSD) and Resilience Research Portfolio Collaboration with the Military Services, VA, National Institutes of Health (NIH), and academic institutions	MOMRP coordinates research across a large portfolio that includes psychological health to develop measures that enhance Service member readiness and resilience. MOMRP engages with and collaborates with other Department offices, VA, NIH, and academic institutions to conduct research on PTSD, suicide prevention, resilience, substance use prevention, family resilience, and violence prevention in the military.

APPENDIX F: RESEARCH, PROGRAM EVALUATION, AND DATA SHARING COLLABORATIONS

Collaboration Example	Program Overview
Millennium Cohort Study (MILCO) Collaboration with the Military Services and VA	MILCO is a research study conducted by the Naval Health Research Center that examines long-term health and well-being associated with military service. The study includes Service members from all Military Services and follows them over a period of many years, including after completion of their military service.
Naval Sleep Study Collaboration with the Military Services and academic institutions	The Naval Sleep Study tracks sleep patterns and mental health in Sailors using wearable technology and self-reported questionnaires. In collaboration with the Naval Postgraduate School's Crew Endurance Team, the study's results are used to monitor the effects of the Navy's watch rotation policy changes. The results inform a larger body of research on sleep, fatigue, and mental health in Active Duty Service members.
Practice-Based Implementation Network (PBIN) Collaboration with the Military Services	The PBIN supports efforts to train clinical and non-clinical providers on using evidence-based mental health mobile apps in their care settings. In collaboration with the PHCoE, researchers are working to identify whether widespread integration of such apps is feasible in accordance with the White House Interagency Task Force and SPRIRC recommendations.
South Texas Research Organizational Network Guiding Studies on Trauma And Resilience (STRONG STAR) Collaboration with VA and academic institutions	The STRONG STAR Consortium is a clinical research hub that works with the Department, VA, and academic institutions, based at University of Texas Health Science Center San Antonio. The Consortium maintains a repository of data that includes participants from STRONG STAR Department-funded research studies. Data access can be requested by researchers. These studies were aimed at studying treatment of PTSD and comorbidities including suicide risk.
Study to Assess Risk and Resilience in Servicemembers — Longitudinal Study (STARRS-LS) Collaboration with the Military Services, VA, and academic institutions	STARRS-LS is a Department-funded research study led by Uniformed Service University of the Health Sciences (USUHS) and University of California, San Diego, with collaborators from University of Michigan, and Harvard Medical School. STARRS-LS follows 72,000 Service members over time with the aim of better understanding suicide risk, mental health, and resilience.
Suicide Prevention Research Impact NeTwork (SPRINT) Collaboration with the Military Services, VA, U.S. Department of Health and Human Services (HHS), and academic institutions	SPRINT is a VA-funded consortium of researchers and operational partners devoted to facilitating suicide prevention research by coordinating priorities, supporting studies, data-sharing, and translating findings into practice. SPRINT manages and administers the sharing of de-identified datasets from research projects funded by the Department's MSRC.

APPENDIX F: RESEARCH, PROGRAM EVALUATION, AND DATA SHARING COLLABORATIONS

Program Evaluation Collaborations

As with research collaborations, the Department also collaborates internally and across academic institutions and non-governmental organizations to perform program evaluations of suicide prevention initiatives. These program evaluations are used to develop effective and supportive services for the military community. This table includes examples and overviews of select program evaluations. This table is not intended to be an exhaustive list of all program evaluations across the Department.

Collaboration Example	Program Overview
Counseling on Access to Lethal Means (CALM) Collaboration with the Military Services and non-governmental organizations	In collaboration with USUHS and private sector partners, an e-learning version of the CALM course, adapted for civilian health care providers and non-clinical military gatekeepers (e.g., chaplains, non-commissioned officers, military and family life counselors) was developed. CALM teaches skills needed to engage in conversations about lethal means safety. This adapted version will be disseminated via the MilLife Learning platform on Military OneSource, filling a critical gap in military suicide prevention resources.
Rational Thinking, Emotion Regulation, and Problem-Solving (REPS)-Online Collaboration with the Military Services	Developed by USUHS and sponsored by DSPO, REPS is a mental fitness program targeted towards early-career enlisted Service members. The goal of the program is to build adaptive, evidence-based coping strategies prior to the stressors of military life. Evaluation studies are currently underway examining the implementation of REPS-Online through the MilLife Learning platform on Military OneSource.
REACH, REACH-Online, REACH-Spouse, and REACH-Civilian Collaboration with the Military Services	Developed in collaboration with the Office of People Analytics (OPA) with input from the Military Services, REACH is a series of four evidence-based programs designed to normalize help-seeking behavior through an in-person, facilitator-led interactive discussion. Evaluation of REACH found that program participation is associated with lower perceptions of barriers to care and increased comfort with seeking help. Originally developed for in-person use with Service members, specialized versions of REACH have also been adapted for online settings for Service members (REACH-Online), military spouses (REACH-Spouse), and civilian employees (REACH-Civilian).
SAIL Collaboration with the Military Services	The voluntary SAIL program supports Active Duty Sailors who experienced suicide ideation or attempts. SAIL case managers maintain contact with Sailors, health care providers, and command leadership. Through caring contacts with Sailors, case managers provide reintegration assistance, ongoing risk assessment, and care coordination.

APPENDIX F: RESEARCH, PROGRAM EVALUATION, AND DATA SHARING COLLABORATIONS

Collaboration Example	Program Overview
SPRIRC-Enabling Actions Collaboration with the Military Services	The Department began implementing actions informed by recommendations made by the SPRIRC. This includes increasing program evaluation capacity to monitor how policies and programs impact suicide risk and protective factors. As a result, collaboration across the Military Services is expected to grow in the coming years.
Suicide Prevention Virtual Reality (SPVR) Training Collaboration with the Military Services	The Department of the Air Force, in collaboration with private sector partners, is evaluating SPVR training. The SPVR training program was designed for Airmen and Guardians to learn and practice "Ask, Care, Escort" behavior in a realistic virtual environment. The evaluation compared SPVR to traditional suicide prevention training. Results indicate that SPVR participants had greater willingness to intervene in a crisis than those with traditional training.

Data Sharing Collaborations

The Department also fosters internal and external collaboration and supports suicide prevention research through its data sharing efforts. Data sharing efforts include (1) using internally collected data to inform policies and practice, and (2) providing access to Departmental suicide-related data to vetted external collaborators. This table includes examples and overviews of select data sharing collaborations. This table is not intended to be an exhaustive list of all data sharing collaborations across the Department.

Collaboration Example	Program Overview
Defense Organizational Climate Survey (DEOCS) Collaboration with the Military Services	The DEOCS provides military commanders and civilian organization leaders in the Department with information on unit (military) or organizational (civilian) climate that can be used to generate actionable feedback regarding command-level risk and protective factors. Aggregate results may also be used by Department offices such as the Office of Command Climate and Well-Being Integration to inform policy and practice.
DoDSER System Collaboration with the Military Services	The DoDSER system collects data on cases of suicide deaths, attempts, and some suicide-related behaviors, such as intentional self-harm and suicidal ideation. The system also tracks contextual factors, such as prior mental health care use as well as life and workplace stressors. Mental health providers and command officials on military installations and military medical treatment facilities across military branches input data into the system.

APPENDIX F: RESEARCH, PROGRAM EVALUATION, AND DATA SHARING COLLABORATIONS

Collaboration Example	Program Overview
Mortality Data Repository (MDR) Collaboration with HHS and VA	MDR is a joint DOW, VA, and HHS database, integrating all-cause mortality data that include data relevant to suicide prevention research. This database includes Service members and Veterans, including Veterans who do not use the VA health system.
Operation Deep Dive Collaboration with non-governmental organizations and academic institutions	America's Warrior Partnership, working with Duke University, launched Operation Deep Dive, a study examining the factors associated with suicide among former Service members. This study integrates state-level mortality data with military records from the Department, identifying demographic, socioeconomic, geographic, and military suicide risk factors.
Spouse and Family Issues Survey (SFIS) Collaboration with the Military Services	Administered by OPA, the SFIS collected data on socioeconomic factors, well-being, support, and suicide prevention from Active Duty as well as Reserve and National Guard military spouses. OPA is currently processing data to understand challenges facing military families. The Department will use these results to help inform policy and practice related to the supportive services available to military families.
Status of Forces Surveys (SOFS) Collaboration with the Military Services	Administered by OPA, SOFS is a Congressionally mandated series of annual web-based surveys of the Active Duty as well as Reserve and National Guard populations. SOFS captures attitudes and opinions of Service members on a range of personnel issues. Results are used by Department offices to evaluate existing programs and policies, establish baselines before implementing new programs and policies, and monitor program effects.

APPENDIX F: RESEARCH, PROGRAM EVALUATION, AND DATA SHARING COLLABORATIONS

Other Collaborations

This table includes three examples of how the DOW and VA share knowledge to enhance understandings of suicide and shape research priorities and initiatives on a national scale. This table is not intended to be an exhaustive list of all collaborations across the DOW and VA.

Collaboration Example	Program Overview
2024 NSSP Collaboration with a Federal Interagency Work Group	The 2024 NSSP sets four strategic directions for national suicide prevention efforts, including community-based prevention, supportive services, research, and health equity. The Department, along with over 20 agencies and offices across the Federal Government, contributed to the 2024 NSSP. The Department also collaborated on the NSSP Federal Action Plan, which outlines priority actions across the Federal Government intended to achieve the goals of the 2024 NSSP.
VA/DoD Biannual Suicide Prevention Conference Collaboration with the Military Services, VA, and academic institutions	This biannual conference, co-hosted by the VA and the Department, is the only national conference dedicated to addressing military and Veteran suicide prevention. Researchers, service professionals, and a variety of suicide prevention stakeholders all participate in this conference, sharing the results of their studies and other initiatives. The most recent conference took place in July 2024 in Portland, Oregon.
VA/DoD Clinical Practice Guidelines for Patients at Risk for Suicide Collaboration with VA	The *VA/DoD Clinical Practice Guidelines for Patients at Risk for Suicide* were updated in 2024, based on a systematic review of clinical and epidemiological research by a panel of multidisciplinary experts from the VA and the Department. This document also informs clinical research priorities and initiatives.

APPENDIX G: OVERVIEW OF THE DEPARTMENT'S SUICIDE PREVENTION RESEARCH AGENDA

The Department engages in research that aims to create practical policies and programs to lower the military suicide rate and improve the readiness of the Total Force. This section explains the Department's research agenda. In addition, this section provides examples of research activities that support the advancement of the research agenda.

Suicide Prevention Strategies that Inform the Research Agenda

The Department bases its approach to suicide prevention research on the *DoD Suicide Prevention Research Strategy, FY 2020 to 2030*.[7] This strategy focuses on military-specific gaps in knowledge and supports the development of effective, evidence-based programs to reduce suicide in the military. The Department works with both internal and external partners to advance this strategy. For example, suicide prevention research is additionally complemented by the *DHA Strategic Research Plan: Psychological Health*.[8] The strategy also aligns with other efforts like the *Defense Strategy for Suicide Prevention (DSSP)*[9] and the NSSP.[10]

Alongside the suicide prevention strategy, the Department also has a research strategy to address a range of harmful behaviors that share risk and protective factors. These harmful behaviors include, but are not limited to, suicide and sexual harassment and assault. The *FY25 Integrated Prevention Research Agenda* brings together research priorities on these issues and sets the direction for the integrated primary prevention workforce.[11] This includes, for example, identifying groups at increased risk for harmful behaviors. By focusing research on policies and programs that make a real difference, the Department works to improve the health, readiness, and well-being of the military community.

Activities that Support the Research Agenda

Beyond strategic planning, the Department also focuses on putting data-driven strategies into action. The Department's Mental Health Research Integration Work Group develops new tools that help transfer research knowledge to practice. For example, dashboards now show researchers how many patients are seeking mental health care and where studies are happening across the country. These tools raise awareness of and share research results, making it easier for researchers, clinicians, and program leaders to work together.

The Department works closely with the the VA, CDC, and other Federal agencies, universities, and non-governmental organizations to share suicide prevention research and data. For example, the MDR Board of Governors (BoG) oversees use of the VA/DoD MDR, which is the country's top source of Veteran and Service member mortality data. As the joint oversight body, the BoG reviews requests to access the data and supports its secure and proper use. The MDR data have been used in over 100 research projects, many of which focused on suicide prevention. By giving researchers quick, reliable data on causes of death and risk factors, the BoG supports the Department's goals in suicide prevention.

Sharing knowledge and resources helps everyone better understand suicide risks and protective factors. These partnerships also help create and test new programs that improve prevention of suicide and other harmful behaviors. Working together makes it easier to track suicide trends and make sure prevention programs help military members and their families. **Appendix F** contains more examples of the Department's research partnerships and data-sharing activities.

APPENDIX H: MILITARY CHAPLAINS AND SUICIDE PREVENTION

For the last 250 years, military chaplains have been integral to Total Force Fitness. Chaplains are commissioned officers who are usually stationed wherever there are military members. They provide support for all Service members, regardless of their religious beliefs or faith affiliation, instilling hope and providing comfort to members of the military community. Given their unique role, Service members and their families sometimes view chaplains as more accessible and approachable than traditional health professionals. This appendix discusses how chaplains contribute to military suicide prevention efforts.

Confidentiality

One of the reasons Service members and their families seek counseling from chaplains is that chaplains have a duty to protect confidential, privileged, and sacramental communications.

Chaplain Accessibility

Accessibility has been a guiding principle for military chaplains since the founding of the Nation. Chaplaincy services are available to all members of the military community, regardless of faith affiliation, including those who identify as non-religious. Chaplains are usually embedded with a unit and deploy to combat and contingency locations as well as disaster areas. Chaplains often engage with Service members in their workplaces in an informal way. Chaplains also offer counseling services in more formal settings (e.g., by appointment, walk-ins). At most installations, a chaplain is also on-call outside of normal hours for crisis situations.[12]

Total Force Fitness and Services Provided by Chaplains

Total Force Fitness, which includes spiritual fitness, is vital to a mission-ready Total Force. The Department and the Services recognize that spiritual fitness is an essential part of well-being.[13] Each Service takes a holistic approach to health. For example, the Army emphasizes readiness as a function of physical, mental, nutritional, sleep, and spiritual fitness.[14] Chaplains support the spiritual formation and fitness of Service members and their families by providing or helping them access religious programs and resources.

Chaplains, first and foremost, help the military community pursue a connection with the transcendent, the sacred, and/or a divine power. Such connections create and sustain hope, giving way to happiness and the strength to live life triumphantly. This sense of hope then informs a sense of meaning and purpose in life. Helping create such connections is what distinguishes chaplains from mental health care providers.

All individuals can receive counsel from chaplains knowing that the chaplain's worldview and philosophies of life are grounded in the divine. Chaplains additionally ensure the free exercise of religion for Service members and dependents around the globe, providing religious worship and rites. These religious services help Service members grow in their faith and character, equipping them for the rigors of life and the battlefield. The support chaplains provide across the military community serves multiple purposes and contributes to Total Force readiness and fitness.

APPENDIX H: MILITARY CHAPLAINS AND SUICIDE PREVENTION

Use of Chaplaincy Services

Across the Department, about a quarter of Service members reported using chaplaincy services.[15] Compared to Service members who did not see a chaplain, those who did tended to be younger (i.e., aged 17 – 24), perceived greater stigma with accessing other support sources, and were more likely to have a history of adverse life experiences (e.g., abuse). Of Service members who reported any counseling or mental health treatment use over the last year, 30% reported speaking with a military chaplain or civilian clergy.[16] In one study of Service members with recent suicidal ideation, 13% reported speaking with a chaplain.[17] Similarly, a recent study of Active Duty military spouses found that 22% reported receiving counseling from a chaplain or civilian religious leader. Of spouses who received counseling, about 70% found the counseling services they received to be "very" or "somewhat" useful.[18] Taken together, these studies suggest there is a real demand for chaplaincy services among Service members and their spouses.

The Chaplain's Role in Military Suicide Prevention

Suicide risk can impact anyone, from all ranks and walks of life. Many chaplains are responsible for teaching suicide prevention and intervention classes. These are predominantly psychoeducational and generally fall outside the scope of a spiritual domain. Yet it is what chaplains do within the spiritual domain that makes them uniquely suited to support suicide prevention efforts.

Here we provide specific examples related to how chaplains support those impacted by loneliness and insecure attachment styles. Human beings are created for connection, but U.S. society finds itself struggling with a loneliness epidemic threatening the health and well-being of our citizens.[19] Thwarted belongingness and perceiving oneself to be a burden to others are posited to be two of the primary reasons for suicide.[20] This means our society will continue to struggle with suicide as long as loneliness, anxiety, and depression remain elevated. U.S. society also has an alarming trend in insecure attachment styles marked by fear, avoidance, or anxiety.[21] Individuals with insecure attachment styles often suffer from chronic anxiety, difficulty trusting others, poor emotional regulation, and strained relationships, all of which increase their risk for suicide.[22,23] Research finds regular participation in faith-based activities can be protective against depression and suicide.[24(p.69,74)]

Military chaplains and off-base clergy working with Service members can help mitigate the harm of loneliness and insecure attachment styles. First, chaplains help Service members create secure attachments with the divine, resulting in increased psychological well-being and decreased psychological distress.[25,26] This is done through regular engagement in individual and group faith-based activities (e.g., religious services, daily prayer). Group activities additionally help Service members create more secure attachments with fellow faith adherents. These group activities create a community for Service members and their families to support one another, sharing in life's joys and struggles. Even when someone moves on to their next duty location, these relationships can be sustained through social media and other technologies, allowing one's faith community to offer support even from a distance. Personal and professional paths will often cross again later. This allows these relationships to resume in person and grow ever deeper.

Another example of how chaplains support suicide prevention efforts is through moral injury counseling. Moral injury is the deep psychological distress that arises when someone perpetrates, witnesses, or fails to prevent actions that violate their moral or ethical beliefs.[27] Studies show that there is a high potential that individuals who have a potentially morally injurious event will experience suicidal ideation and behavior.[28] Over the past year, chaplaincy services across the Department have been equipped with moral injury counseling interventions meant to restore attachment with the divine, to decrease suicidal ideation, and to give individuals increased spiritual and mental health well-being.[29(p.23,24,30)]

APPENDIX H: MILITARY CHAPLAINS AND SUICIDE PREVENTION

Chaplains serve faithful to their call, providing faith-based services which help Service members and their families create and grow vertical and horizontal secure attachments, decrease loneliness, and resolve moral injury. Taken together, chaplaincy support increases protective factors that go far beyond suicide and promote well-being across all domains of Total Force Fitness.

Specialized Training for Chaplains

To ensure Service members are receiving the support they need, when they need it, the Department has trainings available to chaplains. These evidence-based practice trainings (e.g., Applied Suicide Intervention Skills Training) help chaplains promote mental health and support early identification of mental health risk factors.[30,31] There are also training options specifically designed for chaplains (e.g., Chaplains-CARE) to further help them most effectively engage with Service members.[32] Through specialized training resources and opportunities for collaboration with clinical service providers, the contribution of chaplains to military suicide prevention efforts and warrior readiness will likely continue to grow in the coming years.

Conclusion

Military chaplains are integral to the Department's suicide prevention efforts. The role chaplains have in the military community, to maintain confidentiality and accessibility across units, makes them uniquely situated to support the Department's suicide prevention efforts. By providing both spiritual and non-religious counseling services, chaplains shape the lives of the military community in a unique way. They can also help Service members in need to access clinical services. Their role in increasing faith-based engagement among Service members and their families creates and sustains critical protective factors that promote life and well-being. Ultimately, chaplains help members of the military community feel a sense of hope and purpose, which is critical to suicide prevention.

APPENDIX I: OVERVIEW OF THE DEPARTMENT'S SUICIDE PREVENTION POLICIES AND EVALUATION

This appendix describes the policy documents related to suicide prevention and care as established by the following sections of the NDAA.

- Section 582 of the NDAA for FY 2013, Comprehensive Policy on Prevention of Suicide Among Members of the Armed Forces
- Section 567 of the NDAA for FY 2015, Improved Consistency in Data Collection and Reporting in Armed Forces Suicide Prevention Efforts

This appendix also describes the development of an evaluation strategy to assess the effectiveness of these policies.

Suicide Prevention Policies

The Department has several key policies that aim to prevent suicide among Service members. The main policy is DoDI 6490.16, Defense Suicide Prevention Program,[1] which was required by Section 582 of the NDAA for FY 2013. This DoDI lays out the policy on how to identify and treat Service members at higher risk for suicide, how to train mental health providers in suicide prevention, and how to provide support after a suicide (i.e., postvention). It also gives guidance for memorial services and reviews of non-clinical suicide prevention activities, such as programs that promote healthy relationships. Leaders at all levels of the military, from the Chairman of the Joint Chiefs of Staff to Combatant Commanders, are responsible for putting this policy into practice.

Other policies such as DoD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm (DoDI 6400.09)[33] and DoD Integrated Primary Prevention Policy for Prevention Workforce and Leaders (DoDI 6400.11)[34] strengthen suicide prevention by addressing a wider range of harmful behaviors. DoDI 6400.09 outlines the Department's integrated primary prevention strategy to address a range of harmful behaviors, including suicide. DoDI 6400.11 sets up the Department's integrated primary prevention system and workforce.

The Department has also created the DoD Suicide Postvention Response System (Directive Type Memorandum 25-004), which outlines the Department's implementation of its first coordinated, comprehensive, and tiered Suicide Postvention Response System for a suicide death of a Service member, suicide clusters, and suicide contagions.[35] The Postvention Response System is designed to provide immediate and ongoing community-based recovery support to teammates, leaders, families, and friends affected by suicide. It also defines what a suicide cluster means across the Department and sets procedures for notifying Congress when one occurs. Research shows that up to 135 people can be affected by one suicide, with about 60 affected by or experience significant grief due to a suicide death.[36] This underscores the ripple effect each suicide has on the military community and the need for effective postvention support.

In line with the 2024 NSSP, the policies described so far serve to "address risk and protective factors before the onset of a crisis."[10] They are also reflected in the five lines of effort derived from the SPRIRC, which drive the Department'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 lethal means safety.[37] The Department also supports research to make suicide prevention stronger across all military branches in line with the DSSP.

To carry out the 2024 NSSP, the Department committed to 12 short-term Action Items that focus on prevention, intervention, and postvention. These commitments, based on current funding, are meant to bring short-term improvements in suicide prevention while also preparing for long-term progress in lowering suicide rates.

The Action Items also support and enhance the SPRIRC-enabling actions and are part of a broader Federal Action Plan. The Department continues to track how well these goals are being put into action.

Administrative Instruction on Providing Clinical Care in Military Treatment Facilities

The DHA oversees the delivery of clinical care in military medical treatment facilities. The Surgeons General of each Military Department oversee the delivery of clinical care in operational clinical settings and establish their own policies and procedures for the safe delivery of health care. One important instruction, the Suicide Risk Care Pathway for Adult Patients in the Defense Health Agency (Administrative Instruction 6025.06), establishes the procedures for adults who are at risk for suicide.[38] This instruction also provides templates and tools to guide providers in following clinical practice guidelines, and best practices and standard procedures. All health care providers are trained on how to use these suicide risk care processes.

This instruction gives general guidance for providers in primary care and other medical settings, including primary care behavioral health providers. It also gives more detailed instructions for specialty mental health care providers, such as those working in unit-aligned outpatient behavioral health clinics.

The DHA Suicide Risk Care Pathway is a structured approach to reducing suicide risk. It sets clear, standardized steps for identifying, treating, and tracking patients at risk. This pathway includes screening, risk assessment, safety planning, proven treatment methods, and steps to reduce access to lethal means. At the same time, providers are encouraged to use their professional judgment and address the unique needs of each patient.

Data Collection and Reporting in Armed Forces Suicide Prevention Efforts

Section 567 of the FY 2015 NDAA requires the Department to have policies that standardize how information is collected, reported, and reviewed for suicide deaths and suicide attempts by Service members, as well as suicide deaths of military dependents. These policies help strengthen suicide prevention in many ways.

According to the 2024 NSSP and DSSP, standardized data collection, reporting, and assessment support effective surveillance of suicide risk, program quality improvement initiatives, and research advancement. The need for consistent data collection and reporting also features prominently in enabling actions outlined in the 2023 Memorandum on the SPRIRC.[37]

DoDI 6490.16, described previously, lays out the Department's suicide prevention policy and explains how collection and reporting of suicide data should be standardized. For example, AFMES confirms and reports suicide deaths, which are then published in the ARSM, the official source for suicide numbers and rates. PHCoE also manages data on deaths by suicide and suicide attempts through the suicide event reporting system. These data are analyzed and reported in the DoDSER, which is released together with the ARSM. These two reports then published in the ARSM, the official sources for suicide deaths and attempts. Policies such as DoDI 6400.09 and DoDI 6400.11 also require strong data protection measures and state that any prevention activity not data-informed or research-based should be discontinued.[33,34]

Together, these policies guide military suicide prevention, intervention, and postvention. Data not only support program improvement but also inform clinical care guidelines. The Department's focus on reliable data shows its commitment to a comprehensive, evidence-based public health approach to preventing suicide.

The main goal of the Department's suicide prevention program is to reduce suicide rates across the Total Force in a lasting way. To reach this goal, progress must be made in all of the evaluation domains to help the Department build and maintain the systems needed for long-term prevention.

APPENDIX J: ACRONYMS, TERMS, AND DEFINITIONS

Acronyms

ACE – Ask, Care, Escort

AFMES – Armed Forces Medical Examiner System

AGE – Airman and Guardian's Edge

ARSM – Annual Report on Suicide in the Military

ASPIS – Augmenting Suicide Prevention Interventions for Service Members

BoG – Board of Governors

CALM – Counseling on Access to Lethal Means

CARES – Connectedness and Relationship Education System

CDC – Centers for Disease Control and Prevention

CDMRP – Congressionally Directed Medical Research Program

CI – Confidence Interval

CONUS / OCONUS – Continental United States / Outside Continental United States

CY - Calendar Year

DEERS – Defense Enrollment Eligibility Reporting System

DEOCS – Defense Organizational Climate Survey

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

DON – Department of the Navy

DOW – Department of War

DSN – Defense Switching Network

DSPO – Defense Suicide Prevention Office

DSSP – Defense Strategy for Suicide Prevention

FY – Fiscal Year

HHS – Department of Health and Human Services

ICD-10 – International Statistical Classification of Diseases, 10th Revision

ITF – Interagency Task Force

MCTF – Marine Corps Total Fitness

MDR – Mortality Data Repository

MILCO – Millennium Cohort Study

MOMRP – Military Operational Medicine Research Program

MSRC – Military Suicide Research Consortium

NDAA – National Defense Authorization Act

NDI – National Death Index

NIH – National Institutes of Health

NSSP – National Strategy for Suicide Prevention

OPA – Office of People Analytics

PBIN – Practice-Based Implementation Network

PHCoE – Psychological Health Center of Excellence

PSA – Public Service Announcement

PSG – Project SafeGuard

PTSD – Post-Traumatic Stress Disorder

REACH – Resources Exist, Asking Can Help

REPS – Rational Thinking, Emotion Regulation, and Problem-Solving

SAIL – Sailor Assistance and Intercept for Life

SBHP – Star Behavioral Health Providers

SFIS – Spouse and Family Issues Survey

SOFS – Status of Forces Surveys

SPCST – Suicide Postvention Command Support Team

SPRINT – Suicide Prevention Research Impact NeTwork

SPRIRC – Suicide Prevention and Response Independent Review Committee

SPVR – Suicide Prevention Virtual Reality

STARRS-LS – Study to Assess Risk and Resilience in Servicemembers — Longitudinal Study

STRONG STAR – South Texas Research Organizational Network Guiding Studies on Trauma And Resilience

USUHS – Uniformed Service University of the Health Sciences

VA – Department of Veterans Affairs

WGC – Wingman Guardian Connect

WMRP – Warfighter Mental Readiness

APPENDIX J: ACRONYMS, TERMS, AND DEFINITIONS

Terms and Definitions[c]

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, including sustained duty in the Space Force. 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: An organization within the DHA that (1) performs forensic pathology investigations in accordance with Section 1471 of Title 10, U.S. Code and (2) exercises 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, Reserve, or National Guard) 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, a collection of actions and programs that aim to support defined Service member needs.

Enabling Actions: Refers to a series of tasks – adopted and modified from recommendations included in the SPRIRC final report – to be implemented within each of the Department's five suicide prevention lines of effort. These tasks were approved by the then Secretary of Defense in 2023 (https://media.defense.gov/2023/Sep/28/2003310249/-1/-1/1/NEW-DOD-ACTIONS-TOPREVENT-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 using a coordinated approach that promotes unity of effort, avoids unnecessary duplication, and lessens training fatigue (DoDI 6400.09).

Lines of Effort: Refers to five categories of services and supportive options that constitute the core of the Department's suicide prevention program, which 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 lethal means safety.

Military Family Members (or Military Dependents): In this report, military family members 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).

Occupation Code: Alpha-numeric codes used to identify a specific profession in the Armed Forces. Each Service branch has its own military occupation codes. Service members are typically assigned one code reflective of their main job function (DoDI 1312.01).

Postvention: Response activities that should be undertaken in the immediate aftermath of a suicide attempt or suicide death. The goal of postvention is to facilitate healing and reintegration for suicide attempt survivors and to prevent additional suicides by helping suicide loss survivors cope with their grief. It also may provide an opportunity to disseminate accurate information about suicide, encourage help-seeking behavior, and provide messages of resilience, hope, and healing. Postvention is also known as "tertiary prevention" (DoDI 6490.16).

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

APPENDIX J: ACRONYMS, TERMS, AND DEFINITIONS

Terms and Definitions

Primary Prevention: Activities that aim to stop self-directed harm and prohibited abusive or harmful acts before they occur. 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 Departmental military suicide prevention, typically refers to a collection of actions performed by dedicated personnel at an installation-wide or Service-wide level, supported with Department 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., help-seeking behavior, financial literacy). These factors increase the ability to reduce risk factors 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. In suicide prevention, this approach focuses on preventing suicidal behavior before it ever occurs (primary prevention) and addresses a broad range of risk and protective factors (DoDI 6490.16).

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

Risk Factors: Circumstances (e.g., stress, trauma) that may increase the likelihood of an individual developing a disorder or making them more vulnerable to high-risk 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 Reserve Services (DoDI 6490.16).

Statistically Significant: A comparison is considered statistically significant if the probability of observing that difference, or a larger difference, by chance is less than 5%, assuming 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). The negative perception that seeking mental health care or other supportive services will negatively affect or end one's military career (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 (DoDI 6490.16).

Suicide Decedent: An individual who died by suicide, as determined by a manner of death investigation, supported by evidence of intent to die.

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

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

Suicide Ideation: Thinking about, considering, or planning suicide (DoDI 6490.16).

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. In this report, suicide rates are calculated by dividing the number of deaths by suicide in the unit of time (in the Department, typically a calendar year) by the size of the population in the Department (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: Calendar Year 2024 Department of Defense Suicide Event Report

ENCLOSURE: CY 2024 DODSER

The following tables contain summary data from the DoDSER. Tables 1 – 8 display data for events reported among Service members in the Active Component, and tables 9 – 12 display data for events reported among Service members in the National Guard and Reserve. Only events with a form submitted by March 31, 2025, are included in the tables. Each form submitted contains information about one event consisting of either suicide death or nonfatal suicide attempt. 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. Negative responses include instances where information was not available or not provided. Where possible, data for nested response options are provided. Data for items or categories with fewer than 10 events or where there were concerns about individual-level identification are not provided. In some circumstances, partial data are provided for an item or response category and low-event frequencies or implied event counts are suppressed with an asterisk (*).

Tables 13 and 14 provide data as a partial response to reporting requirements stipulated in Section 736 of Public Law 118–159, "Servicemember Quality of Life Improvement and National Defense Authorization Act for Fiscal Year 2025." Table 13 provides a response to requirement (2)(a) – "the number of suicides, attempted suicides, and known cases of suicidal ideation involving a member of the Armed Forces, including the reserve components thereof, listed by Armed Force." Table 14 provides data in response to requirements (B)(i) and (C) – the number of cases identified in (2)(a) that occurred during "[t]he first 180 days of the member serving in the Armed Forces" and "the initial recruit training location of the member." For nonfatal events, data were combined into an 'other/unknown' location if there were fewer than 10 events at the initial entry training location.

One additional reporting requirement is section (D) – "[t]he number of suicides involving a member who was prescribed a medication to treat a mental health diagnosis during the one-year period preceding the death." There were 52 out of 471 suicide decedents with one or more eligible prescriptions during the period.

It should also be noted that data related to suicide events are complex and have limitations, particularly regarding suicide attempts and ideation. These events are not always reported and may not be fully captured in this analysis. The following data describe only those events that have been reported.

The Psychological Health Center of Excellence, Research & Engineering Directorate, DHA prepared this document.

Table 1. Demographic characteristics, suicide deaths, active component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Female	6.1	*	*	*	*
Not heterosexual	4.6	*	*	*	*
Age					
17 – 24	49.8	47.5	72.7	43.9	43.9
25 – 34	30.0	26.3	*	31.7	*
35 – 59	20.2	26.3	*	24.4	*
Race					
Asian/Pacific Islander	6.1	*	*	*	*
Black/African American	16.7	21.2	*	*	*
White/Caucasian	70.3	70.3	75.0	80.5	61.4
Other/Unknown	6.8	*	*	*	*
Hispanic ethnicity	15.6	12.7	*	*	26.3
Education					
High school graduate or less	75.7	72.9	90.9	68.3	77.2
Some college	9.9	*	*	*	*
4-year degree or more	10.3	12.7	*	*	*
Unknown	4.2	*	*	*	*
Marital status					
Never married	50.6	52.5	59.1	46.3	45.6
Married	44.1	*	*	*	*
Separated/divorced/widowed	4.9	*	*	*	*
Rank/grade					
E1 – E4	50.6	47.5	68.2	39.0	54.4
E5 – E9	41.1	*	*	*	*
Officer	8.0	*	*	*	*
Number of contingency operations[a]					
0	64.6	60.2	88.6	63.4	57.9
1	16.7	22.9	*	*	*
2 or more	18.6	16.9	*	*	*
History of direct combat[b]	10.3	16.1	*	*	*

Note: Percentages for total column based on 263 forms (118 Army, 44 Marine Corps, 41 Navy, 57 Air Force, 3 Space Force).

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

[b]Engagement in conflict in support of a U.S. military mission.

*Data suppressed to restrict individual-level identification.

Table 2. Event characteristics, suicide deaths, active component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Occurred in the continental United States	85.6	86.4	*	*	77.2
Event occurred at a military installation	38.4	42.4	59.1	*	*
Mechanism of injury					
Firearm	65.8	69.5	54.5	68.3	63.2
Suffocation/asphyxiation/hanging	25.5	22.9	40.9	*	*
Other/unknown	8.7	*	*	*	*
Communicated intent for self-harm[a]	25.1	24.6	31.8	24.4	21.1
Mental health staff	6.5	9.3	*	*	*
Friend	8.4	*	*	*	*
Spouse/partner	11.8	9.3	*	*	*
Other	10.3	11.9	*	*	*
Garrison duty environment	78.7	83.1	77.3	63.4	82.5

Note: Percentages for total column based on 263 forms (118 Army, 44 Marine Corps, 41 Navy, 57 Air Force, 3 Space Force).
[a]Subcategories are not mutually exclusive.
*Data suppressed to restrict individual-level identification.

Table 3. Mental health characteristics,[a] suicide deaths, active component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Any mental health diagnosis, past two years[b]	46.8	52.5	38.6	43.9	42.1
Alcohol use disorder	13.7	19.5	*	*	*
Substance use disorder	*	*	*	*	*
Depressive disorder	20.9	23.7	*	*	21.1
Anxiety disorder	16.3	24.6	*	*	*
Adjustment disorder	25.9	26.3	29.5	24.4	24.6
Posttraumatic stress disorder	6.1	*	*	*	*
Personality disorder	*	*	*	*	*
Psychotropic medication prescription at time of event	12.2	11.0	*	*	*
Family history of mental illness	14.8	10.2	*	*	24.6
Prior self-harm	17.1	19.5	*	*	*
Primary care encounter, last 90 days	63.9	62.7	68.2	51.2	70.2
Outpatient mental health encounter, last 90 days	34.6	42.4	29.5	24.4	31.6
Discharged from inpatient mental health, last 90 days	6.1	*	*	*	*

Note: Percentages for total column based on 263 forms (118 Army, 44 Marine Corps, 41 Navy, 57 Air Force, 3 Space Force).
[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.

Table 4. Contextual factors, suicide deaths, active component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Intimate relationship problems, last year	44.5	43.2	50.0	43.9	42.1
Death by suicide of friend or family member, last year	7.2	*	*	*	*
Administrative/legal problems, last year[a]	24.0	23.7	*	*	26.3
Nonjudicial punishment	9.1	9.3	*	*	*
Under investigation	14.4	15.3	*	*	*
Administrative separation	5.7	*	*	*	*
Financial difficulties, last year	12.5	13.6	*	*	*
Workplace difficulties, last year	33.8	33.1	25.0	43.9	33.3
Experienced physical or sexual assault or sexual harassment, last year[b]	*	*	*	*	*
Perpetrator of physical or sexual assault or sexual harassment, last year[a]	8.4	9.3	*	*	*
Physical assault	5.3	8.5	*	*	*
Sexual assault	*	*	*	*	*
Sexual harassment	*	*	*	*	*

Note: Percentages for total column based on 263 forms (118 Army, 44 Marine Corps, 41 Navy, 57 Air Force, 3 Space Force).
[a]Subcategories are not mutually exclusive.
[b]Subcategories not shown because of low counts.
*Data suppressed to restrict individual-level identification.

Table 5. Demographic characteristics, suicide attempts, active component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Female	29.7	23.2	25.4	36.5	33.3
Not heterosexual	8.0	8.7	4.9	5.6	10.8
Age					
17 – 24	62.8	62.4	84.0	54.5	57.3
25 – 34	29.6	29.8	*	*	35.1
35 – 59	7.6	7.8	*	*	7.4
Race					
Asian/Pacific Islander	6.9	*	*	9.3	6.5
Black/African American	23.9	27.1	15.7	23.3	26.5
White/Caucasian	61.5	62.6	75.0	56.7	56.0
Other/Unknown	7.7	*	*	10.7	11.0
Hispanic ethnicity	21.8	19.3	29.5	20.8	20.7
Education					
High school graduate or less	84.2	82.6	96.3	85.1	78.4
Some college	6.4	6.7	*	*	9.7
4-year degree or more	6.3	7.1	*	*	7.4
Unknown	3.0	3.7	*	*	4.5
Marital status					
Never married	57.4	63.5	69.0	48.3	51.9
Married	35.8	32.1	28.7	44.4	36.6
Separated/divorced/widowed	5.6	*	*	*	*
Unknown	1.2	*	*	*	*
Rank/grade					
E1 – E4	71.6	72.2	84.7	61.5	72.1
E5 – E9	24.1	22.5	13.4	35.1	23.1
Officer	3.1	*	*	*	*
Unknown	1.2	*	*	*	*
Number of contingency operations[a]					
0	80.1	83.3	92.5	76.4	72.8
1	12.9	*	*	14.9	17.1
2 or more	7.1	*	*	8.7	10.1
History of direct combat[b]	3.2	6.0	*	*	2.5

Note: Percentages for the total column based on 1,515 forms (436 Army, 268 Marine Corps, 356 Navy, 445 Air Force, and 10 Space Force).

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

[b]Engagement in conflict in support of a U.S. military mission.

*Data suppressed to restrict individual-level identification.

Table 6. Event characteristics, suicide attempts, active component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Occurred in the continental United States	76.5	69.3	82.8	81.7	75.3
Event occurred at a military installation	52.7	69.0	71.3	36.2	39.6
Mechanism of injury					
Cutting/piercing	14.6	12.4	18.3	13.2	15.7
Firearm	7.6	6.2	5.6	7.0	10.6
Poisoning	54.9	58.5	54.5	53.9	52.1
Suffocation/asphyxiation/hanging	13.4	16.1	12.3	12.4	12.1
Other/unknown	9.6	6.9	9.3	13.5	9.4
Communicated intent for self-harm[a]	11.3	11.5	4.9	7.3	18.2
Mental health staff	2.4	3.7	*	*	2.9
Friend	4.8	4.6	*	*	9.0
Spouse/partner	3.7	3.4	*	*	6.1
Other	5.3	5.7	*	*	7.9
Garrison duty environment	65.9	70.6	63.1	48.6	76.6

Note: Percentages for the total column based on 1,515 forms (436 Army, 268 Marine Corps, 356 Navy, 445 Air Force, and 10 Space Force).
[a]Subcategories are not mutually exclusive.
*Data suppressed to restrict individual-level identification.

Table 7. Mental health characteristics,[a] suicide attempts, active component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Any mental health diagnosis, past two years[b]	65.2	64.0	60.1	63.2	70.6
Alcohol use disorder	16.6	19.7	16.4	15.7	14.2
Substance use disorder	3.2	3.4	*	3.9	*
Depressive disorder	37.7	38.8	31.7	36.2	41.1
Anxiety disorder	30.3	28.2	22.8	28.9	37.1
Adjustment disorder	36.2	35.3	38.1	34.3	37.5
Posttraumatic stress disorder	10.7	8.9	6.0	14.3	12.1
Personality disorder	4.9	3.0	6.7	5.6	4.9
Psychotropic medication prescription at time of event	30.0	28.4	28.4	25.3	35.7
Family history of mental illness	27.1	26.6	20.1	22.2	36.0
Prior self-harm	35.7	39.7	32.1	32.6	37.1
Primary care encounter, last 90 days	76.5	81.4	84.3	54.8	83.8
Outpatient mental health encounter, last 90 days	56.3	60.8	48.5	47.5	62.9
Discharged from inpatient mental health, last 90 days	13.9	13.8	17.5	12.9	12.4

Note: Percentages for the total column based on 1,515 forms (436 Army, 268 Marine Corps, 356 Navy, 445 Air Force, and 10 Space Force).
[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.

Table 8. Contextual factors, suicide attempts, active component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Intimate relationship problems, last year	37.6	37.6	27.6	28.7	50.1
Death by suicide of friend or family member, last year	6.6	8.7	5.6	3.4	7.6
Administrative/legal problems, last year[a]	19.7	21.8	16.8	16.0	22.7
Nonjudicial punishment	8.8	11.5	9.0	5.1	9.4
Under investigation	8.4	9.4	4.5	5.3	12.6
Administrative separation	7.2	9.4	6.3	6.2	6.5
Financial difficulties, last year	12.7	16.7	8.6	11.0	12.8
Workplace difficulties, last year	37.8	41.1	28.7	22.5	52.1
Experienced physical or sexual assault or sexual harassment, last year[a]	9.0	7.3	10.8	5.1	12.6
Physical assault	3.7	3.7	*	*	4.7
Sexual assault	5.5	5.0	6.3	3.1	7.4
Sexual harassment	3.1	2.5	*	*	3.6
Perpetrator of physical or sexual assault or sexual harassment, last year[a]	2.6	*	*	*	4.5
Physical assault	1.7	*	*	*	2.5
Sexual assault	*	*	*	*	*
Sexual harassment	*	*	*	*	*

Note: Percentages for the total column based on 1,515 forms (436 Army, 268 Marine Corps, 356 Navy, 445 Air Force, and 10 Space Force).
[a]Subcategories are not mutually exclusive.
*Data suppressed to restrict individual-level identification.

Table 9. Demographic characteristics, National Guard and Reserve, percent

Item	Suicide	Suicide Attempt
National Guard	32.9	40.2
Reserve	67.1	59.8
Service		
Army	63.3	37.5
Marine Corps	*	*
Navy	*	*
Air Force	27.8	42.9
Female	*	23.2
Not heterosexual	*	*
Age		
17 – 24	24.1	42.0
25 – 29	34.2	38.4
30 – 59	41.8	19.6
Race		
Asian/Pacific Islander	*	*
Black	*	*
White	63.3	49.1
Other/unknown	27.8	28.6
Hispanic ethnicity	*	18.8
Education		
High school graduate or less	53.2	64.3
Some college	*	23.2
4-year degree or more	19.0	*
Unknown	*	*
Marital status		
Never married	61.7	48.8
Married	31.9	48.8
Separated/divorced/widowed	*	*
Unknown	*	*
Rank/grade		
E1 – E4	38.0	62.5
E5 –E9	54.4	31.2
Officer	*	*
Unknown	*	*
Number of contingency operations[a]		
0	44.3	67.0
1	30.4	14.3
2 or more	25.3	18.8
History of direct combat[b]	20.3	*

Note: Data based on 79 death and 112 attempt forms.

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

[b]Engagement in conflict in support of a U.S. military mission.

*Data suppressed to restrict individual-level identification.

Table 10. Event characteristics, National Guard and Reserve, percent

Item	Suicide	Suicide attempt
Occurred in the continental United States	*	88.4
Event occurred at a military installation	*	33.9
Mechanism of injury		
Firearm	72.2	13.4
Poisoning	*	49.1
Suffocation/asphyxiation/hanging	19.0	11.6
Other/unknown	*	25.9
Communicated intent for self-harm	39.2	17.0
Mental health staff	*	*
Friend	16.5	*
Spouse/partner	15.2	*
Other	22.8	9.8
In a duty status at time of event	16.7	47.3

Note: Data based on 79 death and 112 attempt forms.
*Data suppressed to restrict individual-level identification.

Table 11. Mental health characteristics,[a] National Guard and Reserve, percent

Item	Suicide	Suicide attempt
Any mental health diagnosis, past two years[b]	31.6	35.7
Alcohol use disorder	*	9.8
Substance use disorder	*	*
Depressive disorder	17.7	24.1
Anxiety disorder	12.7	18.8
Adjustment disorder	*	15.2
Posttraumatic stress disorder	*	*
Personality disorder	*	*
Psychotropic medication prescription at time of event	*	14.3
Family history of mental illness	13.9	20.5
Prior self-harm	26.6	33.9
Primary care encounter, last 90 days	12.7	38.4
Outpatient mental health encounter, last 90 days	12.7	28.6
Discharged from inpatient mental health, last 90 days	*	*

Note: Data based on 79 death and 112 attempt forms.
[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.

Table 12. Contextual factors, National Guard and Reserve, percent

Item	Suicide	Suicide attempt
Intimate relationship problems, last year	54.4	36.6
Death by suicide of friend or family member, last year	*	*
Administrative/legal problems, last year[a]	26.6	19.6
Financial difficulties, last year	21.5	24.1
Workplace difficulties, last year	30.4	42.0
Experienced physical or sexual assault or sexual harassment, last year[a]	*	9.8
Perpetrated physical or sexual assault or sexual harassment, last year[a]	*	*

Note: Data based on 79 death and 112 attempt forms.
[a]Subcategories not reported because of low frequencies.
*Data suppressed to restrict individual-level identification.

Table 13. Number of deaths by suicide, suicide attempts, and individuals with suicide ideation for CY 2024, by service.

Service	No. deaths	No. suicide attempts [a]	No. individuals with suicide ideation
Army	258	1,044	8,568
Marine Corps	54	398	2,456
Navy	86	722	3,317
Air Force	70	590	5,026
Space Force	3	12	43

[a] Individuals may have more than one attempt. Events more than 3 days apart were considered separate events for this report.

Table 14. Number of deaths by suicide, suicide attempts, and individuals with suicide ideation that occurred during the first 180 days of service, by initial training location.

Training location [a]	No. deaths (n = 8)	No. suicide attempts (n = 140)	No. individuals with suicide ideation (n = 3,787)
Designated training facilities			
Ft. Benning, GA	2	10	251
Ft. Jackson, SC	1	16	473
Ft. Leonard Wood, MO	0	21	193
Ft. Sill, OK	0	14	118
Naval Station Great Lakes, IL	1	17	1,165
Joint-Base San Antonio, TX	1	17	580
Marine Corps Recruit Depot (MCRD) Parris Island, SC	1	19	356
MCRD San Diego, CA	0	12	186
Other locations [b]			
Alabama	0	*	12
California	0	*	26
Colorado	0	*	10
Florida	0	*	38
Georgia	0	*	21
Illinois	0	*	12
Massachusetts	1	*	12
Michigan	0	*	14
New Jersey	0	*	17
New York	0	*	25
North Carolina	0	*	15
Ohio	0	*	17
Oklahoma	0	*	10
South Carolina	0	*	13
Texas	1	*	35
Virginia	0	*	15
Other/unknown	0	24	173

[a] Determined according to initial medical facility enrollment at entry into service.
[b] Locations not listed had insufficient numbers of events for all outcomes.

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 include events that occurred among Service members in a permanent absent-without-leave or deserter status. The 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 CDC, 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. Cases included in the DoDSER data summary are those with a form submitted to the DoDSER system. Cases included in the analysis required by PL 118-159 were from either DoDSER or the medical record as recorded in the Military Health System Medical Data Repository using the World Health Organization International Statistical Classification of Diseases, 10th Revision (ICD-10) diagnosis code of T14.91X. Suicide attempt data may include multiple events from the same individual.

Suicide Ideation Case Definition

Individuals with suicide ideation at any time in the period were identified using the ICD-10 diagnosis code R45.851. Individuals with more severe suicide behavior in the period (death or nonfatal attempt) were excluded.

Data Collection

Mental health providers and command officials on military installations and at military 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. Form completers may interview the Service member (suicide attempts). If authorized, form completers may conduct interviews with spouses, extended family, friends, and/or peers.

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 demographic data from the DEERS for all events submitted to the DoDSER system. DMDC also provides contingency operations data from the Contingency Tracking System, the repository of official deployment-related information.

The Military Health System Medical Data Repository contains medical record information for direct-care encounters within the health system and for purchased-care encounters that are billed to Tricare. Data on health care utilization, mental health diagnoses, and psychotropic medication use were extracted from the repository. Mental health diagnoses were coded using the ICD-10 codes as aligned to the American Psychiatric Association Diagnostic and Statistical Manual of Mental Health Disorders, Fifth Edition, Text Revision. Finally, psychotropic medications were identified using the American Hospital Formulary Service classification codes.