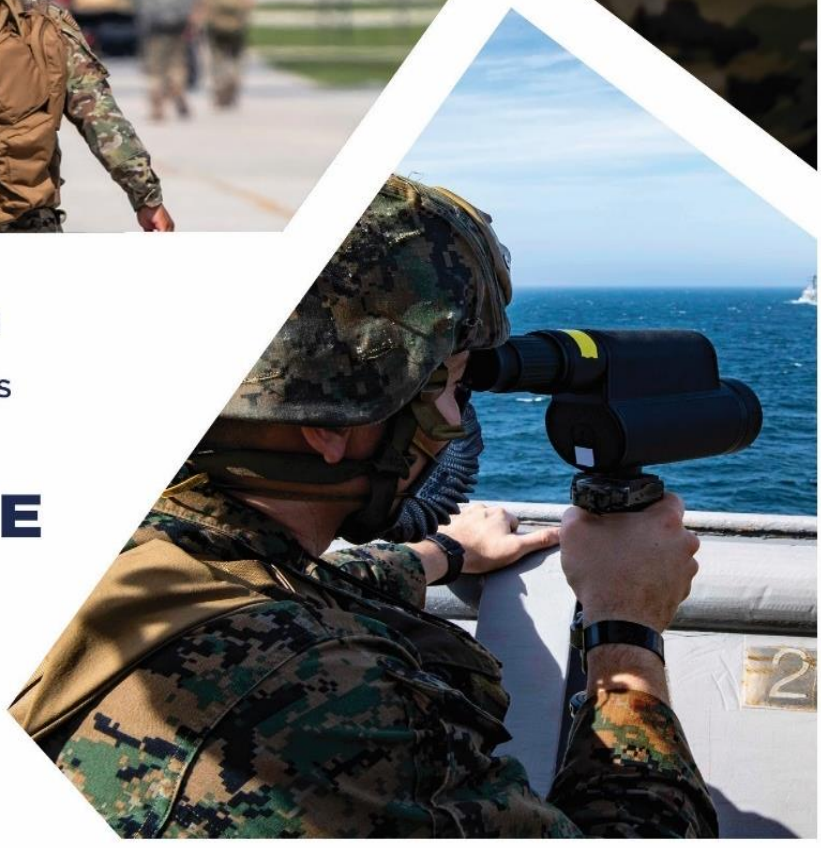

DEPARTMENT OF DEFENSE
UNDER SECRETARY OF DEFENSE
FOR PERSONNEL AND READINESS

ANNUAL SUICIDE REPORT

CALENDAR YEAR 2020

The estimated cost of this report or study for the Department of Defense is approximately $1,894,000 for the 2021 Fiscal Year. This include $1,743,000 in expenses and $151,000 in DoD labor.

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If you, or anyone you know, are experiencing thoughts of suicide, please reach out for help immediately.

- The Veterans/Military Crisis Line is a toll-free, confidential resource, with support 24/7, that connects Veterans, Service members, including members of the National Guard and Reserve, and their family members with qualified, caring responders.

- The Veterans/Military Crisis Line text-messaging service and online chat provide free support for all Service members and Veterans, even if they are not registered with the Department of Veterans Affairs (VA) or enrolled in VA health care. Service members, along with their loved ones, can call 1-800-273-8255 and press 1, chat online at https://www.veteranscrisisline.net/get-help/chat, or send a text message to 838255.

- The Veterans/Military Crisis Line is staffed by caring, qualified responders from the VA. Many are Veterans themselves. They understand what Service members have been through and the challenges members of the military and their loved ones face.

- Need crisis assistance while overseas? The following overseas locations have direct crisis line numbers:

    - In Europe: Call 00800 1273 8255 or DSN 118

    - In Korea: Call 0808 555 118 or DSN 118

    - Crisis chat support is available internationally at https://www.veteranscrisisline.net/get-help/chat

- In an emergency, dial 911 or your local emergency number immediately. An emergency is any situation that requires immediate assistance from the police, fire department, or an ambulance. Contact information:

    - Phone: 911

    - Web: https://www.911.gov/

Table of Contents

Executive Summary

The Department of Defense (DoD) is committed to preventing suicide and reducing stigma for seeking help within our military community, recognizing and valuing the diversity and talent each member contributes to our mission. We owe this to our Service members and families defending our Nation.

In October 2018, the Department established a requirement for a DoD Annual Suicide Report (ASR) to serve as the official source of annual suicide counts and rates for DoD and a means by which to increase transparency and accountability for DoD efforts toward the prevention of suicide.

This ASR provides an update on the Department's efforts to combat suicide, presenting recent suicide data on Service members and, to the extent available, their families; trends over time; and ongoing suicide prevention initiatives, including recent program evaluation, data sharing, collaborative research efforts, and programs to reduce the stigma associated with seeking assistance for mental health or suicidal thoughts. This report also meets requirements of Section 741 of the William M. (Mac) Thornberry National Defense Authorization Act (NDAA) of Fiscal Year (FY) 2020 (Public Law 116-92) as amended in Section 742 of the NDAA for FY 2021 (Public Law 116-283), as noted in **Appendix A**.

Department Actions Taken Since CY 2019 ASR

Since the publication of last year's ASR, the Department collectively has made progress in developing and fielding programs targeting our population of greatest concern identified in the CY 2019 ASR findings—young and enlisted members—as well as supporting our military families (Department of Defense, Under Secretary of Defense for Personnel and Readiness, 2020a). The Department has also taken proactive steps to mitigate the impact on members' well-being caused by the COVID-19 pandemic. Examples of actions taken include:

<u>Support Young and Enlisted Service Members:</u>

- Piloted and evaluated a *Simple Things Save Lives* training video on how to recognize and respond to suicide warning signs on social media. DoD released the video after a successful evaluation pilot, which showed that Service members found the video useful (85%), learned how to recognize warning signs online (80%), and how to respond (84%), including specific resources to share with others (84%).
- Piloted and evaluated a *Resources Exist, Asking Can Help (REACH)* training designed to address perceived help-seeking barriers (e.g., career concerns) and encourage help-seeking and the use of resources before challenges become overwhelming. Evaluation found REACH lowered Service members' perceived barriers, and increased their comfort with seeking help and knowledge of resources available.
- Published *Leaders Suicide Prevention Safe Messaging Guide* to address misconceptions about suicide and increase safe and effective communication about suicide across DoD.

WHAT IS THE ANNUAL SUICIDE REPORT?

The DoD Annual Suicide Report (ASR) serves as the official source for annual suicide counts and rates for DoD. This report also describes Departmental initiatives underway to combat suicide among Service members and their families.

HOW DOES THE ASR DIFFER FROM THE DEPARTMENT OF DEFENSE SUICIDE EVENT REPORT (DODSER) ANNUAL PUBLICATION?

The ASR provides the official annual DoD suicide counts and rates to the public, and reports on trends over time, which may provide an indication of whether recent DoD policy or programmatic initiatives are having the desired effect. The DoDSER Annual Report is the Department's official source for detailed risk and contextual factors associated with suicide and suicide-related behavior in DoD.

KEY FINDINGS

1. Active Component suicide rate statistically increased from CY 2015 - 2020. Near-term, Active Component rate was statistically comparable across CY 2018 to CY 2020.

2. Reserve and National Guard suicide rates did not show evidence of an increase or decrease from CY 2015 - 2020. Near-term, Reserve rate was statistically comparable across CY 2018 to CY 2020. National Guard rate had statistically decreased from CY 2018 to CY 2019, returning to a comparable level in CY 2020.

3. Service members at higher suicide risk are primarily enlisted, male, and under 30 years of age.

4. Suicide rates for military spouses and dependents in CY 2019 were statistically comparable with CY 2017 and CY 2018, and to the U.S. population rates after accounting for age and sex, with the exception of male spouses.

5. Firearms were the primary method of suicide death for Service members and family members. Recent DoD data also revealed Service member hold misconceptions regarding firearms and suicide risk.

WAY FORWARD

The Department will focus its efforts on young and enlisted member populations, and continue to support our military families, as well as track progress and evaluate program effectiveness.

- Collaborated with the Department of Veterans Affairs (VA) and other agencies to implement a national public health communication campaign to increase awareness of resources and help-seeking, and to prepare for "988" crisis line implementation.

- Conducted first-ever DoD survey examining Service member attitudes and behaviors regarding firearm storage and their beliefs about firearms and suicide risk. Leveraged findings to develop evidence-informed means safety communication tools.

- Advanced the Department's public health approach in policy to address risk and protective factors shared across readiness-detracting behaviors, such as suicide.

<u>Support Military Families</u>:

- Established a working group to develop a suite of family safety communication tools (e.g., *Means Safety Guide for Service Members and Family Members*, public service announcement [PSA] video), as well as a means safety campaign reinforcing the importance of safely storing firearms and medications. This suite is scheduled for approval in CY 2021.

- Developed *Resources Exist, Asking Can Help - Spouse* (REACH-S) training to address spouses' barriers to care and increase help-seeking.

- Trained middle and high school students in DoD schools via *Signs of Suicide* (SOS) training on suicide risk factors and help-seeking skills. Trained staff to deliver training in person for schools operating on regular schedules, and adapted training for virtual learning environments, with curriculum accessed at 100% of middle and high schools.

<u>Better Measure Program Effectiveness</u>:

- Collected follow-up Service member data, in addition to the prior baseline data, aligned with the DoD-wide suicide prevention program evaluation framework. Several years of data are required to reliably track changes over time and evaluate effectiveness of programs.

- Developed new DoD-wide suicide prevention program evaluation framework, specific for the military spouse population.

<u>Address Potential Impacts of the COVID-19 Pandemic:</u>

- The Coronavirus Disease 2019 (COVID-19) pandemic has tremendously impacted our Nation, influencing the health, well-being, social isolation, economic strain, and/or suicide risk for many individuals. The Department proactively responded via a variety of initiatives and virtual support efforts to ensure continued delivery of services and resources to the military community. Across the Department, examples of actions taken include the following, with further detail in the report:

▪ Participated in the Federal Coronavirus Mental Health Working Group per Executive Order 13594, *Saving Lives Through Increased Support for Mental and Behavioral Health Needs*.

▪ Launched tailored coronavirus resources on Military OneSource, DoD websites, Service/unit social media channels, and virtual leadership engagements. Offered suicide prevention training and resources virtually and increased communication on available resources (e.g., Veterans/Military Crisis Line, *in*Transition, non-medical counseling, financial education/counseling).

▪ Leveraged DoD's CY 2020 Suicide Prevention Month campaign of "Connect to Protect" throughout the year to focus on promoting connectedness and preventing suicide.

▪ Implemented studies to understand the impact of the pandemic and inform additional DoD actions.

Key CY 2020 Findings:

Service Members: In CY 2020, 580 members died by suicide.

Active Component: The suicide rate statistically increased from CY 2015 to CY 2020 (i.e., 20.3 to 28.7 suicides per 100,000 Service members).[1] A rise in the rate of suicide deaths across all Services was observed. In the near-term, the CY 2020 suicide rate was statistically comparable to both CY 2019 and CY 2018.[2]

Reserve: There was no statistically significant increase or decrease (i.e., no change) from CY 2015 to CY 2020. In the near-term, the CY 2020 rate was statistically comparable to both CY 2019 and CY 2018. The CY 2020 suicide rate, across Services and regardless of duty status, was 21.7 suicides per 100,000 Reservists.

National Guard: There was no statistically significant increase or decrease (i.e., no change) from CY 2015 to CY 2020. In the near-term, the CY 2020 rate was statistically higher than CY 2019, but statistically comparable to CY 2018. The CY 2020 suicide rate, across Services and regardless of duty status, was 27.0 suicides per 100,000 National Guard members.

Service member decedents were largely enlisted, male, and less than 30 years of age, regardless of military population. The demographic profile of Service members who died by suicide in CY 2020 was similar across the Active Component, Reserve, and National Guard, and overall, reflective of the profile of the Total Force.[3] Enlisted members, males, and those under the age of 30 were at higher risk for suicide compared to the population average. The majority of Service member suicide decedents died by firearm (ranging from 64.3% to 79.8%, across military populations). Recent DoD survey data also revealed several misconceptions commonly held by Service members surrounding firearms and suicide risk (e.g., 66% of surveyed Active Component members held the misconception that suicide risk is not related to how a firearm is stored).

The CY 2019 rates for Active Component, Reserve, and National Guard were comparable to the U.S. population, after accounting for age and sex. With respect to CY 2020, the most recent U.S. population suicide data available is for CY 2019. Accordingly, the data needed to compare for CY 2020 are not yet available.

Military Families: In CY 2019, a total of 202 military family members died by suicide, according to the most recent data available.

The CY 2019 military family suicide rates were statistically comparable to CY 2017 and CY 2018. Suicide rates for military spouses and dependents (minor and non-minor) in CY 2019 were comparable to U.S. population rates after accounting for age and sex, with the exception of male spouses. For military spouses, the suicide rate in CY 2019 was 12.6 per 100,000

[1] The term "statistically increased/decreased/higher/lower" means a statistically significant increase or decrease using a *p* value of .05.
[2] The term "statistically comparable" means no differences were statistically significant using a *p* value of .05.
[3] In this report, Total Force includes DoD Active and Reserve Component military personnel. Reserve Component is further limited to members of the Selected Reserve (SELRES).

population. About half of all spouse decedents were male, and about half had a history (current or prior) of military service. When examined by sex, suicide rates for spouses, ages 18 to 60, were 6.8 (female) and 51.7 (male) per 100,000 population, respectively. After adjusting for differences in age, the CY 2019 female spouse rate was comparable to the U.S. population suicide rate for females ages 18 to 60 years, whereas the male spouse rate was statistically higher than for similar-age males in the U.S. population. Suicide deaths in CY 2019 were primarily by firearm (59.5%) for military spouses. For female spouses, firearms were the leading method (41.0%), followed by hanging/asphyxiation (24.6%). This contrasts the similar-age female U.S. population where firearms and hanging/asphyxiation are about equal (about 31%) as the leading method.

For military dependents under 23 years of age, the overall suicide rate in CY 2019 was 4.5 per 100,000 dependents. About 76% of all dependent decedents were male. The suicide rate for male military dependents in CY 2019 (6.7 per 100,000 population) was comparable to similar-age (< 23 years) males in the U.S. population.[4] Suicide deaths in CY 2019 were primarily by firearm for dependents (47.2%).

Ongoing Efforts

The Department embraces a comprehensive public health approach that acknowledges the interplay of individual-, relationship-, and community-level risk factors, as well as recognizes the need to enhance protective factors to help reduce the suicide risk for all Service members and their families.[5] This report highlights efforts underway aligned with this approach.

Based on the CY 2020 ASR findings, the Active Component suicide rate statistically increased from CY 2015 to CY 2020, with young, enlisted Service members being at highest risk. In addition to continuing to support our military families, DoD will continue to focus prevention efforts on young and enlisted Service members due to this population being of greatest concern. Examples of new and ongoing efforts include:

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

To support young and enlisted Service members, the Department is focusing on several efforts to reduce stigma and barriers to care and increase access to care. New efforts include a pilot program wherein Soldiers complete an annual wellness check with a trained counselor on their personal well-being. DoD is also expanding the *REACH* training—designed to reduce stigma and barriers and increase help-seeking—tailoring and piloting this program for geographically isolated and Outside Continental United States (OCONUS) Service members.[6]

The Department also continues to focus on foundational skill development for our young Service members, with training that teaches coping and problem-solving skills to deal with life stressors early in one's military career. To further enhance means safety efforts, the Department is developing and piloting a new training that integrates suicide prevention curricula into firearm safety training for Service members.

The Department is also conducting installation evaluations and command climate assessments to identify any areas of risk or promise in order to advance prevention efforts on the ground for Service members and ensure a workforce trained in prevention.

The Department continues interagency collaboration efforts to advance prevention efforts nationally, and specifically within our military and Veteran communities; for example, via the Suicide Prevention Interagency Policy Committee. DoD continues to partner with the VA on several efforts, including preparing for implementation of the "988" crisis line and its linkage to the Veterans/Military Crisis Line,

[4] DoD did not calculate the suicide rate for female military dependents because of low suicide counts. Per DoD Instruction (DoDI) 6490.16, suicide rates are not reported for groups with fewer than 20 suicides due to statistical instability.
[5] For more information about the social ecological model, which encompasses multiple levels of focus from the individual, relationship, and community to better understand suicide risk and protective factors identified in this report, please visit https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf
[6] OCONUS includes Hawaii and Alaska, U.S. territories, and foreign locations.

as well as joint research collaborations using advanced analytics for assessment of suicide risk and outcomes.

Support Military Families:

To support military families, the Department is developing a first-ever survey focused on better understanding spouse/family member suicide ideations, behaviors, and suicide risk and protective factors to inform DoD policies and programs tailored for military families. To reduce stigma and barriers to care and increase access to care, new efforts include screening for depression and suicide risk during primary care visits for individuals 11 years of age or older seen at a Military Treatment Facility (MTF). The Department also has an outreach campaign called "Re The We" (**RE**KINDLE**, RE**PAIR **OR RE**SET **YOUR RELATIONSHIP)** that serves to normalize help-seeking for relationship stressors and connect military couples to resources, personalized counseling, and other support. The Department also continues to expand Counseling on Access to Lethal Means (CALM) training which is designed to teach strategies to increase safe storage of lethal means and address suicide risk factors while tailoring the training content to military spouses and others in the military community.

Measure Effectiveness of Policies and Programs:

The Department is continuing to take a focused approach to program evaluation to assess existing policies and programs, and leverage evidence-informed science on suicide prevention. DoD continues to collect follow-up enterprise-wide data—aligned with a program evaluation framework—to evaluate progress and the effectiveness of suicide prevention programs as a collective system in combating suicide. In addition, the Department is exploring metrics for a new program evaluation framework for the military spouse population. These and other efforts continue to identify any gaps and needed changes.

To achieve Departmental goals, the DoD will also continue robust research collaborations, data sharing, outreach, and other key efforts with national and local organizations, continuing to strengthen current and build new collaborations. The Department is steadfast in its commitment to the health, safety, and well-being of its military community.

Introduction

Suicide is the culmination of multiple factors and complex interactions. Yet suicide is preventable. Every death by suicide is a tragedy and weighs heavily on the military community. The Department of Defense (DoD) is committed to preventing suicide within its military community, recognizing and valuing the diversity and talent each member contributes to our mission readiness and accomplishments. By pursuing an inclusive and holistic public health approach to suicide prevention, especially during the Coronavirus Disease 2019 (COVID-19) pandemic, the Department has ensured its Service members and military families are informed about and connected with available programs, services, and each other. The Department continues to work to address the stigma associated with seeking help, and identify protective factors through stakeholder and community engagement and collaboration.

Purpose of this Report

The CY 2020 Annual Suicide Report (ASR) presents suicide data on Service members and their families, describes efforts to combat suicide in DoD, including efforts to reduce the stigma associated with help-seeking, and shares program evaluation and policy review efforts, data-sharing initiatives, and research collaborations. This report satisfies reporting requirements established by the Office of the Under Secretary of Defense for Personnel and Readiness (OUSD(P&R)) and addresses requirements in Section 741 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2020 (Public Law 116-92), as amended in Section 742 of the William M. (Mac) Thornberry National Defense Authorization Act for FY 2021 (Public Law 116-283).[7] **Appendix A** details Section 741 reporting requirements in this report (or in the forthcoming CY 2020 DoD Suicide Event Report [DoDSER] Annual Report). This report also satisfies reporting requirements per Section 567 of the Carl Levin and Howard P. "Buck" McKeon NDAA for FY 2015 (Public Law 113-291), including the requirement to report on military family members.

New Sections in this Report

Given the COVID-19 pandemic afflicting the Nation, this report also includes a section describing DoD efforts to support Service members and their families during this unprecedented time as it relates to suicide prevention (**COVID-19 Implications/Efforts**). This year's report also includes a more detailed description of data analysis methods for the reported suicide rates and trends over time (**Appendix B**) and provides key findings from the 2020 Quick Compass Survey of Active Duty Members on attitudes and behaviors around firearm safe storage, and beliefs about firearms and suicide risk (**Appendix C**). Finally, as required by Section 741 of the NDAA for FY 2020, as amended in Section 742 of the NDAA for FY 2021, this report describes key Departmental programs to reduce the stigma associated with seeking assistance for mental health or suicidal thoughts (**Appendix D**).

Collaboration and Transparency

This report was developed in collaboration with the Military Departments, Military Services, National Guard Bureau, Office of the Assistant Secretary of Defense for Manpower and Reserve Affairs, Office of the Assistant Secretary of Defense for Health Affairs, Office of the Assistant Secretary of Defense for Readiness, and the Defense Human Resources Activity. This ASR represents the Department's

[7] Under Secretary of Defense for Personnel and Readiness Memorandum, "Designation of the Defense Suicide Prevention Office as the Official Release Authority of Suicide Data for the Department of Defense," October 30, 2018.

continued efforts to increase transparency and accountability, which the Department believes strengthens its program oversight and policies and commitment to prevent this tragedy.

COVID-19 Implications/Efforts

COVID-19 has tremendously impacted the Nation as well as the entire world. In addition to impacts on health, the pandemic has brought significant social isolation and economic strain to the U.S. population, both of which are associated with mental health conditions like depression, anxiety, and stress (Reger et al., 2018; Salari et al., 2020). Indeed, recent research suggests that depression and anxiety have become more prevalent in the U.S. population (Czeisler et al., 2020; Ettman et al., 2020). The pandemic introduced additional barriers to accessing mental health treatment, and community and religious support across the United States (Reger et al., 2020).

Although U.S. population suicide rates for CY 2020 are still unknown, the increase in mental health challenges during the pandemic has raised concerns regarding impacts on suicide-related outcomes in the U.S. population and in the military community.[8] Surveillance data, by its nature, cannot directly pinpoint changes in suicide rates to any specific causal factor or event; however, DoD is operating with the understanding that the COVID-19 pandemic could be one of multiple factors influencing Service members' present and future well-being and suicide risk. To proactively mitigate against these concerns, the Department quickly adapted its approach to providing support to Service members and their families during this critical time. This included closely monitoring suicide counts and other key indicators, such as support service utilization. In tandem, DoD facilitated multiple enterprise-wide senior leader discussions to implement actions to help counter the effects of the pandemic. Several of these actions are highlighted below.

Department-Wide Efforts

With the COVID-19 pandemic afflicting the Nation in 2020, the Department quickly adapted to the dynamic circumstances to ensure Service members and their families had access to vital mental health support and other resources aimed at decreasing stress, enhancing wellness, and ultimately reducing the risk for suicide. The Department proactively implemented a variety of initiatives and virtual support efforts to ensure the continued delivery of services to Service members and their families. The DoD has been coordinating efforts throughout the Department to mitigate the impact of the pandemic. For example, the Department participated in the Federal Coronavirus Mental Health Working Group per Executive Order (EO) 13594, *Saving Lives Through Increased Support for Mental and Behavioral Health Needs*, to examine existing programs and create a plan to focus on mental health by maximizing therapeutic support to reduce the negative impact of the pandemic. As a result of the work done by the working group, a report was published in December 2020 that highlights actions taken to reduce the number of immediate life-threatening situations related to mental illness and substance use disorders through increased education, crisis intervention, follow-up and support services, and increased telehealth and online behavioral health services.[9] Similar to other agencies and organizations, the Department changed how it operated to get people care. Accordingly, between FY 2019 and FY 2020, there was an increase in the availability of formal telehealth and peer support services, coupled with an increase in awareness, education, and engagement efforts. In terms of utilization, although DoD did not observe an increase in outpatient mental health encounters, it did observe an increase in non-medical service utilization. There was a 14% increase in the number of new peer support services from FY 2019 to FY 2020. Also, Military OneSource saw a more than fourfold increase in the number of video counseling sessions conducted between FY 2019 and FY 2020. The Military Services also established behavioral health teams to support Military Treatment

[8] Final counts and rates for the U.S. population lag 12-18 months after the close of the calendar year from the Centers for Disease Control and Prevention.

[9] For more information per Executive Order (EO) 13594, Saving Lives Through Increased Support for Mental and Behavioral Health Needs, please visit https://www.samhsa.gov/sites/default/files/saving-lives-mental-behavioral-health-needs.pdf

Facility (MTF) staff in critical care/emergency care. Several other example efforts are highlighted below.

One Departmental effort in place to support Service members and in collaboration with the Department of Veterans Affairs (VA) is the Veterans/Military Crisis Line (VCL/MCL). The VCL/MCL is a free, confidential resource for Veterans and Service members designed to provide crisis intervention, and when needed, connect individuals to follow-up care. In CY 2020, a total of 8,254 calls were made to the VCL/MCL by Service members. This was a 9% increase from the 7,548 calls in CY 2019.[10] Further, looking across calls received from both Service members and Veterans in CY 2020, a total of 400 out of 65,181 calls were specifically related to COVID-19 stressors. Another support service is the *in*Transition program, which provides free, specialized coaching and assistance to Service members who need access to psychological health care when they are relocating, returning from deployment, transitioning to/from active duty, or leaving military service. In FY 2020, enrollment ranged from 14,990 to 17,550 by quarter, similar to enrollment observed in the last quarter of FY 2019. This program is also integrated with the VCL/MCL to connect VCL/MCL callers with critical follow-up care after receiving crisis care at a military or civilian emergency department.

The Department also developed and launched tailored products and resources for Service members and their families, sharing them across a variety of communication venues (e.g., Military OneSource, Department websites, virtual leadership engagements, and Service/unit social media channels). For example, Military OneSource activated a coronavirus information page for military community members providing up-to-date coronavirus information, where and how to access resources, recommendations for staying safe, and other information.[11] From its launch to the end of CY 2020, this website was viewed 324,679 times, with users spending an average of 5 minutes on the page. Also, a Google search engine marketing campaign was used to promote this website to active seekers of COVID-19 information for the military. As a result of this campaign, this website was viewed 989,901 times, garnering 83,947 clicks linking directly to the website. In addition, an application (app) for Military OneSource was developed and disseminated to further provide easy reach and access to the military community.

The Department also provided information on financial resources to help navigate the pandemic, including interest-free relief loans, financial counseling, free tax preparation software (MilTax), access to financial counselors via phone or video, and financial educational courses. For example, the Department's centrally managed Personal Financial Counselor (PFC) program shifted from face-to-face delivery to virtual means. Participation data for the year August 2019 to August 2020 showed an increase in counseling (+9%) and presentation (+112%) participation from the previous year, resulting in about 385,000 counseling sessions and 30,000 presentations with more than 1.5 million attendees. The DoD Office of Financial Readiness also developed a coronavirus financial readiness resource page for Service members on its website that contained information on potential financial impacts of the pandemic, including payroll tax deferral, Permanent Change of Station (PCS) moves, and links to other Federal resources. In CY 2020, the site received nearly 50,000 site views. Further, in the three months after launching the coronavirus resource page in April 2020, there was a 90% increase in page views to DoD Office of Financial Readiness website compared to the previous three months.

A COVID-19 fact sheet was also developed and disseminated to Service members, families, and DoD civilian employees that provided information on how to stay safe and connected while physically distancing and where to access resources.[12]

In addition, the Department also collaborated with Federal partners during the pandemic. For example, DoD collaborated with the VA on messaging campaigns to help individuals cope with stress and anxiety, pay attention to their mental health and well-being, and seek support.

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[10] The total number of calls received by the VCL/MCL from Veterans in CY 2020 was 56,927.

[11] https://www.militaryonesource.mil/coronavirus/

[12] https://www.dspo.mil/Portals/113/Documents/COVID%2019%20Info%20Paper%20for%20Military%20Community.pdf?ver=2020-04-28-151037-573

The Department's theme for September 2020's Suicide Prevention Month, which continued throughout FY 2021, was "Connect to Protect" to focus efforts on promoting connectedness and preventing suicide in the military community. Focusing on connectedness highlighted the important role connections to family, friends, the community, and resources can play in preventing suicide. Data demonstrate that leaders' messages impact suicide risk. To that end, "Connect to Protect" also encouraged leaders to help members of the military community recognize there is help and hope. Throughout the campaign, senior leaders throughout the Department—including the Secretary of Defense, Chairman of the Joint Chiefs of Staff, Vice Chairman of the Joint Chiefs of Staff, and Senior Enlisted Advisor to the Chairman of the Joint Chiefs of Staff—shared video messages to the Force emphasizing the importance of remaining socially connected while physically distanced.

As a final example, the Department also ensured access to suicide prevention training and education resources by quickly transitioning to and offering virtual options. For example, previously, the Department used the Signs of Suicide (SOS) in-person curriculum for educating secondary school, military-connected students. SOS is an evidence-based suicide prevention program designed to decrease suicide by increasing knowledge and awareness related to depression (e.g., warning signs), teaching help-seeking skills (e.g., ACT: Acknowledge, Care, Tell), and reducing stigma related to mental illness. In March 2020, the Department of Defense Education Activity (DoDEA) virtually released *ACT at Home* to quickly provide families with resources for building knowledge, skills, and resource awareness. In the Fall of 2020, the full SOS curriculum was adapted and released for virtual implementation. Further, because school counselors are not licensed to provide virtual counseling, DoDEA partnered with the Office of Military Community and Family Policy (MC&FP) to provide students virtual counseling and bridge the care gap created by the COVID-19 pandemic.

Service-Specific Efforts

The Military Departments have also implemented Service-specific efforts to provide additional support to Service members and their family members since the start of the COVID-19 pandemic. Examples of Service-specific efforts are highlighted below.

Army. The U.S. Army implemented several initiatives in response to the pandemic. For example, the Walter Reed Army Institute of Research (WRAIR) created a website with behavioral health resources that address factors such as stress, sleep, fatigue, and resilience.[13] From May to June 2020, WRAIR and the Army Public Health Center conducted the Behavioral Health Advisory Team (BHAT) coronavirus survey to assess Soldier behavioral and public health outcomes and to collect information regarding the impact of the pandemic. Survey results indicated that Soldiers desired more information related to changing rules and regulations, travel for official duties, the impact of COVID-19 on unit and mission readiness, and how to stay safe. Further, Soldiers who reported that their leadership was responsive to the pandemic reported lower rates of depression and anxiety. Efforts were put into place to provide resources to Soldiers and address concerns identified in this survey. Army Resilience Directorate developed a Community Resource Guide to provide commanders with the resources available to support Soldiers across multiple domains. The Army also upgraded and provided guidance for virtual behavioral health.

Navy. To reduce potential coronavirus exposure while ensuring access to care, efforts throughout the Navy have shifted toward digital platforms. For example, the Navy Bureau of Medicine and Surgery (BUMED), as well as Navy Fleet and Family Service Centers (FFSC), increased the use of digital behavioral health services to respond to the pandemic. FFSC adapted quickly, continuing their support of Sailors and families through the critical Sailor Assistance and Intercept for Life (SAIL) program, providing caring contacts telephonically to Sailors who have discussed a suicide-related behavior. Another digital resource was the MyNavy Family Mobile Application, an authoritative source

[13] https://www.wrair.army.mil/node/348

of information for Navy families, including resources to support families on a range of topics like parenthood, deployment, relocation, counseling, and support to help families manage stress associated with COVID-19.[14] The Navy's *Every Sailor, Every Day* campaign has provided online resources to enhance resilience. This program aims to bolster connections among Service members and reduce the stigma of suicide by encouraging communication, ongoing engagement, peer support, and personal responsibility.

Marine Corps. The Marine Corps has provided a range of digital services during the pandemic. For example, the Marine Corps continued Marine Intercept Program (MIP) services that are initiated when a Marine has a reported suicide ideation or suicide attempt. These services are provided telephonically and are intended to assess for risk, create a safety plan, identify barriers to care, and make referrals as needed. The Marine Corps Manpower website[15] was also updated with tools for leaders to implement their suicide prevention programs, such as strengthening access and delivery of suicide care and resources, reducing barriers, and increasing help-seeking. Due to the pandemic, these services were offered online and by telephone.

Air Force. To respond to physical distancing requirements, the Air Force has provided a number of online resources such as the COVID Coach application, which provides information about staying safe and healthy during the pandemic, tools for managing stress and mood tracking, and directs Service members to resources.[16] The Air Force also developed "Call to Action," which empowers Air Force leadership teams with the tools and resources needed to help prevent interpersonal and self-directed violence in the physically distanced COVID environment. The Family Suicide Prevention Training was also designed during the pandemic to equip family members to prevent suicide by recognizing warning signs, informing family members of the available resources, and providing families with strategies to strengthen connectedness and relationships. Due to the pandemic, all trainings were delivered in a virtual environment.[17]

National Guard Bureau (NGB). The NGB partnered with the Center for the Study of Traumatic Stress to conduct the coronavirus Resilience and Readiness survey with New York Army National Guard members to better understand the pandemic's impact. This survey assessed National Guard members' perceptions related to their: (1) unit/supervisor morale and satisfaction; (2) COVID-19 pandemic experience; (3) mental and physical health as well as morale; and (4) community and family support. Findings of this survey, released in February 2021, identified that 15% of the sampled National Guard members were concerned about job loss, 9% reported temporary job loss or furlough, and 6% reported permanent job loss during the pandemic. One-third of respondents reported that they had personal experience with COVID-19 (10% tested positive themselves and 26% reported that a family member tested positive). These National Guard members also reported the following as effective stress reduction techniques and activities: time spent outdoors, exercise, speaking with family and friends, and maintaining a daily routine. The National Guard is applying information gleaned from this study to better support their members moving forward.

In sum, the Department quickly and proactively pivoted to provide resources through a range of avenues to ensure continued support for Service members and their families during the COVID-19 pandemic.

[14] https://www.applocker.navy.mil
[15] https://www.manpower.usmc.mil/webcenter/portal/MRAHome
[16] https://mobile.va.gov/app/covid-coach
[17] At this time, references to Air Force include Space Force unless otherwise stated.

Service Member Suicide Data

To ensure reliability and comparability of surveillance data, clear and consistent terminology with standardized definitions is required. In 2017, the DoD adopted the recommendations by the Centers for Disease Control and Prevention (CDC) on uniform surveillance definitions for self-directed violence and incorporated these definitions into policy. In accordance with DoD Instruction (DoDI) 6490.16, Defense Suicide Prevention Program (Department of Defense, Under Secretary of Defense for Personnel and Readiness, 2020b), suicide is defined as "…death caused by self-directed injurious behavior with an intent to die as a result of the behavior" (CDC, National Center for Injury Prevention and Control, 2011).[18,19]

Suicide Death Reporting in DoD

The Department reports both counts and rates of suicide deaths. Suicide counts are useful for understanding the absolute magnitude of suicide mortality. However, absolute numbers do not account for differences in population size and cannot be used in a meaningful way to compare the number of deaths across groups, or within a single group, over time. Rates account for differences in population sizes and provide commensurable comparisons.[20] In this report, Active Component and Selected Reserve (SELRES) member suicide rates are calculated by the Armed Forces Medical Examiner System (AFMES) in accordance with DoDI 6490.16.[21] The Department reported suicide rates per 100,000 Service members to align with scientific standards for public health surveillance (Stone et al., 2018). All comparisons within a group over time or between groups are adjusted for age and sex unless otherwise noted.

Variability in Suicide Rate Determinations

Per scientific standards, this report presents 95% confidence intervals to account for random error associated with suicide rate estimation. Confidence intervals provide a range of possible values for the suicide rate that account for uncertainty due to estimation, random error, and volatility. For example, a potential source of random error is the misclassification of a suicide (in either direction) due to variation or uncertainty that exists in the manner-of-death-determination process.[22] The confidence interval range includes the true value of the suicide rate with 95% confidence. Stated another way, one can be 95% confident the range of values covers the true suicide rate. As such, all references to suicide "rate(s)" or "unadjusted rate(s)" in the report are estimates. For comparisons of rates across years, two rates are considered to be statistically different if their 95% confidence intervals do not overlap.[23]

[18] Although the Department defines suicide according to this standard, suicidal intent is rarely known. As such, medical examiners and coroners, both internal and external to DoD, must use other criteria to determine manner of death.
[19] The establishment of "intent" in manner of death determinations can be difficult and often varies due to differences in state and/or local laws, inconsistent training of medical examiners and corners, and vague guidelines and/or operational criteria for determining suicide.
[20] Rates are defined as the total number of suicides divided by the population at risk for a given time period. Rates are necessary, but not always sufficient, for making comparisons across time or groups. Adjustments for demographics and other factors may be required for valid comparisons.
[21] AFMES reports conducting approximately 15–20% of active duty all-cause death investigations. Investigations for the remainder of all active duty deaths as well as non-activated members of the SELRES are determined by civilian medical and legal authorities and reported to AFMES via the Military Services.
[22] At times, a death cannot be classified as a suicide due to a lack of evidence of intent.
[23] When 95% confidence intervals do not overlap, rates are considered statistically different. However, the opposite is not always true (i.e., two rates with overlap could potentially be significant, particularly when the amount of overlap is small).

CY 2020 Service Member Data Summary

Table 1 shows suicide counts and rates (per 100,000 Service members) for the Active Component, Reserve, and National Guard for CY 2018 to CY 2020.[24] Data include all known or suspected suicides (both confirmed and pending) reported as of March 31, 2021.[25,26,27] Per DoDI 6490.16, rates are not reported when the number (i.e., count) of suicide deaths is under 20 due to statistical instability.

Table 1. Annual Suicide Counts and Rates per 100,000 Service Members by Military Population and Service, CY 2018–CY 2020[1-2]

Military Population / Service	CY 2018		CY 2019		CY 2020	
	Count	Rate	Count	Rate	Count	Rate
Active Component	**326**	**24.9**	**349**	**26.3**	**384**	**28.7**
Army	141	29.9	146	30.7	175	36.4
Navy	68	20.7	74	22.1	66	19.3
Marine Corps	57	30.8	47	25.3	62	33.9
Air Force	60	18.5	82	24.8	81	24.3
Reserve	**81**	**22.9**	**65**	**18.2**	**77**	**21.7**
Army	48	25.3	36	18.9	42	22.2
Navy	11	--	7	--	13	--
Marine Corps	19	--	9	--	10	--
Air Force	3	--	13	--	12	--
National Guard	**136**	**30.8**	**90**	**20.5**	**119**	**27.0**
Army	119	35.6	76	22.9	103	30.9
Air Force	17	--	14	--	16	--

1. Source(s): Armed Forces Medical Examiner System (AFMES).
2. Suicide rates for the SELRES include all Service members irrespective of duty status.

CY 2020 Suicide Counts and Rates

In CY 2020, a total of 580 Service members died by suicide (384 Active Component, 77 Reserve, and 119 National Guard). The CY 2020 suicide rate in the Active Component was 28.7 suicide deaths per 100,000 Service members.[28] Across the Military Services, suicide rates ranged from 19.3 to 36.4 per 100,000 Active Component Service members. For the Reserve and National Guard, the rates were 21.7 and 27.0 suicide deaths per 100,000 Service members, respectively. For the Army Reserve and Army National Guard, the rates were 22.2 and 30.9 suicide deaths per 100,000 Soldiers, respectively.[29] Per DoDI 6490.16, all other Service-specific CY 2020 rates for Reserve and National Guard were not reported due to low counts.

Suicide Rates Over Time

This report examines near-term suicide rate changes for CY 2018 through CY 2020, and longer-term

[24] These rates are not adjusted for age and sex.
[25] DoD considers both confirmed and pending (or suspected) suicide deaths as "suicides" to reduce the potential for underestimating the extent of suicide mortality in DoD.
[26] Pending (also known as suspected) suicide is a designation by the Armed Forces Medical Examiner as the manner of death when the circumstances are consistent with suicide, but the determination is not yet final.
[27] Service members who are also dependents of other Service members are included in Service member counts *and* in military family counts reported later in this report.
[28] At this time, references to Air Force include Space Force unless otherwise stated.
[29] Although not included in Table 1, U.S. Coast Guard uniformed members suicide counts are as follows: CY 2018: 6, CY 2019: 7, CY 2020: 7.

suicide rate changes from CY 2015 through CY 2020 for each military population and by Service.[30] Comparing the CY 2020 suicide rates to the previous two years (near-term) provides preliminary insights to more recent changes and aligns with the tenure of commanders and other military leaders who are often directly supporting Service members or contributing to suicide prevention efforts more proximally. However, annual rates are volatile year to year and can be imprecise for smaller subpopulations (such as at the Service level), which may miss true underlying change when looking at this smaller window of time. Longer-term (CY 2015–2020) examination of suicide rates over time allows for more reliable trend analysis compared to the shorter-term look and can aid in examining whether more recent DoD policy or programmatic initiatives are having the desired effect. For trend analysis for CY 2011 through CY 2020, see **Appendix E**.

Active Component—CY 2018–2020 (Near-Term)

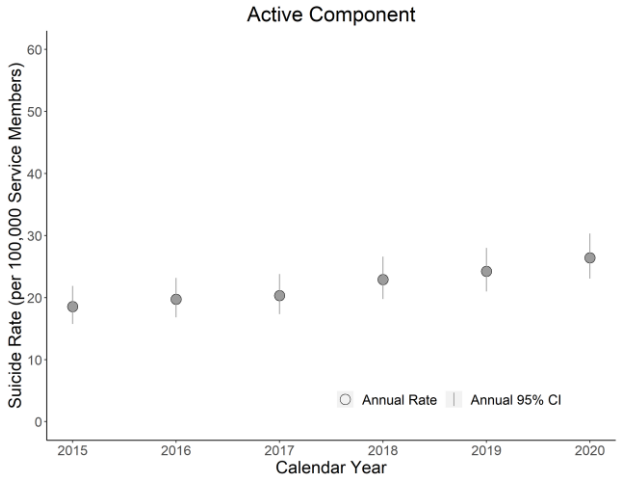
When comparing the CY 2020 suicide rate to each of the recent past two years, the Active Component suicide rate in 2020 (28.7 per 100,000) appears higher than in CY 2018 (24.9 per 100,000) and CY 2019 (26.3 per 100,000), but is statistically comparable across years (i.e., no statistically significant change). When examining suicide rates at the Service level, the CY 2020 suicide rates may appear higher (or lower) compared to their respective rates in CY 2018 and CY 2019 (**Table 1**), but none of these rates are statistically different (i.e., no statistically significant change).[31] Additional and forthcoming years of data are necessary before determining any sustained trends. As previously noted, year-to-year rate comparisons provide preliminary insights, but are notably limited in reliably detecting true changes in suicide trends over time, particularly for smaller subpopulations such as at the Service level.

Active Component—CY 2015–2020 (Longer-Term)

Figures 1 and 2 (A–D) show suicide rates and 95% confidence intervals for the Active Component and each Military Service in the Active Component. The Active Component DoD suicide rate statistically increased between CY 2015 (20.3 per 100,000) and CY 2020 (28.7 per 100,000). An increase in suicide rates was observed between CY 2015 and CY 2020 across all Services. Trend analysis indicates the Active Component suicide rates increased for all the Services across this time period, but did not reach statistical significance for the Air Force.[31,32]

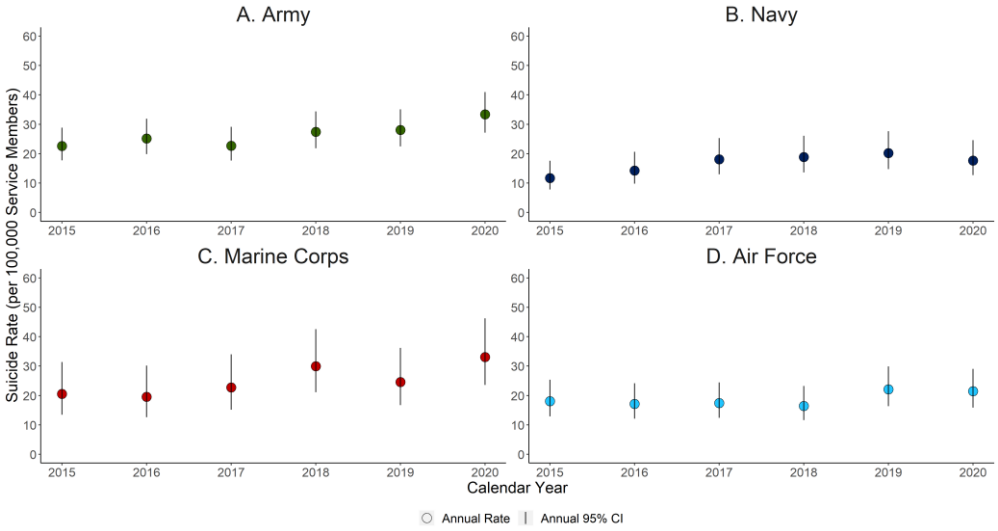
[30] For an even longer-term assessment of DoD suicide trends beginning with CY 2011 to present, see Appendix E. Note this analysis was previously provided in the DoDSER Annual Report. Moving forward, suicide trends over time will be reported via the ASR.
[31] Although the rate difference(s) might not be statistically significant, the magnitude of the suicide rate(s) remain(s) a cause for concern. We recognize that the rates are not going in the desired direction and reaffirm our work to reduce suicide rates across the Services.
[32] See Appendix B for additional details on methodology for trend analysis.

Figure 1. Active Component Suicide Rates per 100,000 Service Members by CY[1-3]



1. Source(s): Armed Forces Medical Examiner System (AFMES).
2. The 95% confidence interval (indicated by bars) represents the range in which the true suicide rate falls with 95% certainty.
3. Rates are adjusted for age and sex differences over time. See Appendix B for additional details.

Figure 2. Active Component Suicide Rates by Service per 100,000 Service Members by CY[1-3]



1. Source(s): Armed Forces Medical Examiner System (AFMES).
2. The 95% confidence interval (indicated by bars) represents the range in which the true suicide rate falls with 95% certainty.
3. Rates are adjusted for age and sex difference across the years. See Appendix B for additional details.

Reserve and National Guard—CY 2018–2020 (Near-Term)

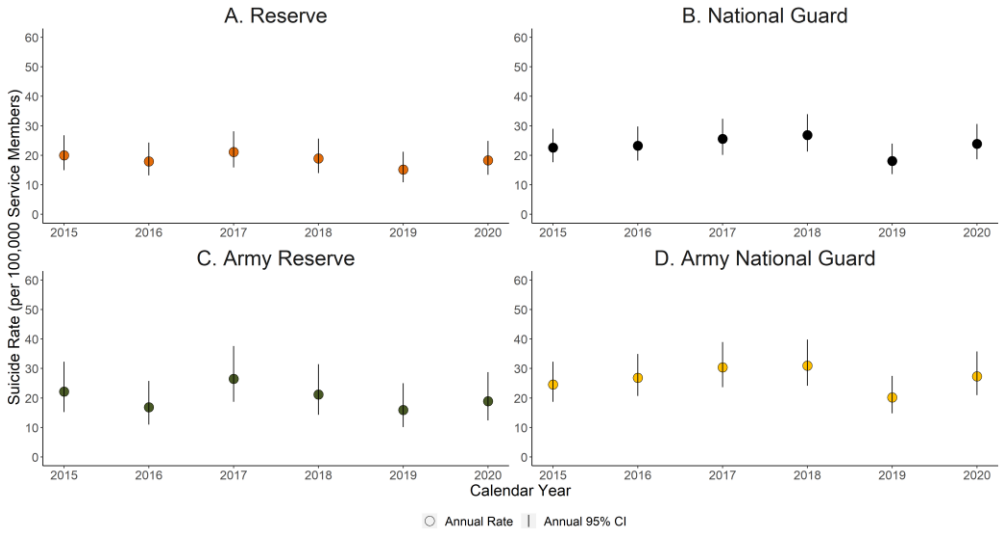
When comparing the CY 2020 suicide rate to each of the prior two years, the Reserve CY 2020 suicide rate (21.7 per 100,000) appears lower compared to CY 2018 (22.9 per 100,000) and higher compared to CY 2019 (18.2 per 100,000), but is statistically comparable across years (i.e., no statistically significant change). The National Guard CY 2020 suicide rate (27.0 per 100,000) statistically increased compared to CY 2019 (20.5 per 100,000); however, the CY 2020 rate was statistically comparable to CY 2018 (30.8 per 100,000). When examined by Service, the same trends were observed for the Army Reserve and Army National Guard, as described for the Reserve and National Guard, respectively. Rates and trends over time for the Navy, Marine Corps, the Air Force

Reserve, and the Air National Guard are not reported due to low counts.[33] As noted, year-to-year rate comparisons provide preliminary insights but are notably limited in reliably detecting true changes in suicide trends over time.

Reserve and National Guard—CY 2015–2020 (Longer-Term)

Figure 3 (A–D) provides suicide rates and 95% confidence intervals for the Reserve and National Guard between CY 2015 and CY 2020. Trend analysis indicates Reserve and National Guard suicide rates did not statistically increase or decrease over this time period (i.e., no statistical change). When examined by Service, the same trends were observed for the Army Reserve and Army National Guard, as described for the Reserve and National Guard, respectively.

Figure 3. Reserve and National Guard Suicide Rates per 100,000 Service Members by CY[1-4]



1. Source(s): Armed Forces Medical Examiner System (AFMES).
2. Per DoDI 6490.16, rates for subgroups with fewer than 20 suicides are not reported because of statistical instability.
3. The 95% confidence interval (indicated by bars) represents the range in which the true suicide rate falls with 95% certainty.
4. Rates are adjusted for age and sex differences over time. See Appendix B for additional details.

Demographic and Military Profile of Suicide Deaths

The demographic profile of Service members who died by suicide in CY 2020 was similar across the Active Component, Reserve, and National Guard (**Table 2**); overall, they are reflective of the profile of the Total Force.[34] Suicide decedents were largely enlisted Service members (ranging from 87.4% to 93.5% across military populations). Service members in pay grades E1 to E4 continued to represent the largest percentage of suicide decedents at 52.1% (Active Component), 50.6% (Reserve), and 50.4% (National Guard). Service members in pay grades E5 to E9 represented the second-largest proportion of decedents at 41.4% (Active Component), 39.0% (Reserve), and 38.7% (National Guard).

[33] Per DoDI 6490.16, rates are not reported when the number of suicides is fewer than 20 because of statistical instability.
[34] Total Force includes DoD Active and Reserve Component military personnel. Reserve Component is further limited to members of the SELRES.

Table 2. Service Member Suicide Counts, Rates per 100,000 Service Members and Percentages by Demographics, CY 2020[1,2]

	Active Component			Reserve			National Guard		
	Count	Percent	Rate	Count	Percent	Rate	Count	Percent	Rate
Total	**384**	**100%**	**28.7**	**77**	**100%**	**21.7**	**119**	**100%**	**27.0**
Sex									
Male	357	93.0%	32.2	73	94.8%	26.8	113	95.0%	31.8
Female	27	7.0%	11.7	4	5.2%	-	6	5.0%	-
Age Group									
17-19	30	7.8%	29.8	4	5.2%	-	5	4.2%	-
20-24	165	43.0%	37.9	20	26.0%	28.9	41	34.5%	39.4
25-29	93	24.2%	30.1	20	26.0%	29.4	25	21.0%	29.9
30-34	46	12.0%	21.9	12	15.6%	-	18	15.1%	-
35-39	28	7.3%	17.8	4	5.2%	-	14	11.8%	-
40-44	16	4.2%	-	8	10.4%	-	6	5.0%	-
45-49	5	1.3%	-	6	7.8%	-	6	5.0%	-
50-54	0	0.0%	-	2	2.6%	-	1	0.8%	-
55-59	0	0.0%	-	1	1.3%	-	3	2.5%	-
60-74	1	0.3%	-	0	0.0%	-	0	0.0%	-
Race									
White	288	75.0%	31.4	52	67.5%	21.9	92	77.3%	26.9
Black or African American	49	12.8%	21.3	12	15.6%	-	15	12.6%	-
American Indian/Alaska Native	8	2.1%	-	4	5.2%	-	5	4.2%	-
Asian/Pacific Islander	18	4.7%	-	6	7.8%	-	2	1.7%	-
Other/Unknown	21	5.5%	21.1	3	3.9%	-	5	4.2%	-
Rank									
E (Enlisted)	359	93.5%	32.9	69	88.3%	24.1	106	87.4%	27.4
E1-E4	200	52.1%	35.2	39	50.6%	28.8	60	50.4%	30.0
E5-E9	159	41.4%	30.3	30	39.0%	20.4	46	38.7%	25.6
O (Commissioned Officer)	16	4.2%	-	7	9.1%	-	10	8.4%	-
W (Warrant Officer)	7	1.8%	-	1	1.3%	-	3	2.5%	-
Cadet	2	0.5%	-	0	0.0%	-	0	0.0%	-
Marital Status									
Never Married	180	46.9%	29.8	44	57.1%	27.1	73	61.3%	31.3
Married	182	47.4%	27.2	31	40.3%	18.6	41	34.5%	22.5
Divorced	22	5.7%	34.6	2	2.6%	-	5	4.2%	-
Widowed	0	0.0%	-	0	0.0%	-	0	0.0%	-

1. Source(s): Armed Forces Medical Examiner System (AFMES).
2. Percent refers to percent of the Total Force represented in each demographic category.

Suicide decedents were largely enlisted, male, and under the age of 30 across the Active Component, Reserve, and National Guard (see **Table 2**). Rate ratios were calculated to determine if these demographics were associated with a greater risk for suicide; indeed, enlisted members, males, and those under the age of 30 in the Active Component were each found to be at higher risk for suicide compared to the population average. For the Reserve Component (Reserve and National Guard combined), males and those under the age of 30 were each found to be at higher risk for suicide compared to the population average.[35] Moreover, 42.2% of the total military population in CY 2020 were enlisted males who were less than 30 years of age, whereas 62.9% of the military suicide decedent population represented these three demographics combined for the same year. For

[35] White Service members were at increased risk compared to the population average. Reserve Component members who died by suicide did not have a large enough sample size to reliably calculate rate ratios for all demographic categories.

information on the demographics of suicide decedents by Service, see **Appendix F**.

Method of Suicide Death

The most common methods of suicide death in CY 2020 across the Active Component, Reserve, and National Guard were firearms followed by hanging/asphyxiation (**Table 3**). The proportion of suicide deaths by these methods has not significantly changed over time (CY 2015 to CY 2020). In CY 2019, approximately 87% of Active Component Service members, 95% of Reservist, and 90% of National Guard members who died by firearm suicide used a personally-owned firearm (i.e., as opposed to a military-issued firearm; PHCoE, 2019).

Rate ratios were calculated to determine if Service members were at greater risk of dying by suicide using firearms compared to the U.S. population. In each year from 2015 to 2019, the proportion of Service members who died by suicide using firearms was significantly higher than the proportion of members of the U.S. population who died by suicide using a firearm, after adjusting for age and sex. For instance, in 2019, 45% of U.S. population decedents died by firearm, compared to 64% of Service member decedents.

Table 3. Method of Suicide Death by Military Population, CY 2020[1-2]

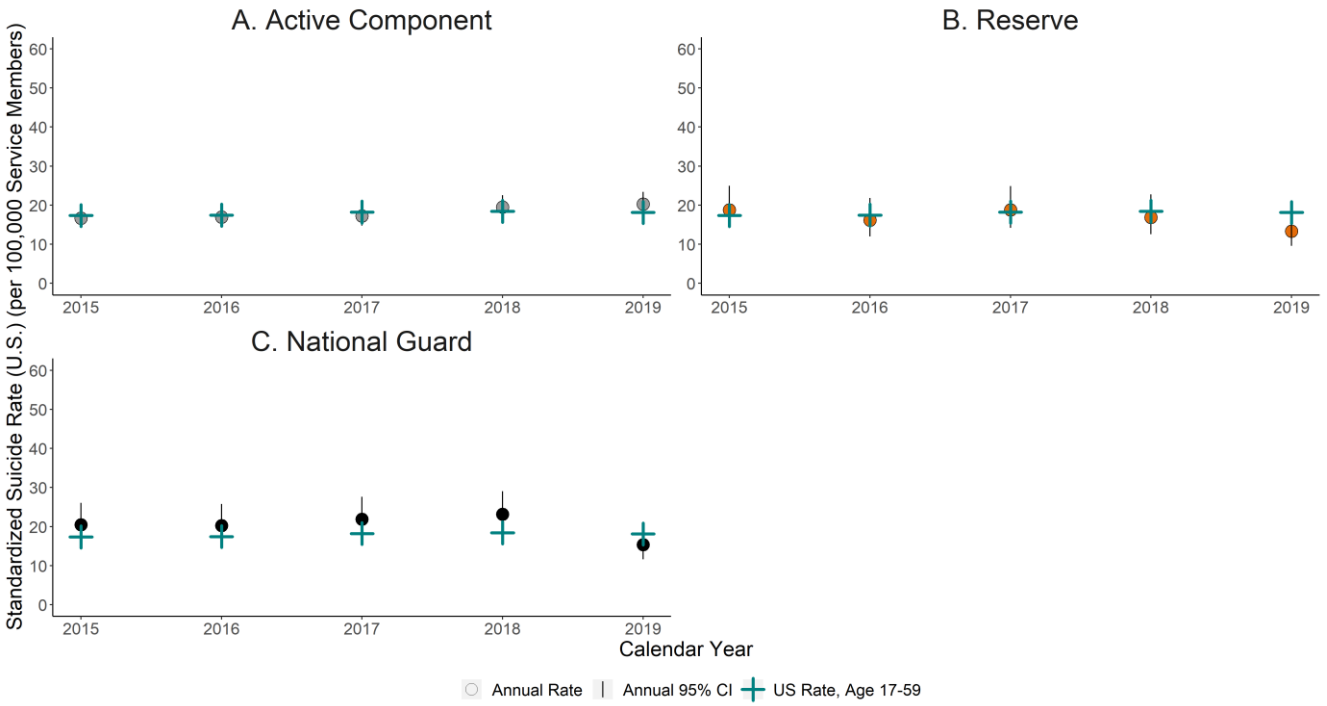
	Active Component		Reserve		National Guard	
Method of Death	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**
Total	**384**	**100%**	**77**	**100%**	**119**	**100%**
Firearm	247	64.3%	58	75.3%	95	79.8%
Hanging/Asphyxiation	106	27.6%	14	18.2%	19	16.0%
Drugs/Alcohol	6	1.6%	2	2.6%	2	1.7%
Sharp/Blunt Object	5	1.3%	0	0.0%	2	1.7%
Poisoning	6	1.6%	2	2.6%	0	0.0%
Falling/Jumping	6	1.6%	0	0.0%	1	0.8%
Other	5	1.3%	0	0.0%	0	0.0%
Pending/Unknown	3	0.8%	1	1.3%	0	0.0%

1. Source(s): CY 2020 method of death data obtained from AFMES for active duty Service members; method of death data for non-duty status Reserve and National Guard obtained from the Military Services.
2. The poisoning category includes deaths unrelated to drug overdose, such as carbon monoxide poisoning.

Suicide Rate Comparisons between the Military and U.S. General Population

The Department is often asked to describe how military suicide rates compare to those in the U.S. general population.[36] Such comparisons can assist in identifying how the military may reflect patterns seen in the civilian population, and how promising initiatives may be applicable to Service members and families. However, directly comparing military and U.S. population suicide rates is misleading. In the United States, males have nearly four times higher risk for suicide death than females (CDC, 2019).[37] Since the military has a higher percentage of males (81.3%) compared to the U.S. population (49.2%; U.S. Census Bureau, 2021), it is not surprising that military suicide rates are higher. Age is another demographic factor associated with suicide risk and also varies substantially between the military and U.S. populations. The military has a higher percentage of younger individuals (mean age 29.7) than the U.S. population (mean age 39.1; U.S. Census Bureau). Given these differences between the military and U.S. populations, any comparison of suicide rates must first account for age and sex. **Figure 4 A–C** displays suicide rates, adjusted for age and sex, for the military and the U.S. population from CY 2015 to CY 2019.[38] After accounting for age and sex, the Active Component, Reserve, and National Guard suicide rates are statistically comparable to the U.S. population rates for 2015–2019.

Figure 4 (A–C). CY 2015–CY 2019 Suicide Mortality Rates, by Military Population, Standardized to the CY 2015–CY 2019 U.S. Adult Population Rate Data[1-3]



1. Source(s): Data from AFMES (military populations) and CDC (U.S. population), ages 17–59.
2. Note: The U.S. population data include data from civilians, as well as current and former Service members.
3. Rates are adjusted for age and sex differences within each military population over time and standardized to the U.S. adult population. See Appendix B for additional details.

[36] Any increases in suicide rates in the military population is likely correlated and/or connected with increases in the U.S. population. As Service members are selected from the U.S. population, they are not necessarily exempt from broader suicide trends in the U.S. population.
[37] Civilian suicide rate data retrieved from the CDC's *Web-based Injury Statistics Query and Reporting System* (*WISQARS*). Most recent year data available are from 2019.
[38] Rates are adjusted for age and sex differences within each military population over time and standardized to the U.S. adult population. See Appendix B for additional details.

U.S. population suicide data are collected by the CDC and typically lag 12–18 months after the close of the calendar year. In the past, the ASR has typically included a comparison of the Service member suicide rate in the current year with the U.S. suicide rate from the previous year. However, as previously noted, the COVID-19 pandemic has substantial potential implications for mental health and suicide risk. Comparing a population who has experienced the pandemic (i.e., the CY 2020 Service member suicide rate) with a population who has not (i.e., the CY 2019 general U.S. population suicide rate) may lead to inappropriate conclusions and/or interpretations.

Contextual Factors and Common Misconceptions Associated with Suicide

Although an in-depth examination of the risk and contextual factors associated with suicide is beyond the scope of this report, it is important to highlight a few additional factors that may contribute to military deaths by suicide.[39] Military-focused research and DoD suicide surveillance reports highlight a number of risk/contextual factors, including relationship, financial, and legal/administrative problems, ineffective life/coping skills, reluctance to seek help, perceived stigma to engage in suicide care/treatment, and access to lethal means. As noted earlier, each military suicide is complex and involves an interaction of many interrelated factors (Hoge, 2019; Knox & Bossarte, 2012).

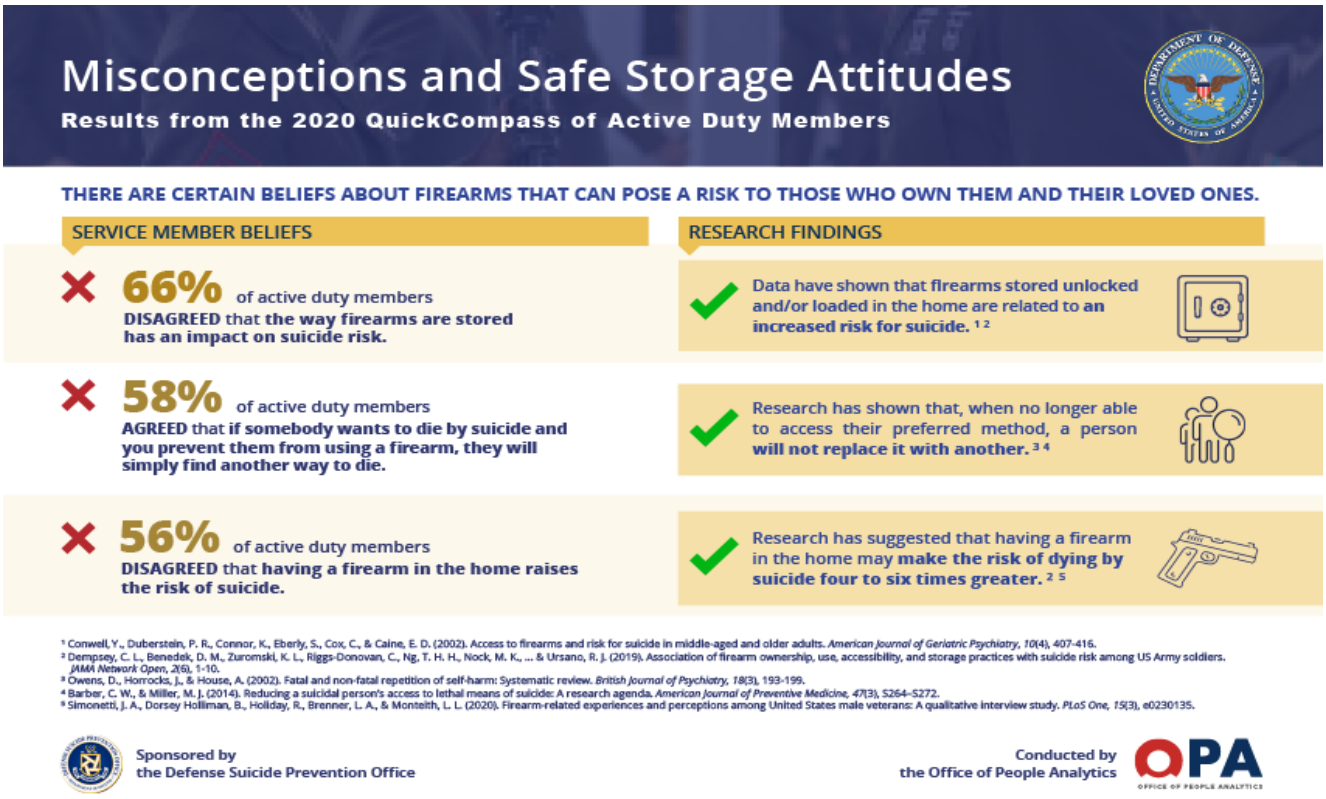
Relationship stressors, such as failed or failing relationships, are frequently cited risk factors for suicide (Crowell-Williamson et al., 2019; LeardMann et al., 2013; Whisman et al., 2019). In the military, failed or failing relationships in the 90 days prior to death were reported in Active Component (42.6%) and Reserve Component (42.9%) Service members who died by suicide in CY 2019 (PHCoE, 2019). For some individuals, financial stress, in combination with other factors (e.g., relationship issues, mental health problems), can increase vulnerability for suicide (Goodin et al., 2019; Turunen & Hiilamo, 2014; Ursano, Fullerton, & Dichtel, 2016). Based on military suicide surveillance data, excessive debt and bankruptcy in the 90 days prior to death were reported for Active Component (5.0%) and Reserve Component (7.1%) Service members who died by suicide in CY 2019 (PHCoE, 2019). Active Component (28.5%) and Reserve Component (25.0%) Service members who died by suicide in CY 2019 also had administrative or legal difficulties (e.g., UCMJ proceedings, administrative separations proceedings, medical evaluation board proceedings, civil legal proceedings) in the 90 days prior to death. Despite such data surveillance and research findings supporting these factors, many still hold the misconception that suicide is mainly due to mental illness and not due to difficult life challenges; as such, this misconception and the associated facts are included in this year's ASR. **Appendix G** presents five common suicide misconceptions and the facts to help clarify (such as this misconception), as well as re-shares the misconceptions published in the prior CY 2019 ASR (Department of Defense, Under Secretary of Defense for Personnel and Readiness, 2020a), with updated facts based on the most recent data and research.

Ineffective life/coping skills, reluctance to seek help, and stigma are also risk factors for suicide. DoD's Office of People Analytics (OPA) 2019 Status of Forces Survey of Active Duty Members (SOFS-A) showed some Active Component Service members reported undesirable coping strategies when asked how they would respond if they felt trapped or stuck in a stressful situation, including dealing with the situation on their own (77.0%), ignoring the situation (28.0%) or avoiding the situation (30%), or using drugs or alcohol to cope (15.0%).[40] Perceived stigma remains a barrier to help-seeking. Active Component Service members endorsed several reasons for not seeking help, including loss of privacy/confidentiality (69.0%), fear of being perceived as "broken" by chain of command or peers (71.0%), and perceived negative impact to their career (68.0%). Another common misconception and its associated facts highlighted in **Appendix G** is that seeking mental health care will negatively impact one's security clearance.

[39] For a detailed examination of these contextual factors, please refer to the most recent DoDSER Annual Report (CY 2019).
[40] For more information about sample size, sampling strategy, and statistical analysis of the SOFS-A, please see the most recent findings: https://www.militaryonesource.mil/data-research-and-statistics/survey-findings/2019-status-of-forces-survey/

There are also misconceptions surrounding firearms and suicide risk. Recognizing that the majority of Service member suicide decedents die by a personally-owned firearm, the Department conducted in 2020 the first-ever Quick Compass Survey of Active Duty Members (QCAM), examining Service member attitudes and behaviors around firearm safe storage, and beliefs about firearms and suicide risk. One of the key opportunities for action highlighted by the survey findings is the need to correct misconceptions Service members have about firearms and the risk for suicide (see **Figure 5**), and to educate and encourage safer firearm storage.

Figure 5. Misconceptions About Firearms and Suicide Risk



The survey results also provide insights into other action areas to target, based on findings among Service members living on-installation (who could be asked directly about personal firearm ownership and storage practices). Although these data suggest that many Service members living on-installation do engage in safe firearm storage, there is room for improvement. Moreover, firearm owners living on-installation who believed more of the misconceptions highlighted above (in Figure 5) were less likely to agree with and practice safe firearm storage practices. For additional findings from this survey, see **Appendix C**; for the full list of misconceptions, see **Appendix G.**

Military Family Suicide Data

The Department uses a multipronged approach that leverages both military and civilian data to collect suicide data involving a military family member. Data are gathered from three sources: (1) Defense Enrollment Eligibility Reporting System (DEERS); (2) Military Services; and (3) CDC National Center for Health Statistics National Death Index (NDI) to determine suicides among military family members (as required by the Carl Levin and Howard P. "Buck" McKeon National Defense Authorization Act for Fiscal Year 2015, Public Law 113-291).[41,42,43] No single source fully captures suicide deaths among military family members. It is important to note the majority of military family members are civilians whose deaths do not occur on a military installation. As a result, the Department does not have visibility of, or jurisdiction over, these deaths and must seek other methods to obtain this information. Through this multipronged approach, the Department ensures it is capturing the most complete information possible from both military and civilian data sources.

Definition of Military Family Member

The definition of dependent (also referred to as "military family members") used for the purposes of this report is informed by Section 1072(2) of Title 10, U.S. Code, which defines a dependent with respect to a uniformed Service member (or former member) as:

1. A spouse;
2. Un-remarried widow or widower;
3. Child who is:
   a. Unmarried and under the age of 21; or
   b. Physically or mentally incapable of self-support (regardless of age); or
   c. Enrolled in full-time course of study at an institution of higher learning; dependent on the member for over one-half of their support; and under the age of 23;[44]
4. Un-remarried former spouse of a current or former Service member;
5. Unmarried person who is placed in the legal custody of the Service member as a result of a court order (e.g., a sibling);[45] and
6. A parent or parent-in-law who is dependent on the Service member for over one-half of his/her support and residing in his/her household.

For the purpose of 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 and are registered in DEERS.[46,47] As a result, DoD may not be able to retrieve all suicide death records of individuals included in the definition set forth in 10 U.S.C. 1072(2), and suicide counts and rates presented in this

[41] In CY 2016, modifications were made to DEERS to allow manner of death to be captured when Service members provide death certificates of their family members via their Real-Time Automated Personnel Identification System (RAPIDS) station. These data were available starting in 2017.
[42] Service members must submit family member death certificates to the Services' Casualty Offices to receive Family Service Members' Group Life Insurance (FSGLI) benefits.
[43] The Air Force Office of Special Investigations (OSI) also collects information on military family member deaths.
[44] Dependents include biological, step-, foster, ward, pre-adoptive, and domestic partner children.
[45] Additional criteria may apply (see section 1072(2) of Title 10, U.S. Code).
[46] DoD is unable to capture information on military family members unless they are registered in DEERS.
[47] Other types of family members (e.g., parents, siblings, former spouses) who meet the specifications of Title 10 are not as reliably captured in DEERS, as they must be registered by the Service member. As a result, DoD cannot reliably track the deaths by suicide among these individuals.

report may be underestimated for this population. For simplicity, this report will hereafter refer to dependent children as "dependents."

CY 2019 Family Member Data Summary

Table 4 shows the annual suicide counts and rates for family members overall (spouses and dependents combined across all military populations), as well as for military spouses and dependents, for the Active Component, Reserve, and National Guard for CY 2017 to CY 2019.[48] Data for CY 2020 were unavailable for this report because of the time lag inherent in the collection of civilian death data.[49]

There were 202 reported suicide deaths among military family members in CY 2019. The family member suicide rate was 7.7 per 100,000 military family members (**Table 4**); this rate was consistent with the CY 2017 and CY 2018 rates (i.e., no statistical changes). The overall family member suicide rates were similar for the Active Component, Reserve, and National Guard, ranging from 7.1 to 8.8 deaths per 100,000 individuals.

Table 4. Family Member Suicide Rates per 100,000 by Military Population, CY 2017–CY 2019[1-3]

	CY 2017		CY 2018		CY 2019	
Military Population	**Count**	**Rate**	**Count**	**Rate**	**Count**	**Rate**
Total Force	**182**	**6.8**	**191**	**7.2**	**202**	**7.7**
Spouse	121	11.6	126	12.2	130	12.6
Dependent	61	3.7	65	4.0	72	4.5
Active Component	**118**	**7.0**	**116**	**7.0**	**117**	**7.1**
Spouse	90	13.3	82	12.2	85	12.7
Dependent	28	2.8	34	3.4	32	3.3
Reserve	**29**	**6.3**	**29**	**6.4**	**40**	**8.8**
Spouse	--	--	18	--	17	--
Dependent	--	--	11	--	23	7.9
National Guard	**35**	**6.4**	**46**	**8.5**	**45**	**8.5**
Spouse	11	--	26	13.4	28	14.7
Dependent	24	6.9	20	5.8	17	--

1. Source(s): DEERS, Military Services, and NDI (suicide counts); Defense Manpower Data Center (DMDC) (denominators).
2. Per DoD Instruction 6490.16, rates for subgroups with fewer than 20 suicides are not reported because of statistical instability.
3. Per CDC requirements, counts under 10 were suppressed in order to protect the confidentiality of military family members. Additional cells were also suppressed to ensure low counts could not be recreated. Per DoDI 6490.16, rates are not reported when the number (i.e., count) of suicide deaths is under 20 due to statistical instability.

In this report, family members could also be Service members. The Department included Service members who are spouses of other Service members in its family member suicide counts and rate estimation to better capture the full extent of suicide among military family members. In CY 2019, 41 family members (20.3%) who died by suicide were also Service members at the time of their death.[50] When these family members who were also Service members were *excluded* from the family member population, the family members (spouses and dependents combined across all military populations)

[48] Note that, although not included in Table 4 counts for the DoD military family members, per the FY 2015 NDAA, DoD collects data on suicide deaths for family members of the U.S. Coast Guard. In CY 2019, there were four U.S. Coast Guard military family member suicide deaths.
[49] It can take between 12 and 18 months for CDC to receive death information from the state vital statistics offices. As a result, there is a two-year lag between the most recent available NDI death information and any related report on military family member suicides.
[50] In CY 2018, of the family members who died by suicide, 18% were also Service members at their time of death.

suicide rate was 6.5 per 100,000 individuals. All analyses examining military spouse decedents were conducted inclusive and exclusive of spouses who were themselves Service members at their time of death. No differences were noted in the conclusions reached for either analysis. For this reason, the rates reported below include military spouse decedents who were themselves Service members at their time of death.

Military Spouses

Of the 130 military spouses who died by suicide in CY 2019, the majority were under 40 years of age (79.2%; **Table 5**). This aligns with the overall military spouse population demographics, wherein a majority of spouses are under 40 years of age (i.e., 79%);. However, the suicide decedent population does not align with the overall military spouse population regarding sex. Although male spouses account for a little over half of suicide decedents (53.1%), they only account for 13% of the overall military spouse population.

Note that in CY 2019, 51.5% of military spouses (*n* = 67) had a history of military service (of whom 37 spouses were currently serving at the time of their death by suicide).[51] Examined by sex, 79.7% of male spouses (*n* = 55) had a service history (of whom 34 males were currently serving at time of death), and 19.7% of female spouses (*n* = 12) had a service history (of whom less than 10 females were currently serving at time of death).

Table 5. Military Spouse Suicide Counts and Percentages by Demographics

	Count	Percent
Sex	**130**	**100%**
Male	69	53.1%
Female	61	46.9%
Age Group	**130**	**100%**
<40	103	79.2%
≥40	27	20.8%
Service History	**130**	**100%**
Any Service History	67	51.5%
Prior Service (Not Currently Serving)	30	23.1%
Currently Serving	37	28.5%
No Service History	63	48.5%

1. Per CDC requirements, counts under 10 were suppressed to protect the confidentiality of military family members.

For military spouses, the CY 2019 suicide rate was 12.6 deaths per 100,000 individuals; this rate was consistent with the CY 2017 and CY 2018 rates (no statistical changes; **Table 4**). **Table 6** presents suicide rates for spouses by sex.[52] When examined by sex and ages 18 to 60, the female spouse suicide rate was 6.8 deaths per 100,000, and the male spouse rate was 51.7 deaths per 100,000 in CY 2019. Note that although these may appear different than prior years, these CY 2019 suicide rates are not statistically different when compared to the CY 2017 or CY 2018 rates. The suicide counts are low, and the number of family members who died by suicide is a relatively smaller population compared to both the Service member and U.S. population. Therefore, small changes to the male spouse suicide counts can dramatically affect the suicide rate.

[51] In CY 2018, there were 62 (49%) spouses with any prior service history, of whom 32 spouses were currently serving at the time of death.
[52] Per DoDI 6490.16, age-specific rates were not presented as the number of suicide counts were fewer than 20 for each age grouping.

Table 6. Military Spouse Suicide Rates per 100,000 Individuals by Sex, CY 2017–CY 2019[1-2]

DoD Component	CY 2017		CY 2018		CY 2019	
	Male	Female	Male	Female	Male	Female
Total Force	**29.1**	**9.2**	**40.9**	**8.1**	**51.7**	**6.8**
Active Component	30.2	11.1	36.9	8.8	52.3	7.0
Reserve	--	--	--	--	--	--
National Guard	--	--	--	--	--	--

1. Source(s): DEERS, Military Services, and NDI (suicide counts); DMDC (denominators).
2. Per DoDI 6490.16, rates are not reported when suicide counts are less than 20 due to statistical instability.

Compared to the U.S. population, the CY 2019 female spouse rate was comparable to the female suicide rate in the CY 2019 U.S. population, ages 18 to 60 years (8.2 per 100,000). However, the CY 2019 male spouse rate was statistically higher than the U.S. population (28.4 per 100,000 for ages 18 to 60 years).

Military Dependents

Of the 72 military dependents who died by suicide in CY 2019, the majority were male (76.4%; **Table 7**). Ages ranged from 12 to under 23 years old, with 62.5% of dependent deaths among dependents who were under the age of 18. In CY 2019, less than 6% of dependents were also Service members at the time of their death.

Table 7. Military Dependent Suicide Counts and Percentages by Demographics

	Count	Percent
Sex	**72**	**100%**
Male	55	76.4%
Female	17	23.6%
Age Group	**72**	**100%**
0-9	0	0%
10-17	45	62.5%
18 to less than 23	27	37.5%

1. Per CDC requirements, counts under 10 were suppressed in order to protect the confidentiality of military family members.

For military dependents, the CY 2019 suicide rate was 4.5 deaths per 100,000; this rate was consistent with the CY 2017 and 2018 rates (i.e., no statistical changes; **Table 4**). **Table 8** presents suicide rates for dependents by sex.[53]

Table 8. Military Dependent Suicide Rates per 100,000 Individuals by Sex, CY 2017–CY 2019[1-3]

DoD Component	CY 2017		CY 2018		CY 2019	
	Male	Female	Male	Female	Male	Female
Total Force	**5.1**	--	**5.9**	--	**6.7**	--
Active Component	--	--	5.2	--	4.4	--
Reserve	--	--	--	--	--	--
National Guard	--	--	--	--	--	--

1. Source(s): DEERS, Military Services, and NDI (suicide counts); DMDC (denominators).
2. Per DoDI 6490.16, rates are not reported when suicide counts are less than 20 due to statistical instability.
3. To facilitate comparisons with the U.S. general population, 95% confidence intervals for the rates were calculated.

The male military dependent suicide rate in CY 2019 was 6.7 per 100,000 population, which was

[53] Per DoDI 6490.16, age-specific rates were not presented as the number of suicide counts were fewer than 20 for each age grouping.

statistically consistent with the CY 2017 and CY 2018 rates. This is statistically comparable to the rate among males aged < 23 years in the U.S. population (8.0 per 100,000 population). Military dependents are younger on average than are dependents in the U.S. population.[54] Per DoD policy, the female military dependent suicide rate was not reported (i.e., counts were under 20 for this group).

Method of Family Member Suicide Death

Similar to CY 2017 and CY 2018, among all family members (spouses and dependents combined across all military populations), suicide deaths in CY 2019 were primarily by firearm (55.1%) and hanging/asphyxiation (29.8%). For both spouses and dependents individually, the most common methods of suicide death in CY 2019 were firearms followed by hanging/asphyxiation, consistent with CY 2017 and 2018 (**Table 9**).

Firearms remained the leading method of suicide death when examined by sex. For female spouses, firearms were the leading method (41.0%), followed by hanging/asphyxiation (24.6%). This is in contrast to the U.S. population wherein firearms (30.7%) and hanging/asphyxiation[55] (30.6%) are about equivalent as the leading method of suicide death for adult females ages 18 to 60. Suicide by firearm was the leading method among male spouses and male dependents (72.5% and 45.5%, respectively), followed by hanging/asphyxiation (21.7% and 41.8%, respectively), which are comparable to the primary methods of suicide among males in the U.S. population ages 18 to 60 and among males in the U.S. population ages under 23 years of age. Due to low counts among female dependents when broken down by method of suicide, we are unable to determine leading methods or comparisons among females under 23 years of age.

Table 9. Method of Suicide Death by Family Member Type, CY 2019[1-3]

	Total	Spouse	Dependent
Method of Death	**Percent**	**Percent**	**Percent**
Total	**100%**	**100%**	**100%**
Firearm	55.1%	59.5%	47.2%
Hanging/Asphyxiation	29.8%	23.8%	40.3%
Drugs/Alcohol	7.6%	10.3%	<3.0%
Sharp/Blunt Object	<1.0%	<1.0%	0.0%
Poisoning	<2.0%	<3.0%	0.0%
Falling/Jumping	<1.0%	0.0%	<3.0%
Other	<4.0%	<4.0%	<5.0%

1. Source(s): DEERS, Military Services, and NDI (suicide counts); DMDC (denominators).
2. The poisoning category includes deaths unrelated to drug overdose, such as carbon monoxide poisoning.
3. Per CDC requirements, if counts were under 10, the corresponding percentages were suppressed or masked (i.e. <1.0%) to protect the confidentiality of military family members.

Overall, there must be caution drawing strong conclusions based on three years of data for our military family members. The Department will continue to work to effectively capture military family suicide deaths and report these data in a transparent and timely manner. Once the Department has gathered data for a sufficient number of years to enable longer-term trend identification, we will target efforts to identify key trends for our military family members.

[54] In CY 2019, DoD dependents ages 0–11 made up 71% of the total dependent population, and the remaining 29% were 12 to less than 23 years old. In the U.S. population, individuals who were 0–11 years old made up 51% of all individuals younger than 23, and the remaining 49% were 12 to less than 23.
[55] Not including suicide by asphyxiation/drowning.

Current Departmental Efforts

Current Suicide Prevention Strategy, Governance, and Efforts

The DoD suicide prevention efforts are guided by the 2015 Defense Strategy for Suicide Prevention (DSSP). This strategy created the foundation for our prevention activities by using a public health approach, which acknowledges a complex interplay of individual-, relationship-, and community-level risk factors. In 2017, the CDC released a bundled public health approach as a technical package, presenting seven broad, evidence-informed strategies to focus suicide prevention activities that have been found to effectively impact risk and protective factors surrounding suicide (Stone et al., 2017). The Department's goals within the DSSP align with these seven strategies:[56]

1. Strengthening economic supports
2. Strengthening access and delivery of suicide care
3. Creating protective environments
4. Promoting connectedness
5. Teaching coping and problem-solving skills
6. Identifying and supporting people at risk
7. Lessening harms and preventing future risk

The Suicide Prevention General Officer Steering Committee (SPGOSC) is composed of senior executive leaders and general officers across the Department and leads the Department's suicide prevention efforts. This governance body addresses present and future suicide prevention needs by employing data-driven, evidence-informed practices that have DoD-wide applicability. In addition, the Suicide Prevention and Risk Reduction Committee (SPARRC)—a complementary, enterprise-wide, action-officer level committee—is responsible for coordinated implementation of the guidance provided by the SPGOSC. The SPARRC provides an opportunity for collaboration, communication, and documentation of promising suicide prevention practices across DoD.

The Department has a number of efforts underway to support Service members and their families, including those aimed at increasing access to support, reducing barriers to receiving support, and targeting our population of greatest concern. The CY 2019 ASR presented numerous suicide prevention initiatives—as examples of suicide prevention efforts occurring across the Department—that are aligned to the DSSP goals and seven broad, evidence-informed strategies (Department of Defense, Under Secretary of Defense for Personnel and Readiness, 2020a). **Appendix H** offers updates to those previously highlighted initiatives—organized by the seven strategies—and introduces new evidence-informed initiatives underway. Note these examples are by no means an exhaustive list. These initiatives address some of the key findings in this report, as well as data collected by the DoD Suicide Event Report (DoDSER) Annual Report and other sources. **Appendix I** provides more detailed information on chaplains and other spiritual resources available to our military community. **Appendix D** highlights efforts to address and reduce the stigma associated with seeking help for mental health or suicidal thoughts.

Evaluating and Assessing Effectiveness of Policies, Programs, and Initiatives

Suicide is a complex and multifaceted issue that requires a comprehensive, holistic approach to prevention. Collectively, Departmental policies, programs, and initiatives are designed to address various suicide risk and protective factors that have been shown to impact suicide within our military

[56] For more information on the Department's goals within the DSSP and its alignment with the seven strategies, please visit https://www.dspo.mil/Portals/113/Documents/TAB%20B%20-%20dssp_final%20USD%20PR%20signed.pdf

community. Likewise, our program evaluation efforts must account for such complex interactions of suicide risk and protective factors and examine the effectiveness of our ongoing suicide prevention efforts more holistically as a collective system. The following sections describe the Department's policy review and program evaluation efforts for our suicide prevention efforts.

Policy Review

The Department originally published an enterprise-wide suicide prevention policy through DoD Instruction (DoDI) 6490.16, Defense Suicide Prevention Program, on November 6, 2017 (Department of Defense, Under Secretary of Defense for Personnel and Readiness, 2020b). This policy was updated on September 11, 2020, to better align with DoD's broader public health approach to violence prevention.[57] DoDI 6490.16 provides direction to the Military Services and other DoD Components on their responsibilities with respect to the Defense Suicide Prevention Program (Department of Defense, Under Secretary of Defense for Personnel and Readiness, 2020b). This policy also establishes standards for suicide prevention, intervention, and postvention efforts that reflect a holistic, public health approach to suicide prevention. The policy also requires standardized collection and analysis of suicide data. Program evaluation efforts, detailed in the next section, will also help evaluate overall effectiveness and inform enhancements to our public health approach and policies.

The Department also published an integrated violence prevention policy—the first of its kind—through DoDI 6400.09, DoD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm, on September 11, 2020.[58] Informed by best practices in the field, this policy creates a unity of effort across prevention programs and policies; establishes a common, research-based framework for violence prevention; and focuses prevention efforts on those activities that have the greatest potential to reduce multiple forms of violence (e.g., suicide, harassment, sexual assault, domestic abuse, child abuse, and substance misuse) that affect the military community. This holistic approach allows DoD to address common factors shared by multiple readiness-detracting behaviors, with young and enlisted Service members being a key population of focus. Together with DoDI 6490.16, the Department can better support our Service members and their families on suicide prevention.

To ensure unity of effort, the Defense Suicide Prevention Office (DSPO), in collaboration with the Military Services and relevant DoD Components, regularly reviews implementation of DoDI 6490.16, which represents a broad range of activities that address the various aspects of suicide prevention.[59] This enables the Department to identify areas for improvement as well as leverage promising practices to enhance policy efforts. In the CY 2020 review of policy responsibilities, the Department determined all Components, including the Military Services, were in alignment with DoDI 6490.16, with minimal disruption due to the COVID-19 pandemic.[60] The few Components that indicated initial impact on policy implementation due to the pandemic also noted that they were able to quickly mitigate issues to ensure Service members and their families had access to helpful resources. For example, several Components noted initial impact on accessing some integrated services and suicide

[57] DoDI 6490.16 was updated twice in CY 2020. The June 15 update was reported in the CY 2019 ASR, which can be accessed at https://www.dspo.mil/Portals/113/Documents/CY2019%20Suicide%20Report/DoD%20Calendar%20Year%20CY%202019%20Annual%20Suicide%20Report.pdf?ver=YOA4IZVcVA9mzwtsfdO5Ew%3d%3d

[58] DoDI 6400.09 can be accessed at https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/640009p.pdf?ver=2020-09-11-104936-223

[59] Per DoDI 6490.16, DSPO oversees the Military Services' compliance of this policy. DSPO collaboratively works with the relevant Components to review implementation.

[60] For the CY 2020 review, Components submitted self-assessments to DSPO. Key Military Service policies that were reviewed included AR 600-63 (Army), OPNAVINST 1720.4B (Navy), MCO 1720.2 (Marine Corps), AFI 90-5001 (Air Force), and CNGBI 0300.01 (National Guard Bureau). In addition, to account for the COVID-19 pandemic, DoD included a special interest item as part of the policy review asking Components to identify any policy that was impacted due to the pandemic and efforts to mitigate the impact.

prevention training, but were able to move integrated services and training to secure virtual platforms. Overall, Components demonstrated adaptability in meeting DoDI 6490.16 responsibilities during the pandemic.

In addition, on November 17, 2020, the Department published the "Defense Suicide Prevention Office (DSPO) Guidelines for Collaboration with Non-Government Organizations" to provide guidance and criteria as a deliberate way to help encourage and extend suicide prevention, intervention, and postvention efforts beyond the military community.[61] This effort reinforces our commitment to collaborating with non-government organizations in advancing our holistic, data-driven suicide prevention approach to positively impact individual beliefs and behaviors, as well as instill systemic culture change.

The Department also participated in a Government Accountability Office (GAO) evaluation of DoD suicide prevention programs and activities, as required per the Section 741(b) of the National Defense Authorization Act (NDAA) for FY 2020. GAO Report 21-300, "DoD Needs to Fully Assess Its Non-Clinical Suicide Prevention Efforts and Address Any Impediments to Effectiveness," published on April 26, 2021, determined that DoD has responded to the growing rate of death by suicide among the military population with a variety of suicide prevention efforts, including those that are non-clinical.[62] GAO also identified impediments that may hamper the effectiveness of DoD's suicide prevention efforts, and included three recommendations: (1) Develop a process to ensure that individual, Service-level non-clinical suicide prevention programs are assessed for effectiveness; (2) develop consistent suicide-related definitions and require their use across DoD; and (3) minimize duplication across the Annual Suicide Report (ASR) and the DoDSER Annual Report. The Department is actively addressing these recommendations. As a way forward, the Department will continue to monitor and regularly review implementation of DoDI 6490.16 as well as use program evaluation, stakeholder engagement and collaboration, and other means to identify gaps and enhance policies, programs, and other key efforts.

In addition, the Department, through the Prevention Collaboration Forum (PCF)[63] and the Office of Force Resiliency Violence Prevention Cell (VPC), continues to focus on an integrated and public health approach to violence prevention and reduction of harmful behaviors toward self and others. The VPC was established after the PCF was chartered on February 26, 2020, to support the activities of the PCF, develop and monitor integrated policy, and synchronize efforts toward a more rigorous DoD prevention model. As the Department leverages new command climate data to report on risk and protective factors across the Force, suicide prevention will be integral in this process and subsequent recommendations and mitigating actions. Further, PCF working groups are identifying gaps and opportunities in prevention workforce training standards, program evaluation, and to help reduce unnecessary redundancies across policies. DSPO, as a PCF member, remains actively engaged with working groups that help streamline suicide prevention efforts while providing mutual support toward the Department's efforts to reduce and stop these readiness-detracting behaviors and to promote readiness of the Total Force. These integrated efforts feed into the Department's actions to address command climates across all installations to mitigate risks for those behaviors within the integrated violence prevention framework.

Program Evaluation

[61] The Defense Suicide Prevention Office Guidelines for Collaboration with Non-Government Organizations is accessible at https://www.dspo.mil/Portals/113/DSPO%20Collaboration%20Guidelines%20with%20Non-Governmental%20Organizations%202020.pdf

[62] GAO conducted this audit from March 2020 to April 2021. GAO Report 21-300 is accessible at https://www.gao.gov/assets/gao-21-300.pdf

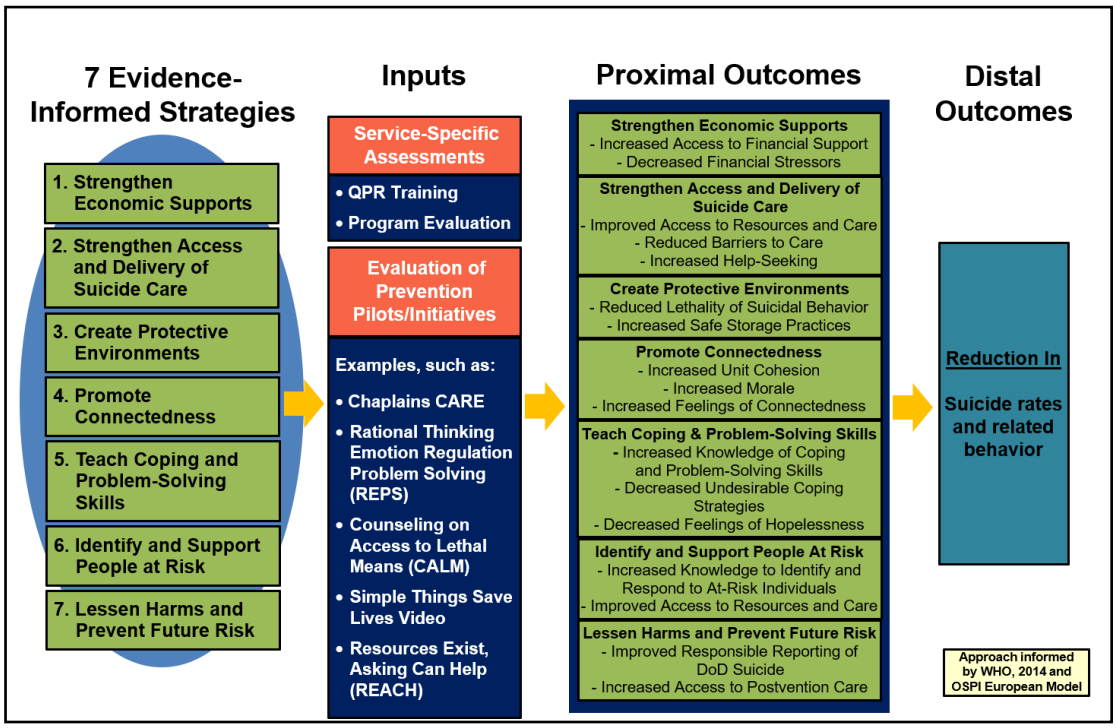
[63] The PCF, chartered in February 2020, focuses on policy actions to address violence prevention, including before, immediately surrounding, and the long-term response after allegations of violent, abusive, or harmful acts are reported. The PCF also focuses on the assessment and evaluation of actions across the spectrum of violence prevention.

Over the past decade, the Department has focused on implementing suicide prevention programs and initiatives with the intent of reducing suicide rates within our military community. We have expanded our focus to ensure that program evaluation is an integral part of program development and implementation.

Program Evaluation Framework, Metrics, and Data

The Department uses an enterprise-wide program evaluation framework to evaluate the effectiveness of its suicide prevention efforts (see **Figure 6**). Our current framework integrates the seven broad, evidence-informed strategies from CDC, and aligns with the 2015 DSSP goals. As illustrated in **Figure 6** the seven broad, evidence-informed strategies are used to develop specific suicide prevention programs and initiatives that will impact suicide risk and protective factors (i.e., the proximal outcomes). Positive changes in the proximal outcomes are expected to lead to decreases in distal outcomes, which is the reduction of suicide deaths and attempts. Although reductions in these behaviors constitute the ultimate indicators for success, achieving a reduction in these behaviors requires a coordinated implementation of multiple suicide prevention initiatives and activities over a long period of time. For a more immediate understanding of the progress and effectiveness of suicide prevention initiatives, the Department leverages the proximal outcomes. In sum, both types of outcomes help us assess progress and effectiveness of ongoing non-clinical programs and activities in order to determine whether modifications are needed and/or whether these efforts should continue. Moreover, the Department of Veterans Affairs (VA)/DoD Clinical Practice Guidelines and the Joint Commission serve to ensure that high-quality, evidence-based clinical treatment and care is provided to our military community (Department of Veterans Affairs & Department of Defense, 2019).

Figure 6. Enterprise-Wide Program Evaluation Framework



Before one can track *changes* on proximal outcomes or begin to understand if suicide prevention efforts are working, one needs baseline data—a critical starting point for comparison. Then, follow-up metrics can provide valuable information about what, if any, impact the programs and initiatives have on outcomes. The Department leverages several sources of data to track standardized metrics for the proximal and distal outcomes over time, including Departmental suicide data from the Armed Forces Medical Examiner System (AFMES) and DoDSER system, as well as DoD-wide surveys representative of the entire population (e.g., Status of Forces Surveys [SOFS]), administered by

DoD's Office of People Analytics [OPA]).[64] These data and metrics do not indicate the effectiveness of one specific program, but rather reflect a progress indicator of the ongoing programs and activities, more holistically, as a collective system.

Many DoD programs and initiatives were implemented enterprise-wide in CY 2019.[65] However, it is crucial to note that, as with all public health interventions, these programs require coordinated implementation and take time to translate into changes in beliefs and behaviors. Although we present CY 2019 data in this report, these data are temporally aligned with the start of these programs and initiatives in CY 2018 (i.e., preceding this enterprise-wide implementation, many of these programs and initiatives were rolled out only in select locations throughout CY 2018).[66] As such, the data presented here are strictly for the purpose of descriptive comparisons and should not be used or interpreted as an indication of program effectiveness. These descriptive comparisons are not intended to represent findings indicative of a full program evaluation. Still, these descriptive comparisons between CY 2018 and CY 2019 allow for a degree of insight into the status of the Total Force on various proximal outcomes.

Below are a few examples of CY 2019 data aligned with two of the seven broad, evidence-informed strategies. Additional CY 2019 data aligned to the seven strategies are presented in **Appendix J**. As one evidence-based strategy example, consider the broad strategy of *Strengthen Economic Supports.* A key proximal outcome aligned with this strategy is *decreased financial stressors.* On the 2019 SOFS, 46% of Active Component members indicated that their financial situation was much better or somewhat better as compared to 12 months ago (42% in 2018) whereas 39% indicated their situation was the same. On the 2019 SOFS, 50% of Reserve Component members indicated that their financial situation was much better or somewhat better as compared to 12 months ago (46% in 2018) whereas 35% indicated their situation was the same. Moreover, 83% of both Active Component and Reserve Component members had an emergency savings fund; and of these, 66% had at least one month of expenses saved in 2019. Two example programs underway to strengthen economic supports are the Financial Readiness Required Common Military Training and the Financial Counseling programs.

As a second evidence-based strategy example, take the broad strategy—*Strengthen Access and Delivery of Suicide Care.* A key proximal outcome aligned with this strategy is *reduced barriers to care*, as Service members will be less likely to access needed care and support if they perceive barriers to be present. Results from the 2019 SOFS showed that overall 18% of Active Component Service members talked to a counselor within the past six months (overall 16% in 2018).[67] Common topics for discussion with a counselor included coping with stress (80% in CY 2019 and 77% in CY 2018), problem-solving (48% in CY 2019 and 53% in 2018), and family issues (51% in both years).

Stigma has been shown to act as a barrier to help-seeking and mental health service utilization; and as such, reducing stigma is one approach to help reduce barriers to care and increase help-seeking. Perceived stigma remains a barrier to help-seeking within the military community. Active Component Service members endorsed several reasons for not seeking help, including concerns of being perceived as "broken" by one's chain of command or peers (71% in CY 2019 and 67% in CY 2018) and of experiencing a negative impact on their career (68% in CY 2019 and 65% in CY 2018). The Department has a range of efforts underway to address stigma for help-seeking (as highlighted in **Appendix D**).

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[64] The SOFSs use valid scientific survey methods, including random sampling procedures that are used to select a sample representing the military population based on combinations of demographic characteristics. Demographic groups with lower response rates are oversampled. Data for the SOFS are weighted to compensate for nonresponders and produce survey estimates of population totals that are representative of their respective populations.

[65] Baseline metrics data were published in the CY 2019 ASR, which can be accessed at https://www.dspo.mil/Portals/113/Documents/CY2019%20Suicide%20Report/DoD%20Calendar%20Year%20CY%202019%20Annual%20Suicide%20Report.pdf?ver=YOA4IZVcVA9mzwtsfdO5Ew%3d%3d

[66] This represents the most recent data available for analysis at the time of writing this report.

[67] The SOFS-A does not define counselor, and may include military and civilian, medical or non-medical, providers.

With respect to Departmental clinical suicide prevention efforts—which also align under the broad strategy of *Strengthen Access and Delivery of Suicide Care*—the 2019 VA/DoD Clinical Practice Guidelines serve as a guide for health care providers to understand which clinical approaches and treatments for suicide prevention have the most scientific evidence (Department of Veterans Affairs & Department of Defense, 2019). The Department continues to develop official procedural instructions to guide the implementation of best practices and treatment in the Military Treatment Facilities (MTF) based on these most current findings (with publication expected by CY 2022). In CY 2021, the Department published the *Defense Health Agency Procedural Instruction - Standardization of Depression and Suicide Risk Screening in Primary Care During and Subsequent to the Coronavirus Disease 2019 Pandemic* to establish procedures to screen for depression and suicide risk in the Military Health System in Primary Care during and subsequently to the COVID-19 pandemic. MTFs follow the Joint Commission standards for U.S. health care organizations. Note that both clinical behavioral health care providers and non-medical providers receive training on best practices for evidence-based care for assessment, management, and intervention of suicide-related behavior, mandated reporting, duty to warn, and reporting of adverse incidents.

Regarding program evaluation metrics for clinical suicide prevention efforts, the Department is developing policy to include metrics associated with clinical suicide treatment and prevention. Specifically, the Department is focused on creating and implementing policy with associated outcomes and process metrics that will: (1) identify whether effective treatment modalities are being used for those at risk for suicide; (2) examine the rate of integration of mental health screenings and suicide risk and prevention for members during the delivery of primary care; and (3) ensure that training standards for behavioral health care providers are being met. Given the complexity and sensitivity of the subject matter, and the need to review, assess, and incorporate evidence-based best practices, the Department continues to collaborate with subject matter experts across the Department to inform its policies and develop measures that define and quantify program effectiveness.

Pilot Programs

Public health best practices advise the development of pilot programs to test the content and methods of new programs using a smaller population prior to larger-scale implementation. Aligned with these best practices, the Department has developed and is piloting and conducting program evaluation on several new promising programs. Below, we highlight a few such pilot programs that were occurring in the Department in CY 2020, aligned with the seven broad strategies for suicide prevention.

As a first example, DoD developed a 6-minute training video—*Simple Things Save Lives*—based on research findings to educate Service members and families on how to recognize warning signs of suicide on social media, safely intervene in a crisis, and refer someone to appropriate care (Supporting the broad strategy—Identify and Support People at Risk). This pilot program, called *Recognizing the Signs of Intent to Die by Suicide on Social Media Training*, was conducted in CY 2020 through early CY 2021. Pilot evaluation results indicated that over 80% of participants found the video useful in learning to how to recognize and respond when someone's social media posts indicate life stress and risk for suicide. Given the positive evaluation findings, this training video was made available in CY 2021 for use consideration by leaders and commanders throughout the Department.

The *Resources Exist, Asking Can Help (REACH) Training* is a small group discussion intervention that aims to reduce barriers and address the most prevalent help-seeking concerns of Service members (e.g., career impact, privacy/confidentiality), familiarize them with resources, and encourage them to seek help before challenges become overwhelming (Supporting the broad strategy—Strengthen Access and Delivery of Suicide Care). REACH was pilot-tested at multiple military installations in CY 2020. Preliminary findings from the CY 2020 pilot demonstrated that REACH significantly lowered Service members' perceptions of barriers to care. These barriers included concerns about privacy and confidentiality; fear of being seen as broken; worries about negative career impact, and beliefs that mental health resources are ineffective. REACH also significantly increased Service members' comfort with reaching out for help in the future and their knowledge of

available resources. Based on these initial positive results, follow-up REACH activities include the development and testing of virtual facilitator training, broader testing and implementation for Service members, and the development of a REACH-Spouse training for military spouses.

The Army *Engage* training pilot is a training targeting junior enlisted Soldiers and designed to increase the following: awareness of risk indicators for suicide, substance misuse, and sexual harassment; individual sense of responsibility for intervening; and indirect and direct plans for effective intervention (Supporting the broad strategy—Identify and Support People at Risk). An evaluation of *Engage* began in CY 2019, with the intent to measure knowledge and attitude change, as well as behavior change over time. Evaluation results show a statistically significant increase in knowledge in nine of 13 key areas, and that 92% of Soldiers reported the training was beneficial, with 83% agreeing that it should be taught to other Soldiers. In addition, the trainers (performance experts) also had approval ratings that exceeded 95%. However, the COVID-19 pandemic affected the ability to conduct planned booster training and the ability to measure behavior change over time. Based on these positive results, the *Engage* training is being implemented more broadly across the force and within the Basic Leaders Course through the Army Non-Commissioned Officer (NCO) Professional Military Education Schools.

As a final example, the *Rational Thinking—Emotional Regulation—Problem-Solving (REPS)* training pilot is an interactive program that teaches foundational skills to deal with life stressors early in Service members' careers (Supporting the broad strategy—Teach Coping and Problem-Solving Skills). REPS aims to reduce risk among Service members while meeting their preferences for self-management. The pilot and evaluation are nearing completion, with promising initial findings leading to online curriculum development.

The Way Forward

In terms of the way forward for program evaluation efforts, the Department will continue to collect follow-up, enterprise-wide data aligned with the program evaluation framework in order to evaluate progress and the effectiveness of our suicide prevention programs and activities more holistically as a collective system in combating suicide at DoD. The Department is also actively developing a more standardized process to ensure all individual suicide prevention programs across DoD are assessed for effectiveness in the military population. The Department also continues to develop, pilot, and evaluate new promising programs for the military population using criteria from the DoD program evaluation framework, before implementing such new individual programs more broadly across DoD. These collective efforts will strengthen the Department's understanding of our current suicide prevention policies and programs, helping to identify gaps, deficiencies, and when modifications are necessary.

Current Research Collaborations and Data Sharing

In addition to program evaluation and the previously mentioned initiatives, the Department collaborates regularly on efforts, both internally and externally, with other organizations in order to continually advance its understanding of suicide and our evidence base of effective suicide prevention policies and programs. Collaborations with national and local organizations, such as other Federal agencies, nonprofit organizations, and academia, are essential in creating a robust safety net for the military community and advancing the public health approach to suicide prevention.

The Department published the enterprise-wide *DoD Suicide Prevention Research Strategy FY 2020 to 2030* in CY 2020. This strategy focuses on addressing military-specific gaps in knowledge through research to reduce suicides in our military community. The strategy represents a collaborative effort with internal and external stakeholders and aligns with the DSSP, the CDC's seven evidence-

informed strategies, and other key foundational documents.[68] The strategy prioritizes military suicide research efforts that will ultimately lead to evidence-based policies and programs that benefit the health and readiness of Service members and their families.

To meet the goals and objectives of the aforementioned strategies and plans, the Department engages in research collaborations and data sharing, both internally and externally, with the Department of Veterans Affairs (VA), other Federal Government agencies, academia, and non-governmental organizations. Cross-agency data and research collaboration allow for a mutually beneficial exchange of knowledge and resources, thus advancing the understanding of suicide risk and development of effective programs and policies. Collaborative efforts are critical to surveillance efforts, as well as the implementation and evaluation of evidence-based suicide prevention programs for Service members and their families. The following represent some research collaborations and data-sharing activities. **Appendix K** provides additional research collaborations and data-sharing efforts that occurred across the Department in CY 2020.

New Efforts Highlights

- *Interagency Suicide Prevention Research Working Group*: Initiated in 2017, the Interagency Suicide Prevention Research Working Group helps research funding organizations to maintain interagency awareness of planned initiatives, identify potential collaborations to coordinate efforts and maximize resources and investments, and share advances as well as lessons learned. Participating organizations include the DoD, VA, National Institute of Mental Health (NIMH), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). All aspects of suicide prevention research are discussed in this forum.
- *Suicide Prevention Research Portfolio, MOMRP:*[69] A newer area of emphasis for this research portfolio is comprehensive lethal means safety. Projects currently funded and underway include a project investigating lethal means safety counseling and firearm storage practices in a National Guard sample and a prevention study examining the impact of specific aspects of messaging on openness to safe firearm storage for suicide prevention. In 2020, more than 20 DoD and Service offices as well as Federal partners collaborated to develop a cross-cutting prevention funding opportunity focused on research that will directly support *DoDI 6400.09, DoD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm*.
- *Clinical Support Tools for Suicide Prevention:* DoD and the VA are actively collaborating on the development of clinical support tools designed to help patients, family members, military leaders, and providers understand and/or implement recommended interventions in the 2019 VA/DoD Clinical Practice Guideline (CPG) for the Assessment and Management of Patients at Risk for Suicide. The CPG provides thorough guidance on evidence-based practices for suicide risk care for military and Veteran patients. The tools will be disseminated from pdhealth.mil and healthquality.va.gov websites.
- *Airman's Edge:* The Department of the Air Force (DAF) collaborated with The Ohio State University (OSU) on a peer-to-peer program for suicide prevention in CY 2020. OSU's work began in 2019, but the DAF collaboration began in CY 2020 and is expected to continue until CY 2021.

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[68] For additional information on the DoD Suicide Prevention Research Strategy FY 2020 to 2030, please access DoD's CY 2019 ASR at https://www.dspo.mil/Portals/113/Documents/CY2019%20Suicide%20Report/DoD%20Calendar%20Year%20CY%202019%20Annual%20Suicide%20Report.pdf?ver=YOA4IZVcVA9mzwtsfdO5Ew%3d%3d

[69] MOMRP develops effective biomedical countermeasures against operational stressors and to prevent physical and psychological injuries during training and operations in order to maximize the health, readiness, and performance of Service members and their families. For additional information, visit https://momrp.amedd.army.mil/

- *Individual and Community and Organizational Factors for Suicide Risk in the United States Air Force (USAF):* The DAF collaborated on research examining risk and protective factors among Airmen, as well as effectiveness of the Suicide Prevention Program with the University of Rochester. This collaboration began in CY 2016 and concluded in CY 2020.
- *Ask, Care, Escort—Suicide Intervention Curriculum Update and Evaluation:* The Army G-1 and Army Public Health Center and Walter Reed Army Institute of Research (WRAIR) collaborated on research and evaluation of the new Ask, Care, Escort–Suicide Intervention (ACE-SI) curriculum for the Army, designed to train personnel to intervene in a suicidal crisis. The ACE-SI curriculum will be executed across all three components, and the National Guard and Reserve have been partners in its development, evaluation, and implementation. The research collaboration and data sharing began in CY 2018, with a planned completion of CY 2022, unless otherwise extended.
- *VA/Substance Abuse and Mental Health Services Administration (SAMHSA) Governor's Challenge to Prevent Suicide Among Service Members, Veterans, and their Families:* Several states' Joint Force Headquarters participate in the VA/SAMSHA Governor's Challenge wherein an interagency military and civilian team of leaders develops an implementation plan to prevent suicide among Service members, Veterans, and families that will advance the VA's National Strategy for Preventing Veteran Suicide. This collaboration started in CY 2019 and is ongoing.
- *Explosive Ordnance Disposal (EOD) Personnel Suicide Risk:* At the request of stakeholders from the Joint Explosive Ordnance Disposal (EOD) Military Acceptance Board (Joint Services), the Psychological Health Center of Excellence (PHCoE) completed a retrospective cohort study of EOD personnel, using administrative and health care utilization data from FY 2004 to 2015. The purpose was to assess the EOD personnel risk for suicide mortality (primary outcome), traumatic brain injury, post-traumatic stress disorder, and other psychological disorders. A report titled "Longitudinal Investigation of Diagnosed Psychological Outcomes among EOD Personnel in the U.S. Military" was completed.

Other Example Ongoing Efforts[70]

- Executive Order 13822—*Supporting our Veterans During Their Transition from Uniformed Service to Civilian Life*
- Executive Order 13861—*President's Roadmap to Empower Veterans and End a National Tragedy of Suicide*
- Executive Order 13625—*Improving Access to Mental Health Services for Veterans, Service Members, and Military Families*
- *DoD and VA Military Mortality Database (MMDB)*
- *Military Suicide Research Consortium* (MRSC)
- *DoD Suicide Event Report (DoDSER)—National Violent Death Reporting System (NVDRS) Database Linkage Effort*
- *The National Action Alliance for Suicide Prevention*
- *DoD/VA Suicide Prevention Conference*
- *The Study to Assess Risk and Resilience in Service Members—Longitudinal Study*

[70] For additional information about these efforts, please see the CY 2019 ASR, which can be accessed at https://www.dspo.mil/Portals/113/Documents/CY2019%20Suicide%20Report/DoD%20Calendar%20Year%20CY%202019%20Annual%20Suicide%20Report.pdf?ver=YOA4IZVcVA9mzwtsfdO5Ew%3d%3d

Conclusion

The health, safety, and well-being of our military community is paramount to the readiness of the Total Force. The DoD is committed to addressing suicide prevention through a holistic public health approach that recognizes suicide as a complex interaction between environmental, psychological, biological, and social factors. Department efforts must address the many aspects of life that impact suicide. Although the Department has made progress to help keep the military community socially connected and informed of resources and services during the COVID-19 pandemic, there is much more work ahead of us.

This third Annual Suicide Report (ASR) reflects the Department's continued efforts to increase transparency and accountability, which strengthens program oversight and policies and assists the Department in its commitment to prevent this tragedy. The Department continues to leverage standardized processes to collect Service member and military family suicide death data and report these data in a transparent and timely manner each year. These data, alongside program evaluation efforts, research initiatives, and other collaborations, will continue to inform the Department's efforts on suicide prevention, intervention, and postvention.

The Department will continue to take a focused approach to program evaluation to assess its policies and programs, as well as explore promising practices from the ever-evolving science on suicide prevention. This includes collaboratively developing a DoD-wide process to ensure that individual, Service-level, non-clinical suicide prevention efforts are assessed for effectiveness within the military population. Moreover, this also includes ensuring our policies and programs are crafted within a broader, evidence-based, violence prevention framework that addresses the factors shared by multiple readiness-detracting behaviors.

To achieve our goals, we must also continue robust research collaborations, data sharing, outreach, and other key efforts with national and local organizations, such as other Federal agencies, non-government organizations, and academia. This report highlights some of those recent efforts, and we look forward to the way ahead—by bolstering existing relationships and fostering new strategic collaborations to ultimately achieve our shared mission of preventing suicides among our Service members and military families.

Suicide is preventable. The Department will work to promote positive help-seeking behaviors, eliminate stigma, promote lethal means safety, and increase visibility and access to critical resources through integrated efforts across DoD and stakeholder and community engagement.

Appendix A: Section 741, National Defense Authorization Act

Section 741 of the FY 2020 NDAA (P.L. 116-92), as amended in Section 742 of the William Mac Thornberry National Defense Authorization Act (NDAA) for Fiscal Year 2021 (P.L. 116-283), requires DoD 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 table identifies where each of the requirements are specifically addressed in this report (or the forthcoming CY 2020 DoDSER Annual Report).

Requirement	Location
The number of suicides involving a dependent of a member.	p. 6–7; 25–28
A description of any research collaborations and data sharing by the DoD with the Department of Veterans Affairs (VA), other Departments or agencies of the Federal Government, academic institutions, or non-governmental organizations.	p. 35-37; 73–88 (Appendix K)
Identification of a research agenda for the DoD to improve the evidence base on effective suicide prevention treatment and risk communication. The *DoD Suicide Prevention Research Strategy FY 2020-2030* is accessible at https://mrdc.amedd.army.mil/assets/docs/DoD_Suicide_Prevention_Research_Strategy.pdf	p. 35
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.	Appendix I
A description of the effectiveness of the policies developed pursuant to section 567 of the NDAA for FY 2015 (Public Law 113–291; 10 U.S.C. 1071 note) and section 582 of the NDAA for FY 2013 (Public Law 112–239; 10 U.S.C. 24 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 DoD (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.	p. 29-35; Appendix J
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	Appendix D
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.	*CY 2020 DoDSER*
The number of suicides, attempted suicides, or known cases of suicidal ideation 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*	*CY 2020 DoDSER*
During the first 180 days of the Service member serving in the Armed Forces: the initial recruit training location of Service members who died by suicide, attempted suicide, or are known cases of suicidal ideation.	*CY 2020 DoDSER*
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	*CY 2020 DoDSER*

Appendix B: Methodology Approach

This appendix describes common questions about suicide surveillance in the military and briefly overviews the analytic methods used with the ASR to answer them.[71]

What is the annual suicide rate for the military?

Analysis Method: Annual unadjusted suicide rates.

For questions about a military population for a single year, an unadjusted suicide rate ("unadjusted rate") is calculated to provide information on the occurrence of suicide deaths during this one year. For the population of interest (e.g., Active Component Service members), an unadjusted rate is based on both the number of suicide deaths that occurred and the size of the population. Unadjusted rates are expressed as a number of suicide deaths per 100,000 individuals. (Example: See **Table 1** in the main report.)

What are the annual suicide rates for the military after changes in age and sex within the military population are accounted for?

Analysis Method: Suicide rates adjusted for age and sex over a defined time period.

The number of Service members of certain age or sex can vary across years or subpopulations (e.g., Active Component and National Guard). Since both sex and age are associated with suicide risk, adjusting rates helps account for age and sex differences when making comparisons. This avoids potentially misleading comparisons of unadjusted rates. Adjusted rates are estimated using a generalized log-linear regression model based on the Poisson distribution (i.e., change is linear in the log of the rate) and a large matrix or contingency table with decedent and population totals by strata (e.g., year, age category, sex, Component or Service). When adjusting for age and sex, the model also uses weighted effects coding.[72] A Poisson distribution is well-suited to estimating counts or rates for rare events. (Example: Figure 1 shows age and sex adjusted rates for each year.)

How have military suicide rates changed over time or in specific time frames?

Analysis Method: Estimating log-linear trends over time using adjusted rates.

To describe a trend in suicide rates over time, we calculate a line of best fit using log-linear modeling, that is well suited for rate data with a low base rate.[73,74, 75] This approach assumes that change over time is log-linear in nature and that is follows a Poisson distribution.[76] We apply this method to describe trends from CY 2015–2020 (see Service Member Section) and from CY 2011–2020 (see **Appendix E**). In order to describe shorter or more near-term changes, the ASR compares the rate for a given year to each of those for the last two years using a pair-wise comparison approach. The result of the trend analysis, for both the near- and long-term, is a single estimated rate of change for the time period, also known as the incidence rate ratio. A statistical test is then performed to determine if the trend direction (increasing or decreasing) is statistically significant for the time period of interest.

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[71] The ASR and the DoDSER Annual Report use the same analytic approach for rate standardization and trend analysis, and comparison of rates the U.S. population.
[72] https://journal.r-project.org/archive/2017/RJ-2017-017/RJ-2017-017.pdf
[73] Joinpoint regression (often used by the CDC to analyze longer-term trends for the U.S. population) can additionally evaluate how and when the trend changes within a specific period of time as each year is added to the overall timeframe. The ASR does not use this approach and only looks at a single trend over the entire period of time.
[74] Rates are adjusted to account for age and sex differences across the time period of interest.
[75] This approach models the observed event count, with consideration for the population size, and uses the distribution as a weight, which is well-suited to account for high variance in low count data. More specifically, a log-link function is used to account for population size as well as suicide death counts. The estimated rates are obtained by exponentiating the log rates from the trend analysis and the trend of the rates is then a slight curve.
[76] A Poisson distribution is used to determine the probably of rare events and allows for contingency tables or a matrix for adjustment for multiple variables like age and sex.

What is the risk for death by suicide for specific demographics groups?

Analysis Method: Estimating rate ratios for different demographic groups compared to the population average.

To assess suicide risk for specific demographic groups, we estimate rate ratios between the rate for each demographic group (listed in **Table 2**) and the average population rate. A generalized log-linear regression model based on the Poisson distribution is used to obtain the rate estimates for each group of being compared. Weighted effects coding is applied for each of the demographic group to ensure the rate ratios reflect a risk relative to the population average. The model's parameter estimates (regression coefficients) then describe the ratio of the suicide rate of any given demographic group to that of the population average (i.e., the rate ratio). (Example: Assessing whether male Service members have a higher risk for suicide in the military population, see section on *Demographic and Military Profile of Suicide Deaths* the main report.)

How do military suicide rates compare to the U.S. population suicide rates?

Analysis Method: Indirect standardization.

When making comparisons between the military and U.S. populations, the ASR uses indirect standardization to account for differences in demographic make-up because the number of suicide deaths within subsets of the military population are very small.[77] CDC WISQARS data are used for the U.S. population.[78] An indirectly standardized rate for the military can be compared with the U.S. population rate, but not to another indirectly standardized rate. The 95% confidence interval associated with the indirectly standardized rate is used to test for a significant difference between the military and U.S. populations. If the span of the confidence interval for the military population does not cover the U.S. population rate, then the probability of observing no true difference is less than 5%—or that we can be 95% confident that the two rates are likely not comparable. (Example: See subsection **"Suicide Rate Comparisons between the Military and U.S. General Population"** in the main report.)

[77] A Poisson distribution along with the military age- and sex-specific stratum population size is then used to estimate the standardized mortality ratio between the military and U.S. populations. This approach mirrors the approach used in prior DoDSER Annual Reports. For more details, see CY2019 DoDSER Appendix D.
[78] WISQARs data obtained from https://www.cdc.gov/injury/wisqars/index.html visited May 2021.

Appendix C: Results from the 2020 Quick Compass Survey of Active Duty Members On Firearm Ownership and Safe Storage Practices

Recognizing that the majority of Service member suicide decedents die by a personally-owned firearm, the Department conducted the first-ever Quick Compass Survey of Active Duty Members (QCAM) in 2020 to examine Service member attitudes and behaviors around firearm safe storage, and beliefs about firearms and suicide risk.[79] Previous research has shown that access to firearms increases risk for suicide, and safer storage practices reduces risk for suicide (Kellermann et al., 1992; Kposowa, Hamilton, & Wang, 2016; Miller et al., 2013). As such, understanding Service member beliefs and attitudes on safe storage can help the Department understand where to target efforts to encourage safe storage of firearms to decrease suicide risk.

One of the key opportunities for action highlighted by this survey is the need to correct misconceptions Service members have about firearms and the risk for suicide. Specifically, the majority of Service members surveyed (58%) believe the misconception that if someone wants to die by suicide and are prevented from using a firearm, the person will find another way. Similarly, the majority of Service members (56%) believe the misconception that having a firearm in the home does not increase the risk for suicide, and two-thirds (66%) of Service members believe the misconception that suicide risk is not related to how a firearm is stored. Targeting these misconceptions through education and outreach campaigns is critical to increasing safe firearm storage practices and reducing suicide risk among the military community.

A second key finding was Service members' openness to discussing and learning more about safe firearm storage. Specifically, nearly all Service members (97%) agreed that anyone with a firearm should discuss firearm safety with their family and nearly 80% or more of Service members stated providing training on how to store a firearm safely and the benefits of doing so, as well as advocacy from peers and superiors, would encourage safe storage. This highlights a receptivity among Service members to training and advocacy about safe storage that the Department is leveraging through the development and dissemination of a suite of evidence-informed communication tools to reinforce the criticality of safely storing firearms, among other lethal means (such as medications).

The survey results also provide insights into other action areas to target, based on findings among Service members living on-installation (who could be asked directly about personal firearm ownership and storage practices). Approximately 10% of Service members living on installation reported having a personal firearm(s) at their on-installation residence.[80] Of those with personal firearms, the majority (89%) indicated always or frequently keeping the firearm locked. Yet, about 20% reported always or frequently keeping their firearm loaded and 28% reported that they keep their ammunition with their weapon. Moreover, firearm owners living on-installation who believed more misconceptions were less likely to agree with and practice safe firearm storage practices.

Taken together, the findings from the QCAM highlight important opportunities for the Department to develop and engage in targeted outreach to educate Service members about the facts about firearms and suicide, as well as the benefits and specific techniques for safe firearm storage (e.g., keeping firearms locked, unloaded, and with ammunition stored separately). The results from the survey have informed the development and dissemination of a suite of evidence-informed communications tools, such as a Means Safety Guide for Service Members and Families, and a Means Safety PSA.

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[79] Direct questions about personal firearm ownership (and safe storage practices) could only be asked of Service members who live on a military installation due to Section 1062 of the Ike Skelton National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2011 (P.L. 111-383), as amended in Section 1057 of NDAA for FY 2013 (P.L. 112-239), which prohibits DoD from issuing any requirement relating to (or collect or record any information relating to) lawful acquisition, possession, ownership, carrying, or other use of privately owned firearms, ammunition, or other weapons by a Service member on property that is not on a military installation or other DoD-owned or operated property, unless otherwise provided for in law.

[80] This may not reflect personal preferences for all individuals on installation because firearms are not permitted in barracks.

Appendix D: Programs to Address/Reduce Stigma Associated with Help-Seeking for Mental Health or Suicidal Thoughts

Stigma has been shown to act as a barrier to help-seeking and mental health service utilization in civilian and military populations (Clement et al., 2015; Griffis et al., 2017; Haugen et al., 2017; Nearchou et al., 2018; Pease et al., 2016; Sickel, Seacat, & Nabors, 2019). Attitudes toward help-seeking, self-stigma, and perceived public stigma can all influence help-seeking behaviors. In particular, studies have found that Service members fear they will be viewed as weak or a burden or liability to the unit if their peers or command find out they are experiencing mental health issues or suicidal ideation (Griffis et al., 2017; House et al., 2018; Pease et al., 2016). Service members experiencing suicidal ideation also fear being stigmatized by their command or peers, losing career opportunities, and being asked to leave the military (Griffis et al., 2017).

Concerns about career impacts is a primary barrier to seeking mental health services (Naifeh et al., 2016). This is corroborated by 2019 Status of Forces Survey of Active Duty Members (SOFS-A) data, which found that Service members' fear of negative impact to their career is a primary influential factor in determining their willingness to seek help. In addition to career concerns, the 2019 SOFS-A found another primary barrier to seeking treatment is Service members' concerns over confidentiality. Accordingly, some Service members have been found to use other providers that ensure confidentiality, such as chaplains (Griffis et al., 2017).

Reducing stigma is one approach to help reduce barriers to care and increase help-seeking. For example, greater knowledge regarding causes of, symptoms of, and treatment for suicide among Service members has been found to be correlated with less stigma and more help-seeking behavior (Calear et al., 2014). Overall, the military environment can be seen as influential in deterring or promoting help-seeking behavior among Service members. The Department leverages the CDC's seven evidence-informed strategies for suicide prevention. Stigma reduction aligns with the second strategy, Strengthening Access and Delivery of Suicide Care. The Department is implementing programs and initiatives to reduce stigma and barriers to care through education, care delivery, governance, and screening. Education informs Service members about available resources and services and real-life examples of peers/leaders who used those resources and services. Care delivery focuses on reducing barriers to care and alleviating concerns about confidentiality and adverse career impacts. Governance focuses on updating policy to reduce institutionalized stigma. Lastly, screening supports identifying Service members who are in need of mental health care and ensuring referral and follow-up care with a mental health professional. Accordingly, the Department and Services have implemented various programs and initiatives to reduce and address the stigma associated with seeking assistance for mental health concerns, including suicidal thoughts. The following describes some DoD-wide and Service-specific example efforts from CY 2020.

Department-Wide Efforts

In CY 2020, the Suicide Prevention General Officer Steering Committee (SPGOSC) established one of their top focus areas/goals as Reducing Stigma and Barriers to Care, and stood up a cross-functional working group to conduct a DoD-wide landscape analysis and identify gaps and recommendations for policy and program modifications and enhancements focused on reducing stigma and barriers to care. This SPGOSC focus is ongoing.

New training pilots and research were underway in CY 2020 to better understand and address stigma and help-seeking. From CY 2019 to CY 2020, the Services collaborated with various DoD-level offices to develop and pilot a new training: *Resources Exist, Asking Can Help* (REACH). REACH was designed to directly address a variety of help-seeking concerns and perceived barriers of Service

members head on, and to encourage Service members to seek help early on, before life challenges become overwhelming. REACH was pilot-tested at multiple military installations in CY 2020. Results from the 2020 field test showed that REACH lowered Service members' barriers to help-seeking, including concerns about privacy and confidentiality, fears of being seen as "broken," worries about negative career impact, and beliefs that mental health and financial resources are ineffective.

The U.S. Army Medical Research and Development Command, Military Operational Medicine Research Program (MOMRP) manages a portfolio of psychological health research that includes efforts to understand and reduce stigma and self-perceptions as barriers to help-seeking and accessing care in the context of behavioral health issues, psychiatry and mental health disorders, and suicide prevention. In 2020, MOMRP launched new studies on development and testing of treatment approaches that are non-stigmatizing and address barriers to access through computer, web-based, or telehealth delivery. Studies also focus on developing and testing methods to increase awareness and positive attitudes toward behavioral health and treatment seeking.

The Department had multiple efforts underway in CY 2020 targeting messaging related to stigma and help-seeking. One such initiative is the Real Warriors Campaign. This campaign promotes a culture of support by encouraging the military community to reach out for help for psychological health whether coping with daily stressors (such as relationship and financial stressors), or concerns like depression, anxiety, and post-traumatic stress disorder. Founded in 2009, the campaign supports the Department's mission to break the stigma associated with psychological health and encourages those who are coping with a psychological health concern to seek help. The campaign links Service members, Veterans, and their families with care and provides free, confidential resources like online articles, print materials, videos, and podcasts.[81] In CY 2020, 3,466 help-seeking actions were recorded, including calls to the Veteran/Military Crisis Line, live chats, and care link referrals. These actions were up 109% from the previous year. Another initiative that targeted messaging included asking senior leaders across the Department to play a direct role in outreach messaging to reduce stigma and increase help-seeking. Senior leaders developed video messages in which they shared their own stories and experiences with mental health and help-seeking to normalize the experiences of Service members and demonstrate their ability to address their challenges and achieve successful careers.

As a final example, clinical efforts are also being implemented to address suicide prevention by reducing stigma. DoDI 6490.04, Mental Health Evaluations of Members of the Military Services, was updated in 2020 to continue mandated mental health evaluation referrals by Commanders and supervisors when a Service member indicates possible harm to self or others, or they believe the Service member may be suffering from a mental illness. Further, DoDI 6490.08, Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members, was implemented to ensure Service member confidentiality by providing instructions for health care providers regarding when, what, and to whom to disclose mental health treatment information.

Service-Specific Efforts

The Military Services have also implemented targeted efforts in CY 2020 to provide additional support for Service members and to address stigma. Some examples are provided below.

Army. In the Army, an effort being implemented is the Ask, Care, Escort (ACE) curriculum, which is being developed by the Army Resilience Directorate and Army Public Health Center for use across the Army enterprise for annual training requirements. The 60-minute training is modular, with one mandatory 30-minute module covering suicide impact, risk reduction, protective factors, warning signs, and Question-Persuade-Refer training. Currently under development are three additional 30-minute modules covering stigma, active listening, and practicing ACE.

[81] https://www.health.mil/Military-Health-Topics/Centers-of-Excellence/Psychological-Health-Center-of-Excellence/Real-Warriors-Campaign

Navy. In the Navy, the WARRIORTalk video series was created to break down stigma and reinforce the message that using resources is a strength. In these videos, three Naval Special Warfare Service members offer an intimate and courageous firsthand look at suicide within the Force.

Marine Corps. The Marine Corps is implementing Operational Stress Control and Readiness Generation III (OSCAR Gen III) Training. OSCAR is a peer-to-peer support training that teaches OSCAR team members to act as internal sensors of stress for Commanders. Preliminary results indicate that OSCAR Gen III increases help-seeking behaviors through a reduction in stigma and referring others to behavioral health services. OSCAR is currently under evaluation, with tools to evaluate knowledge change and behavioral outcomes and a checklist to assess implementation fidelity currently being developed.

Air Force. The Air Force has been implementing Resilience Tactical Pause (RTP) since August 2019. This program focuses on preventing suicide by enhancing meaningful connections among Airmen, which has also helped to reduce stigma and break down barriers.[82]

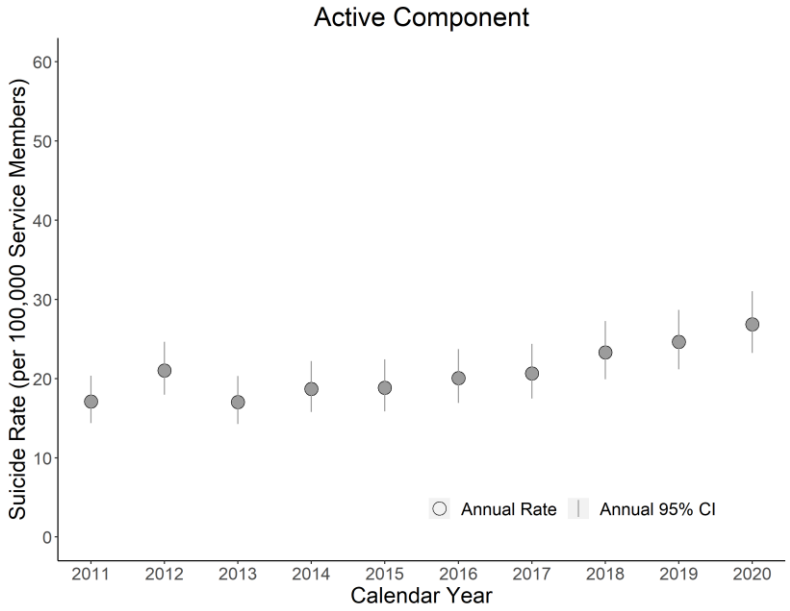
[82] At this time, references to Air Force include Space Force unless otherwise stated.

Appendix E: Suicide Trends: CY 2011–Present

This appendix provides suicide rates for CY 2011–2020 for each military population and by Service is presented below. This trend analysis provides an even longer-term assessment of Department of Defense (DoD) suicide trends beginning with CY 2011 than highlighted in the main body of the report.

Figures 7 and 8 (A–D) show suicide rates and 95% confidence intervals for the Active Component and each Military Service in the Active Component. The Active Component DoD suicide rate statistically increased between CY 2011 (18.7 per 100,000) and CY 2020 (28.6[83] per 100,000). An increase in suicide rates was observed between CY 2011 and CY 2020 across all Services. Trend analysis indicates the Active Component suicide rates significantly increased for all the Services between CY 2011 and CY 2020.

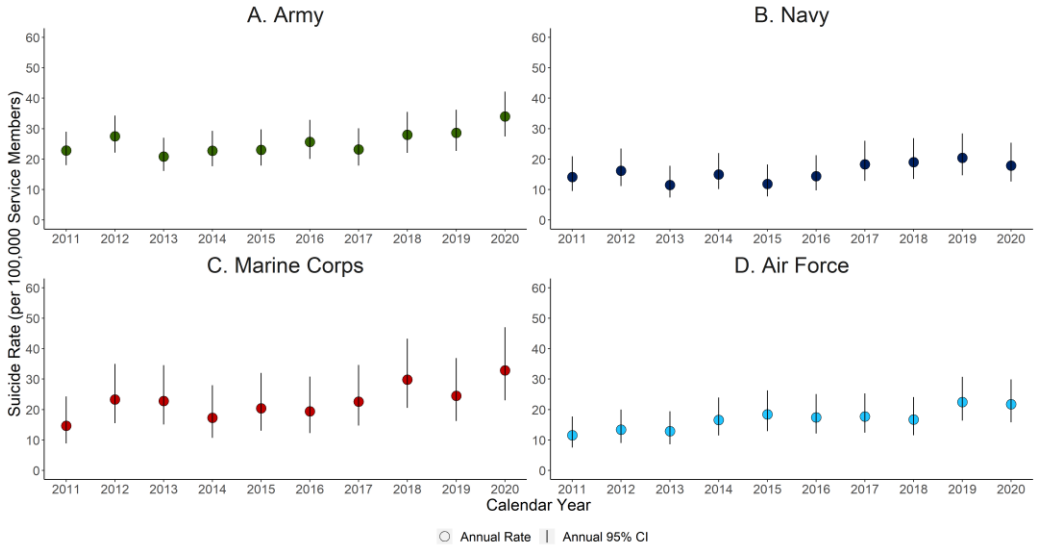
Figure 7. Active Component Suicide Rates per 100,000 Service Members by CY[1-3]



1. Source(s): Armed Forces Medical Examiner System (AFMES).
2. The 95% confidence interval (indicated by bars) represents the range in which the true suicide rate falls with 95% certainty.
3. Rates are adjusted for age and sex differences over time. See Appendix B for additional details.

[83] The unadjusted CY 2020 suicide rate for the Active Component reported in Table 1 is 28.7. Trend analyses using an age bound of 17–59 to ensure rigorous age adjusting results in a rate of 28.6.

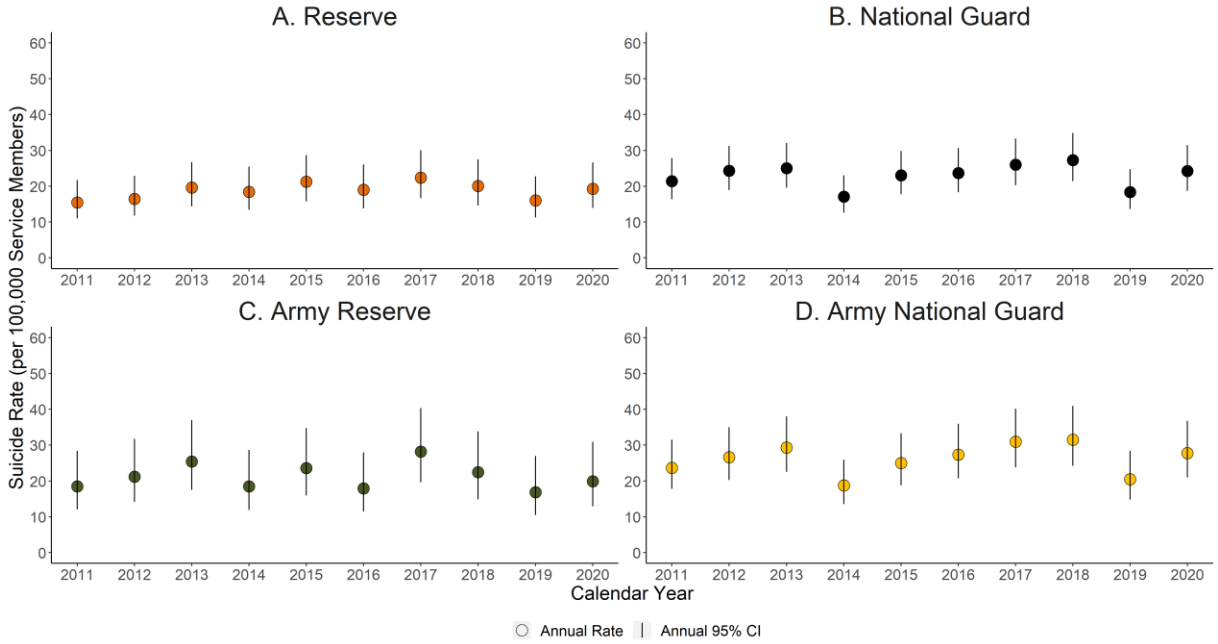
Figure 8. Active Component Suicide Rates by Service per 100,000 Service Members by CY[1-3]



1. Source(s): Armed Forces Medical Examiner System (AFMES).
2. The 95% confidence interval (indicated by bars) represents the range in which the true suicide rate falls with 95% certainty.
3. Rates are adjusted for age and sex differences over time. See Appendix B for additional details.

Figure 9 (A–D) provides suicide rates and 95% confidence intervals for the Reserve and National Guard between CY 2011 and CY 2020. Trend analysis indicates the Reserve and National Guard suicide rates did not statistically increase or decrease over this time period (i.e., no statistical change). When examined by Service, the same trends were observed for the Army Reserve and Army National Guard.

Figure 9. Reserve and National Guard Suicide Rates and by Service per 100,000 Service Members by CY[1-3]



1. Source(s): Armed Forces Medical Examiner System (AFMES).
2. The 95% confidence interval (indicated by bars) represents the range in which the true suicide rate falls with 95% certainty.
3. Rates are adjusted for age and sex differences over time. See Appendix B for additional details.

Appendix F: Demographics of Suicide Decedents by Service

Table 12. Active Component Service Member Suicide Counts by Service, Rates per 100,000 Service Members and Percentages, CY 2020[1]

	Army			Navy			Marine Corps			Air Force[84]		
	Count	Percent	Rate	Count	Percent	Rate	Count	Percent	Rate	Count	Percent	Rate
Total	**175**	**100%**	**36.4**	**66**	**100%**	**19.3**	**62**	**100%**	**33.9**	**81**	**100%**	**24.3**
Sex	175	100%	36.4	66	100%	19.3	62	100%	33.9	81	100%	24.3
Male	166	94.9%	40.8	59	89.4%	21.6	55	88.7%	33.1	77	95.1%	29.3
Female	9	5.1%	--	7	10.6%	--	7	11.3%	--	4	4.9%	--
Age Group	175	100%	36.4	66	100%	19.3	62	100%	33.9	81	100%	24.3
17-19	17	9.7%	--	1	1.5%	--	9	14.5%	--	3	3.7%	--
20-24	67	38.3%	44.8	26	39.4%	25.6	36	58.1%	41.2	36	44.4%	37.1
25-29	45	25.7%	39.8	17	25.8%	--	9	14.5%	--	22	27.2%	27.1
30-34	16	9.1%	--	12	18.2%	--	8	12.9%	--	10	12.3%	--
35-39	15	8.6%	--	6	9.1%	--	0	0.0%	--	7	8.6%	--
40-44	10	5.7%	--	4	6.1%	--	0	0.0%	--	2	2.5%	--
45-49	5	2.9%	--	0	0.0%	--	0	0.0%	--	0	0.0%	--
50-54	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%	--
55-59	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%	--
60-74	0	0.0%	--	0	0.0%	--	0	0.0%	--	1	1.2%	--
Race	175	100%	36.4	66	100%	19.3	62	100%	33.9	81	100%	24.3
White	129	73.7%	39.6	46	69.7%	21.9	53	85.5%	36.3	60	74.1%	25.6
Black or African American	33	18.9%	32.2	6	9.1%	--	3	4.8%	--	7	8.6%	--
American Indian/ Alaska Native	3	1.7%	--	0	0.0%	--	1	1.6%	--	4	4.9%	--
Asian/ Pacific Islander	5	2.9%	--	7	10.6%	--	3	4.8%	--	3	3.7%	--
Other/Unknown	5	2.9%	--	7	10.6%	--	2	3.2%	--	7	8.6%	--
Rank	175	100%	36.4	66	100%	19.3	62	100%	33.9	81	100%	24.3
E (Enlisted)	166	94.9%	43.2	62	93.9%	22.0	57	91.9%	35.4	74	91.4%	27.9
E1-E4	89	50.9%	43.2	28	42.4%	22.0	38	61.3%	35.2	45	55.6%	35.4
E5-E9	77	44.0%	43.2	34	51.5%	22.0	19	30.6%	--	29	35.8%	21.0
O (Commissioned Officer)	4	2.3%	--	3	4.5%	--	3	4.8%	--	6	7.4%	--
W (Warrant Officer)	5	2.9%	--	0	0.0%	--	2	3.2%	--	0	0.0%	--
Cadet	0	0.0%	--	1	1.5%	--	0	0.0%	--	1	1.2%	--
Marital Status	175	100%	36.4	66	100%	19.3	62	100%	33.9	81	100%	24.3
Never Married	76	43.4%	36.9	36	54.5%	22.5	29	46.8%	28.0	39	48.1%	28.7
Married	87	49.7%	34.8	28	42.4%	16.8	31	50.0%	42.2	36	44.4%	20.2
Divorced	12	6.9%	--	2	3.0%	--	2	3.2%	--	6	7.4%	--
Widowed	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%	--

1. Source(s): Armed Forces Medical Examiner System (AFMES).

[84] At this time, references to Air Force include Space Force unless otherwise stated.

Table 13. Reserve Service Member Suicide Counts by Service, Rates per 100,000 Service Members and Percentages, CY 2020[1]

	Army Reserve			Navy Reserve			Marine Corps Reserve			Air Force Reserve		
	Count	Percent	Rate	Count	Percent	Rate	Count	Percent	Rate	Count	Percent	Rate
Total	**42**	**100%**	**22.2**	**13**	**100%**	**--**	**10**	**100%**	**--**	**12**	**100%**	**--**
Sex	42	100%	22.2	13	100%	--	10	100%	--	12	100%	--
Male	40	95.2%	28.0	12	92.3%	--	10	100%	--	11	91.7%	--
Female	2	4.8%	--	1	7.7%	--	0	0.0%	--	1	8.3%	--
Age Group	42	100%	22.2	13	100%	--	10	100%	--	12	100%	--
17-19	4	9.5%	--	0	0.0%	--	0	0.0%	--	0	0.0%	--
20-24	10	23.8%	--	4	30.8%	--	6	60.0%	--	0	0.0%	--
25-29	12	28.6%	--	1	7.7%	--	3	30.0%	--	4	33.3%	--
30-34	8	19.0%	--	3	23.1%	--	0	0.0%	--	1	8.3%	--
35-39	1	2.4%	--	2	15.4%	--	0	0.0%	--	1	8.3%	--
40-44	3	7.1%	--	2	15.4%	--	1	10.0%	--	2	16.7%	--
45-49	4	9.5%	--	0	0.0%	--	0	0.0%	--	2	16.7%	--
50-54	0	0.0%	--	0	0.0%	--	0	0.0%	--	2	16.7%	--
55-59	0	0.0%	--	1	7.7%	--	0	0.0%	--	0	0.0%	--
60-74	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%	--
Race	42	100%	22.2	13	100%	--	10	100%	--	12	100%	--
White	29	69.0%	23.5	8	61.5%	--	8	80.0%	--	7	58.3%	--
Black or African American	7	16.7%	--	4	30.8%	--	0	0.0%	--	1	8.3%	--
American Indian/ Alaska Native	1	2.4%	--	1	7.7%	--	1	10.0%	--	1	8.3%	--
Asian/ Pacific Islander	4	9.5%	--	0	0.0%	--	1	10.0%	--	1	8.3%	--
Other/Unknown	1	2.4%	--	0	0.0%	--	0	10.0%	--	2	16.7%	--
Rank	42	100%	22.2	13	100%	--	10	100%	--	12	100%	--
E (Enlisted)	38	88.1%	25.2	12	92.3%	--	9	90.0%	--	10	83.3%	--
E1-E4	27	64.3%	33.0	2	15.4%	--	9	90.0%	--	1	8.3%	--
E5-E9	11	26.2%	--	10	76.9%	--	0	0.0%	--	9	75.0%	--
O (Commissioned Officer)	3	7.1%	--	1	7.7%	--	1	10.0%	--	2	16.7%	--
W (Warrant Officer)	1	2.4%	--	0	0.0%	--	0	0.0%	--	0	0.0%	--
Cadet	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%	--
Marital Status	42	100%	22.2	13	100%	--	10	100%	--	12	100%	--
Never Married	28	66.7%	31.2	5	38.5%	--	8	80.0%	--	3	25.0%	--
Married	14	33.3%	--	8	61.5%	--	2	20.0%	--	7	58.3%	--
Divorced	0	0.0%	--	0	0.0%	--	0	0.0%	--	2	16.7%	--
Widowed	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%	--

1. Source(s): Armed Forces Medical Examiner System (AFMES).

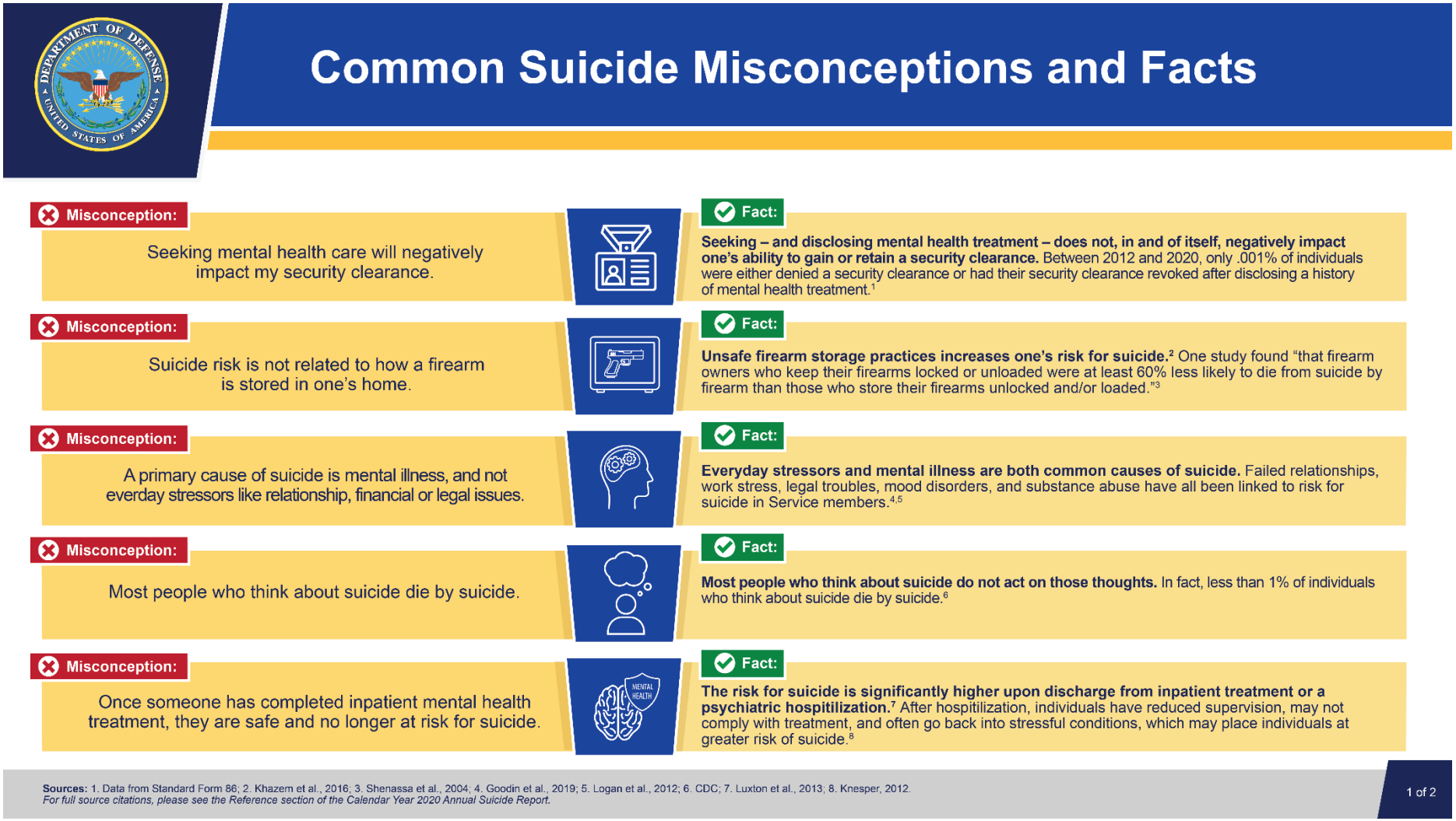
Table 14. National Guard Service Member Suicide Counts by Service, Rates per 100,000 Service Members and Percentages, CY 2020[1]

	Army National Guard			Air National Guard		
	Count	Percent	Rate	Count	Percent	Rate
Total	103	100%	30.9	16	100%	--
Sex	103	100%	30.9	16	100%	--
Male	100	97.1%	36.9	13	81.2%	--
Female	3	2.9%	--	3	18.8%	--
Age Group	103	100%	30.9	16	100%	--
17-19	5	4.9%	--	0	0.0%	--
20-24	36	35.0%	40.5	5	31.2%	--
25-29	24	23.3%	36.6	1	6.2%	--
30-34	17	16.5%	--	1	6.2%	--
35-39	12	11.7%	--	2	12.5%	--
40-44	1	1.0%	--	5	31.2%	--
45-49	5	4.9%	--	1	6.2%	--
50-54	1	1.0%	--	0	0.0%	--
55-59	2	1.9%	--	1	6.2%	--
60-74	0	0.0%	--	0	0.0%	--
Race	103	100%	30.9	16	100%	--
White	81	78.6%	31.7	11	68.8%	--
Black or African American	14	13.6%	--	1	6.2%	--
American Indian/ Alaska Native	4	3.9%	--	1	6.2%	--
Asian/ Pacific Islander	0	0.0%	--	2	12.5%	--
Other/Unknown	4	3.9%	--	1	6.2%	--
Rank	103	100%	30.9	16	100%	--
E (Enlisted)	91	88.3%	31.6	15	93.8%	--
E1-E4	55	53.4%	32.1	5	31.2%	--
E5-E9	36	35.0%	30.7	10	62.5%	--
O (Commissioned Officer)	9	8.7%	--	1	6.2%	--
W (Warrant Officer)	3	2.9%	--	0	0.0%	--
Cadet	0	0.0%	--	0	0.0%	--
Marital Status	103	100%	30.9	16	100%	--
Never Married	66	64.1%	33.9	7	43.8%	--
Married	32	31.1%	26.3	9	56.2%	--
Divorced	5	4.9%	--	0	0.0%	--
Widowed	0	0.0%	--	0	0.0%	--

1. Source(s): Armed Forces Medical Examiner System (AFMES).

Appendix G: Common Suicide Misconceptions

Misconceptions about contextual factors and suicide, more broadly, can hinder suicide prevention efforts in our military community and across our Nation. Knowing the facts may allow us to take life-saving steps to help our loved ones. Given the importance of dispelling misconceptions in suicide prevention, the following section contains five new misconceptions and facts (infographic 1 of 2) as well as several misconceptions that were published in the CY 2019 ASR (infographic 2 of 2; Department of Defense, Under Secretary of Defense for Personnel and Readiness, 2020a).



Common Suicide Misconceptions and Facts

Misconception: Suicide is never impulsive.

Fact:

Research shows it can take less than 10 minutes between thinking about suicide to acting on it. Putting time and distance between a person at risk and a means for suicide is an effective way to prevent death.[1]

Misconception: Suicidal behavior is hereditary.

Fact:

There is no genetic predisposition to suicide – that is, it does not "run in the family." [2] Although there may be over-representation of suicide in some families, behaviors such as suicide ideation and/or attempts do not transmit genetically.[3,4]

Misconception: Only mental health professionals can help individuals who are at risk for suicide.

Fact:

A public health approach to suicide prevention includes mental health professionals, but everyone has a role to play in preventing suicide. For example, financial distress is one of the risk factors for suicide that can be mitigated with help from financial counselors.[5]

Misconception: Owning a firearm is not associated with suicide risk.

Fact:

Owning a firearm does not cause someone to be suicidal; however, there is a considerable amount of research suggesting that **ownership of firearms is associated with a significantly higher risk of suicide.** Studies have estimated having a firearm in the home may make the risk for dying by suicide anywhere from four to six times greater.[6,7]

Misconception: Most military firearm deaths are by combat.

Fact:

Most firearm deaths of Service members are the result of suicide (83.0%), as compared to combat (3.5%), accident (1.8%), homicide (9.3%).[8]

Sources: 1. Simon et al., 2001; 2. Edwards et al., 2019; 3. Brent & Mann, 2006; 4. Cheung et al., 2020; 5. Stone et al., 2017; 6. Dempsey et al., 2019; 7. Simonetti et al., 2020; 8. National Death Index (2013-2017).
For full source citations, please see the Reference section of the Calendar Year 2020 Annual Suicide Report.

Appendix H: Example DoD Initiatives Aligned with the Seven Broad Suicide Prevention Strategies

The Department has a number of efforts underway to support our Service members and military families. The following table provides a description of select initiatives addressing each of the seven broad evidence-informed suicide prevention strategies that align with the Department's approach to suicide prevention. This appendix provides updates to initiatives highlighted in the CY 2019 ASR and introduces new initiatives underway (Department of Defense, Under Secretary of Defense for Personnel and Readiness, 2020a). Please note that these examples are by no means an exhaustive list.

Strengthening Economic Supports	
Financial Literacy *Provides Service members with a variety of financial education resources and programs including the financial readiness common military training. One-on-one personal financial counseling from accredited professionals at installations offered and remotely offered via Military OneSource.* *Aims to increase access and reduce barriers to support, and to develop skills to manage financial stressors particularly among young and enlisted Service members.*	**Status: Ongoing Program.** Results from the CY 2019 Status of Forces Survey of Active Duty Members and the CY 2019 Status of Forces Survey of Reserve Component Members indicated that 72% of Active Component (AC) and 69% of Reserve Component (RC) Service members reported a comfortable financial condition. Moreover, 46% AC and 50% RC reported that their financial condition was better compared to 12 months ago, whereas 39% AC and 35% RC indicated their situation was the same. Results also showed that 83% of both AC and RC Service members had an emergency savings fund and of these, 66% had at least one month of expenses saved. Lastly, 43% of AC and 34% of RC Service members reported using military financial counseling. Based on FY 2020 data, users reported 98% overall satisfaction with Military OneSource financial counseling.
Strengthening Access and Delivery of Suicide Care	
Spouse and Family Issues Survey (SFIS) *First-ever surveys for Active and Reserve Component spouses focused on their suicide ideations, behaviors, and risk and protective factors to inform DoD policies and programs to enhance suicide prevention efforts tailored for military families.* *Aims to increase access to care and reduce barriers to receiving support.*	**Status: New initiative approved, surveys under development.**
Zero Suicide Systems Approach Pilot (ZSSA) *Trains medical personnel on suicide risk assessment and safety planning in Air Force*	**Status: Phase 2 of pilot, ongoing.** The second phase of ZSSA is continuing at one of the five initial pilot locations from Phase 1.

hospitals and clinics. The Phase 1 pilot was implemented at five installations. *Aims to increase access to care and reduce barriers to receiving support.*	
Resources Exist, Asking Can Help (REACH) *Designed to familiarize Service members with help-seeking resources and address their perceived barriers to care. Includes an icebreaker; a short video modeling stressors and problems Service members face; a small group discussion about barriers, solutions, and resources; and a practice call to Military OneSource. Empowers Members to use DoD, Service-specific, and local resources.* *Aims to increase access to resources and reduce barriers to receiving support; develop and enhance skills to address life stressors among young and enlisted Service members.*	**Status: Ongoing, with Phase 1 of pilot and evaluation complete.** REACH was pilot tested at multiple military installations in CY 2020. Results from the CY 2020 evaluation showed that REACH significantly lowered Service members' barriers to seeking care, significantly increased their comfort with reaching out for help in the future, and significantly improved their knowledge of resources. REACH is currently being implemented at select military installations. **New initiative:** Given positive evaluation findings, a web-based REACH Facilitator Training is under development. Further, an additional effort to broaden testing/piloting of REACH, focused on geographically isolated and OCONUS Service members, is underway.
Resources Exist, Asking Can Help–Spouse (REACH-S) *Designed to address spouses' barriers to care, connect them to resources, and increase awareness of self-care practices.* *Also, equips spouses with the knowledge and skills to encourage their Service member to reach out for help.*	**Status: Ongoing.** REACH-S training materials developed and available for implementation. Initial implementation and evaluation plans specific to the Services are in development.
The Veteran Center Outreach Initiative *Enhance National Guard members' access to mental health care and support in remote areas via VA Readjustment Counseling Service (RCS) Vet Centers during training periods. Provides a range of services, including individual, group, and marriage and family counseling, for National Guard members and their families.* *Aims to increase access to care and reduce barriers to receiving support.*	**Status: Ongoing Program.** The NGB and VA have partnered to provide greater access to behavioral health services for National Guard members and their families. There has been a 58% increase in Mobile Vet Center utilization with 6,547 Service members using Mobile Vet Center Services in FY 2020, up from 4,132 in FY 2019. Overall VA Vet Center utilization is up 158% for National Guard members, with 20,977 members using counseling services at National Vet Centers in FY 2020, up from 8,139 in FY 2019.
Victory Wellness Checks	**Status: New initiative, pilot underway.**

Program where Soldiers complete an annual wellness check with a trained counselor on their personal well-being. *Supports personal resilience, promotes personal development, educates Soldiers regarding resources, encourages help-seeking, and reduces stigma for seeking behavioral health services.*	
Creating Protective Environments	
Counseling on Access to Lethal Means Training Pilot *Train non-medical military providers on strategies to reduce access to lethal means and increase safe storage of lethal means.* *Aims to increase awareness of risk factors for suicide and to increase safe storage of lethal means.*	**Status: Phase 2 of pilot, ongoing.** Based on positive program evaluation findings for the Phase 1 Pilot with Military and Family Life Counselors and Military OneSource call center staff, Phase 2 is underway focusing on training other influencers in the military community, such as spouses.
Evidence-Informed Communications Tools for Lethal Means Safety *Reinforces the importance, and the positive impact, of safely storing firearms and medications.* *Aims to increase awareness of risk factors for suicide; increase safe storage of lethal means.*	**Status: New initiative (building from prior efforts below); DoD-wide dissemination of suite of tools began late CY 2021.** Developed and disseminated a suite of evidence-informed communications tools (e.g., a Means Safety Guide for Service Members and Families, Means Safety Public Service Announcement for Family Safety, and Prevention of Suicide by Firearm: A Communication Guide for Military Leaders and Support Providers).
Social Norms for Safe Firearm Storage *Provides messaging on safe firearm storage to promote firearm safety practices as an acceptable norm and to decrease risk for suicide.*	**Status: Complete.** Research tested firearm safety messages at multiple military installations to learn which safety messages resonate with Service members. Evidence-based messages to encourage safe firearm storage were included within suite of evidence-informed communications tools described above.
Lethal Means Safety Video *Video to encourages military families to keep methods of suicide safe and secure.*	**Status: Complete.** Video developed and included within suite of evidence-informed communications tools described above.
Firearm Safety Training Pilot	**Status: Newly approved initiative, in development.**

Designed to integrate suicide prevention curriculum into firearms safety training for Service members. *Aims to increase awareness of risk factors for suicide; increase safe storage of lethal means.*	
Suicide Prevention Plan Pilot *Designed to test and evaluate new initiatives in an operational environment, in order to receive critical feedback from Soldiers and Leaders, reduce high risk behaviors and psychological health problems, and increase unit cohesion, trust, coping skills, and communication skills.*	**Status: Ongoing. Pilot began in 2019 and expected to be completed by CY 2022.** The Army is currently conducting this pilot at Forts Bliss, Campbell, Hood, and select companies in the Army Reserve (Texas) and the Army National Guard (South Carolina). The results of the pilot will inform the decision on whether to begin implementing more broadly.
TeamCORE Evaluation *A two-hour, platoon-level training with a focus on fortifying unit cohesion through instruction about social isolation, unit culture, connections, trust, and communication.* *There is an additional one-hour leader module to help platoon leadership develop personalized plans for their unit. The training is derived from Social Fitness Training created by University of Chicago, and validated with an active duty population.*	**Status: Ongoing. Pilot began in 2019 and expected to be completed by CY 2021.** WRAIR is conducting an evaluation of Team Cohesion and Organizational Readiness Enhancement (TeamCORE). A pilot of the curriculum was conducted in 2019 and a modified version of the curriculum has been developed for assessment in 2021. Evaluation results are not yet available.
Time-Based Prevention *Time-based prevention efforts include marketing/communications, educational information, policy, and physical barriers (distribution of cable-style locks).* *Aims to increase awareness of risk factors for suicide; increase safe storage of lethal means—by going SLO—using Safes, Locks, or Outside the home storage options.*	**Status: Ongoing. Began in CY 2019.**
Promoting Connectedness	
Peer-to-Peer Support through Military OneSource *Offers confidential, peer-to-peer specialty consultations to Service members. Military OneSource consultants are Veterans, National*	**Status: Ongoing Program.** The Military OneSource program tracks satisfaction measures and program outcomes on a monthly basis. In FY 2020, Military OneSource provided 14% more (804) peer support consultations compared to 2019 (705). Military OneSource users

Guard/Reserve members, and military spouses. *Aims to increase connectedness, and access and reduce barriers to receiving support.*	reported 97% overall satisfaction with specialty consultations, including peer support services.
Non-Medical Counseling *Delivers valuable face-to-face counseling services, briefings, and presentations to the military community both on and off the installation by Military and Family Life Counselors (MFLCs) trained to work with the military community.* *Aims to increase connectedness, and access and reduce barriers to receiving support.*	**Status: Ongoing Program.** More than 90% of participants reported positive experiences with non-medical counseling provided through MFLC and Military OneSource programs (e.g., how quickly they were connected to a counselor; how easy it was to make an appointment; continuity of care and confidentiality they received), and reported they were likely to use the non-medical counseling services again.
Teaching Coping and Problem-Solving Skills	
Rational Thinking—Emotional Regulation—Problem-Solving (REPS) Training Pilot *Interactive educational program to teach foundational skills to deal with life stressors early in military career.* *Aims to develop and enhance skills to address life stressors among young and enlisted Service members in particular.*	**Status: Pilot and evaluation of in-person curriculum nearing completion (with expected completion late CY 2021).** Data collection and evaluation delayed due to the COVID-19 pandemic. **New Initiative:** Based on preliminary initial findings, an online REPS curriculum is underway for piloting.
Ready and Resilient Quality Control Evaluation *Institutional Resilience Training (IRT) is conducted at each Army Professional Military Education level as Soldiers progress through their careers.* *IRT is sequential and progressive so the skills and concepts delivered at each rank are appropriate to the challenges Soldiers are most likely to encounter in the next phase of their careers.*	**Status: Ongoing.** WRAIR is currently conducting a program evaluation of the IRT.
Identifying and Supporting People at Risk	
Service Member Gatekeeper and Leadership Interventions *Question-Persuade-Refer (QPR) training teaches Service members and others, including chaplains, to act as "gatekeepers" for*	**Status: Ongoing Programs.** According to recent Status of Forces Survey of Active Duty Members 2019 data, 64% of Service members indicated suicide prevention training was at least somewhat helpful (and of those, 36%

individuals at risk and detect behavior changes or warning signs. *Aims to increase awareness of risk factors for suicide.*	indicating it was very to extremely helpful) in identifying and responding to suicidal behavior in others.
Recognizing the Signs of Intent to Die by Suicide on Social Media Training Pilot *Teaches Service members how to recognize and respond to suicide warning signs on social media.* *Aims to increase awareness of risk factors for suicide among young and enlisted Service members in particular.*	**Status: Complete.** Pilot was conducted in CY 2020 through early CY 2021. Pilot evaluation results indicated that most participants (over 80%) found the video useful in learning to how to recognize and respond when someone's social media posts indicate life stress and risk for suicide. Given the positive evaluation findings, this training video was disseminated in CY 2021 to be used and promoted by leaders and commanders throughout the Department.
Chaplains-CARE Training Pilot *Teaches chaplains cognitive behavioral strategies aimed at reducing suicide risk.* *Aims to enhance existing suicide prevention efforts by systematically producing an evidence-informed cognitive behavioral suicide prevention guide culturally adapted for use by military chaplains and religious affairs specialists.*	**Status: Ongoing.** Pilot and evaluation of in-person curriculum complete with positive results. The online version of the course has been developed and is available through MilLife. Pilot and evaluation of online curriculum nearing completion (with expected completion late CY 2021).
Suicide Prevention and Readiness Initiative for the National Guard (SPRING) *Leverages a data-driven, holistic approach for data collection and predictive analytics.* *Aims to increase awareness of risk factors for suicide***.**	**Status: Ongoing.** In CY 2020, the National Guard Bureau (NGB) initiated the rollout of the SPRING board pilot. During the year, National Guard leaders representing 35 states received training on the tool. In addition, NGB began using military health data in addition to augmenting its publicly available data at the county and state levels.
Signs of Suicide (SOS) for Secondary Students in DoD Schools *Aims to increase awareness of warning signs for suicide and how to ACT (Acknowledge, Care, Tell) to connect at-risk students with a trusted adult if they are worried about themselves or friends.* *Aims to decrease suicide and suicide attempts by increasing student knowledge and adaptive attitudes about depression; to encourage help-*	**Status: Ongoing.** Department of Defense Educational Activity (DoDEA) implemented the SOS program during school year 2020–2021. Based on CY 2020 evaluation data, at least one educator at each DoDEA secondary school completed the SOS facilitator professional learning during school year 2020-2021. The average score earned on the Professional Learner SOS Knowledge Check was 90%.

seeking for oneself or on behalf of a friend; to reduce the stigma of mental illness and acknowledge the importance of seeking help or treatment, and to engage parents and the school staff as partners in prevention. *In the Fall of CY 2020, the middle and high school virtual SOS curriculum was released. This curriculum had the same learning objectives, minus the depression screener, which facilitators must administer in person.*	Data also show the SOS curriculum was accessed at 100% of DoDEA's middle and high schools, including the DoDEA Virtual High School. The middle and high school In-Person SOS Classroom Curriculum was accessed by DoDEA educators 6,842 times, and the Virtual SOS Classroom Curriculum was accessed by DoDEA educators 3,118 times.
Behavioral Health Readiness and Suicide Risk Reduction Review (R4) *The Secretary of the Army directed: (1) the development of a tool to assist military first line leaders with cutting-edge scientific and practical knowledge necessary for suicide prevention, and (2) the resulting tools (R4) be studied as a pilot intervention. The R4 tool supports a process designed to improve the Army's current tool-based methods for identifying and optimizing the behavioral health and welfare of Soldiers at risk for suicide.*	**Status: Ongoing. Began in 2019 and expected to be completed by late CY 2021.** The R4 study is an evaluation of the tool and associated training. To date, thousands of Service Members have reported using the R4 tool and processes. Results of the evaluation are expected by late CY 2021.
Family Suicide Prevention Training *Designed to equip family members with the necessary skills to help prevent suicide.* *The training focuses on recognizing the signs of distress and educating viewers on available resources. It also provides strategies for strengthening relationships and connectedness among family members and loved ones.*	**Status: New initiative.** The Department of the Air Force established a Family Suicide Prevention Training to equip family members with the necessary skills to help prevent suicide.
Lessening Harms and Preventing Future Risk	
Safe Messaging and Reporting on Military Suicide *Aims to ensure safe reporting guidelines are followed by media and DoD leaders when reporting or talking about DoD suicide deaths.* *Aims to increase safe message of suicide and awareness of risk factors for suicide.*	**Status**: **Complete.** A collaborative effort to ensure national safe reporting guidelines are understood and followed by Service Public Affairs Officers and DoD leaders. Completed a *Leaders Suicide Prevention Safe Messaging Guide* that was disseminated in CY 2021 to be used and promoted by leaders and commanders throughout the Department.

Department of Defense-Wide Annual Suicide Death Review Methodology *Develop a DoD-wide standardized and unified public health theory-guided methodology to perform military suicide death reviews.* *Aims to develop lessons learned to apply to future suicide prevention efforts.*	**Status: Ongoing.** In CY 2020, suicide experts began review panels of suicide death cases to pilot test the methodology. Review panel work of additional cases is in progress (with expected completion of project late CY 2022 due to delays associated with the COVID-19 pandemic). Individual-, Service-, and DoD-level results of the panels will provide lessons learned and recommendations for future actions.

Appendix I: Chaplains and Other Spiritual Resources

Spirituality is one of the domains of Total Fitness of Service members and the Department recognizes and encourages spirituality as a coping modality that is protective to military personnel. Research indicates that spirituality and religious service attendance are associated with fewer divorces, better social support, and greater satisfaction with life—all of which help reduce the risk for suicide (Júnior et al., 2020; VanderWeele, 2017; VanderWeele et al., 2016). More recently, many have turned to spirituality as a means to navigate the challenges posed by the COVID-19 pandemic (del Castillo, 2021; Roman et al., 2020). Chaplains play an important role in the promotion of spiritual well-being among Service members and their families, as well as the prevention of risk factors for suicide. Chaplains have been shown to be a first line of defense when it comes to caring for Service members who are coping with mental health issues (Kopacz et al., 2016) and with suicide ideation.

Chaplains promote spiritual fitness and resilience by integrating within units to provide religious and spiritual support, coordinating with support agencies in the community, and acting as primary advisors to commands at every echelon on religion, morals, ethics, and morale. Chaplains serve as an important resource to the military community, starting with basic training and continuing throughout a Service member's military lifecycle. Service members and their families are made aware of chaplains and the services they provide through email, chapel websites, social media, and face-to-face visits. Chaplains have long served as a key component in addressing mental health concerns and prevention of suicide.

Given the privileged communication of one-on-one interactions, limited data are collected for individuals who receive services from chaplains. However, surveys show that Service members have access to these resources and find them useful. The 2019 Status of Forces Survey of Active Duty Members (SOFS-A) found that 18% of Active Component Service members talked to a counselor within the past six months. Among those Service members, 32% talked to a military chaplain or civilian religious or spiritual leader, and, of these, 83% found it useful. Similarly, the 2018 Status of Forces Survey of Reserve Component Members (SOFS-R) found that 10% of Reserve Component Service members saw a military chaplain in the past two years and 94% were satisfied with the services provided.[85]

Some of the Department's key spiritual services, resources, and programs, as well as training provided to chaplains to enhance their knowledge and skills with regard to suicide prevention, are highlighted below.

Integration into Communities

Chaplains occupy a crucial role as members of installation-based, multidisciplinary teams and councils that help promote an understanding of the potential for suicide in the community. The Navy and Marine Corps continue to support the work of chaplains through Navy Safe Harbor and the Wounded Warrior Battalion, respectively. Through these programs, chaplains deliver pastoral care to those who may be at risk for suicide secondary to exposure to trauma. Further, the Navy and Marine Corps include chaplains as key members of their suicide response teams to provide postvention support and reduce the potential risk of contagion effects. These teams respond to any known or suspected suicide by offering additional support to unit commanders, ensuring that proper guidelines are followed for local media coverage, and monitoring completion and submission of appropriate reports. The Air Force Chaplain Corps program increased access to mental health services in CY 2020 by integrating religious support teams (RST) in units, and coordinating and fostering

[85] The SOFS-R assesses utilization of military programs or services, including military chaplains. This survey does not assess Reserve Component Service member utilization of civilian religious or spiritual leaders.

cooperation and communication with other helping agencies by involving chaplains in Community Action Boards and the Community Action Teams.[86]

Protective Factor Identification and Promotion

Chaplains support Service-wide efforts to identify factors that may reduce an individual's risk for suicide and develop initiatives to promote these protective factors. A few examples are highlighted below.

The Army developed two programmatic models aimed at enhancing resilience and decreasing suicide risk using chaplains as force multipliers and direct resources for Soldiers. The Strong Bonds Program is an Army-wide model wherein chaplains are encouraged to coordinate with local commands and garrisons to develop contextualized religious and spiritual programs that increase wellness and spiritual fitness tailored to local needs. Building on the theme of research on the value of protective factors, the Army has partnered with academic scholars and experts at Columbia University to develop the Chaplain Corps Spiritual Well-Being Initiative. A Spirituality and Suicide Prevention pilot program is also currently being conducted.

The Air Force's spiritual programs include marriage and family retreats/workshops, singles programming, Chaplain Corps-facilitated podcasts on resiliency topics, and SafeTALK/Applied Suicide Intervention Skills Training led by chapel personnel to equip Service members with skills for suicide intervention. The Air Force Chaplains Corps' RSTs use virtual reality technology in deployed settings to help support Service members and provide virtual connections with family back home.

As a final example, Navy chaplains work closely with recruits at boot camp through the Warrior Toughness program to equip Sailors with resources and coping skills even before they are sent to their first assignment.

Training for Chaplains

Chaplains receive continuous training related to suicide prevention to ensure they are able to respond to the military community's evolving needs. For example, Army chaplains are trained in advanced counseling practice through their attainment of marriage and family counseling, psychotherapy, and clinical counseling degrees/certifications in addition to their general pastoral responsibilities. Navy personnel have access to Chaplains Religious Development Operation (CREDO) retreats; during the COVID-19 pandemic, these retreats were delivered in a virtual seminar format to continue providing services to Sailors. In 2020, the Air Force developed and rolled out Strong Bonds, a spiritual fitness training program for chaplains. By the end of FY 2020, a total of 700 Chaplain Corps personnel were trained and will themselves have provided at least two training courses to Airmen, Guardians, and their families. The Air Force also launched the Let's Talk campaign to advertise availability of RSTs. Chaplains enhanced their training to include the use of avatar-based scenarios to develop skills in working with distressed Airmen. This practice was extended to include delivery of virtual spiritual counseling and support in a manner akin to telehealth/telemedicine practice.

All of the Military Services also have implemented the *Question-Persuade-Refer* training framework as part of their suicide prevention efforts to empower Service members and others in the military community, including chaplains, to act as "gatekeepers" to recognize the warning signs of suicide, ask individuals in trouble if they are suicidal, and refer the individual to a trained helping professional. Other ongoing training efforts have included the *Training Chaplains in Evidence-Based and Integrated*

[86] At this time, references to Air Force include Space Force unless otherwise stated.

Care to Promote Suicide Prevention training *and Mental Health* and a *Special Operations Command Suicide Prevention Workbook for Chaplains*.[87]

The Department has also continued to promote and provide resources that are available to chaplains addressing a range of topics, as well as to pilot new efforts to further enhance our chaplains' skillsets with respect to suicide prevention. For example, the *Postvention Toolkit for a Military Suicide Loss,* published in July 2020, provides a comprehensive, evidence-informed guide to providing postvention services and bereavement support to unit members and next-of-kin who survive military suicide loss. This toolkit was developed for unit commanders, chaplains, first responders, and other key stakeholders. Based on Service feedback for CY 2020 utilization, this tool has been adopted, adapted, or shared alongside Service-specific postvention resources to audiences that include chaplains. In addition, the Department has also made available to chaplains and other stakeholders resources specific to identifying risk and warning signs, social media strategies, coping strategies, and tips on staying safe and connected during the pandemic—all of which have reinforced the Department's 2020 campaign *Connect to Protect* emphasizing proactive connection with peers, families, caregivers, and the community, as well as suicide prevention resources.[88] Finally, another example is the *Cognitive Behavioral Strategies for Suicide Prevention Training* pilot, which is a self-paced, e-learning course developed in collaboration with military chaplains to enhance chaplains' knowledge, skills, and abilities to intervene with Service members at risk for suicide. This pilot is expected to be completed in late CY 2021 and results will inform the decision to implement this training more broadly across DoD.

Chaplains will continue to play a critical role in meeting the spiritual and counseling needs of military members. Their activities enhance Service members' well-being, connectedness, and resilience as well as support the Department's overall goal to prevent suicide.

[87] For additional information about the noted training, please access DoD's CY 2019 ASR at https://www.dspo.mil/Portals/113/Documents/CY2019%20Suicide%20Report/DoD%20Calendar%20Year%20CY%202019%20Annual%20Suicide%20Report.pdf?ver=YOA4IZVcVA9mzwtsfdO5Ew%3d%3d

[88] For additional information about or to access these resources, please visit https://www.dspo.mil/download/

Appendix J: CY 2019 Proximal Outcomes Data

Suicide is a complex and multifaceted phenomenon that requires a comprehensive, holistic approach to prevention. Collectively, DoD policy, programs, and initiatives are designed to address various suicide risk and protective factors that have been shown to impact suicide within our military community. Likewise, our program evaluation efforts must account for such complex suicide risk and protective factors, examining the effectiveness of our ongoing suicide prevention efforts more holistically as a collective system. To evaluate the effectiveness of its suicide prevention efforts, the Department uses an enterprise-wide program evaluation framework, which integrates the seven broad, evidence-informed strategies from CDC, and is aligned with the 2015 Defense Strategy for Suicide Prevention (DSSP) goals.

The following table provides examples of metrics for our suicide prevention efforts that align with proximal outcomes for each of the seven broad strategies. It includes examples of suicide prevention initiatives underway that align with each strategy and are designed to impact the proximal outcomes; these illustrative examples are by no means an exhaustive list.

In this section of the report, we present CY 2019 data,[89] which is temporally aligned with the start of these programs and initiatives in CY 2018 (i.e., preceding enterprise-wide implementation, many of these programs and initiatives were rolled-out only in select locations throughout CY 2018).[90,91] As such, the data presented here are strictly for the purposes of descriptive comparisons between CY 2018 and CY 2019 and should not be used or interpreted as an indication of program effectiveness. These descriptive comparisons are not intended to represent findings indicative of a full program evaluation. Future ASRs will be better equipped to evaluate the effectiveness of programs or initiatives instituted enterprise-wide in CY 2019. Still, these descriptive comparisons between CY 2018 and CY 2019 allow for a degree of insight into the status of the Total Force on various proximal outcomes.

[89] This represents the most recent data available for analysis at the time of writing this report.
[90] Please note that the CY 2018 baseline metrics have slight variations as reported in the CY 2019 ASR and the CY 2020 ASR due to small difference in rounding percentages. This has no significant impact on the data.
[91] Please note that the CY 2019 ASR included some Defense Organizational Climate Survey (DEOCS) metrics; however, the CY 2020 ASR does not include these DEOCS metrics due to the Department's effort to revitalize this survey. As such, data collected using the revised DEOCS are not comparable to data from previous administrations of the DEOCS.

1. Strengthen Economic Supports				
Example DoD Initiatives • Financial Readiness Required Common Military Training • Financial Counseling (Installation and Military OneSource)		**Proximal Outcomes** • Increased Access to Financial Support • Decreased Financial Stressors		
Metric	**Data Source/ Population**	**Baseline (2018)**	**2019**	**Implication**
Compared to 12 months ago, Service members' financial situation was much worse or somewhat worse.	Active Component SOFS-A	17% overall 18% enlisted 12% officers	15% overall 16% enlisted 10% officers	Reducing financial stressors may result in an increase in economic security, which can lead to a reduction in suicide-related behaviors.
	Reserve Component SOFS-R	15% overall 15% enlisted 12% officers	14% overall 15% enlisted 10% officers	
Compared to 12 months ago, Service members' financial situation was much better or somewhat better.	Active Component SOFS-A	42% overall 42% enlisted 41% officers	46% overall 46% enlisted 45% officers	
	Reserve Component SOFS-R	46% overall 46% enlisted 47% officers	50% overall 50% enlisted 49% officers	
Service members experienced excessive debt or bankruptcy within 90 days prior to the suicide event.[92]	Active Component DODSER	5% of suicide decedents 5% of Service members who attempted suicide	5% of suicide decedents 6% of Service members who attempted suicide	
	Reserve Component DODSER	10% of suicide decedents 12% of Service members who attempted suicide	7% of suicide decedents 7% of Service members who attempted suicide	

[92] Economic and financial strain, when combined with other factors, may increase an individual's risk for suicide or may indirectly increase risk by exacerbating related physical and mental health concerns (Ursano, Kessler, Stein, et al., 2016).

2. Strengthen Access and Delivery of Suicide Care					
Example DoD Initiatives • Resources Exist, Asking Can Help (REACH) Training • National Guard Bureau and VA Readjustment Counseling Service (RCS) Vet Center Initiative			**Proximal Outcomes** • Improved Access to Resources and Care • Reduced Barriers to Care • Increased Help-Seeking		
Metric		**Data Source/ Population**	**Baseline (2018)**	**2019**	**Implication**
In the past six months, Service members talked to a counselor.[93]		Active Component SOFS-A	16% overall 17% enlisted 12% officers	18% overall 19% enlisted 15% officers	Reducing perceived barriers to help-seeking may result in an increase of Service members at risk for suicide who access resources and care, which can lead to a reduction in suicide-related behaviors.
Reasons for not seeking help with personal problems	Loss of privacy/ confidentiality	Active Component SOFS-A	68% overall 66% enlisted 73% officers	69% overall 69% enlisted 73% officers	
	Fear of being perceived as "broken" by chain of command or peers	Active Component SOFS-A	67% overall 65% enlisted 74% officers	71% overall 70% enlisted 73% officers	
	Negative impact to career	Active Component SOFS-A	65% overall 63% enlisted 72% officers	68% overall 67% enlisted 72% officers	
	Not knowing who to turn to	Active Component SOFS-A	50% overall 51% enlisted 44% officers	49% overall 51% enlisted 42% officers	

[93] The Status of Forces Survey for Active Duty Members (SOFS-A) does not define counselor, and may include military and civilian, medical or non-medical, providers.

3. Create Protective Environments					
Example DoD Initiatives • Counseling on Access to Lethal Means (CALM) Training • Evidence-Informed Communication Tools for Lethal Means Safety			**Proximal Outcomes** • Reduced Lethality of Suicidal Behavior • Increased Safe Storage Practices		
Metric		**Data Source/ Population**	**Baseline (CY 2018)**	**CY 2019**	**Implication**
Method of death/injury is a proxy for lethality. Most common methods of suicide behavior.[94]	Firearms	Active Component DODSER	60% of suicide decedents	60% of suicide decedents	Decreasing access to firearms and other lethal means may result in a reduction in deaths by suicide and other suicidal behavior.
	Drugs/alcohol	Active Component DODSER	60% of those who attempted suicide	53% of those who attempted suicide	
	Firearms	Reserve Component DODSER	80% of suicide decedents	68% of suicide decedents	
	Drugs/alcohol	Reserve Component DODSER	51% of those who attempted suicide	47% of those who attempted suicide	

[94] A study examining lethality rates for suicide methods found firearms to be most lethal—at 90% lethal—followed by hanging (53%) and drugs (2%; Conner, Azrael, & Miller, 2019). If access to the most lethal means of suicide is limited, then other means are not substituted; therefore, the suicide rate may reduce (Owens, Horrocks, & House, 2002; Barber & Miller, 2014).

4. Promote Connectedness				
Example DoD Initiatives • Peer-to-Peer Support through Military OneSource • Non-Medical Counseling		**Proximal Outcomes** • Increased Feelings of Connectedness • Increased Unit Cohesion • Increased Morale		
Metric	**Data Source/ Population**	**Baseline (2018)**	**2019**	**Implication**
Service members reported a moderate to high level of morale.	Active Component SOFS-A	76% overall 74% enlisted 85% officer	Metric not available[95]	An increase in feelings of connectedness can serve as a protective factor against suicide risk factors, which can lead to a reduction in suicide-related behaviors.
Service members reported satisfaction with their unit's morale.	Reserve Component SOFS-R[96]	56% overall 54% enlisted 67% officer	Metric not available[97]	

[95] This is a rotational item and was not included on the CY 2019 SOFS.
[96] Note that the Active Component and Reserve Component metrics for unit morale are not comparable as different scales were used to assess unit morale across the Status of Forces Survey of Reserve Component Members (SOFS-R) and SOFS-A.
[97] This is a rotational item and was not included on the CY 2019 SOFS.

5. Teach Coping and Problem-Solving Skills					
Example DoD Initiatives • Rational Thinking – Emotional Regulation – Problem-Solving (REPS) Training Pilot			**Proximal Outcomes** • Increased Knowledge of Coping and Problem-Solving Skills • Decreased Undesirable Coping Strategies • Decreased Feelings of Hopelessness		
Metric		**Data Source/ Population**	**Baseline (2018)**	**2019**	**Implication**
In the past six months, Service members talked to a counselor…[98]		Active Component SOFS-A	16% overall 17% enlisted 12% officers	18% overall 19% enlisted 15% officers	Decreasing undesirable coping and strategies and replacing them with coping and problem-solving skills can result in a decreased risk for suicide.
Most common topics discussed with a counselor	Coping with stress	Active Component SOFS-A	77% overall 77% enlisted 75% officers	80% overall 81% enlisted 78% officers	
	Problem-solving	Active Component SOFS-A	53% overall 55% enlisted 41% officers	48% overall 50% enlisted 38% officers	
	Family issues	Active Component SOFS-A	51% overall 50% enlisted 54% officers	51% overall 49% enlisted 60% officers	
Reported strategies when asked how they *would likely respond if* they felt trapped or stuck in a stressful situation.	Dealing with the situation on their own	Active Component SOFS-A	77% overall 75% enlisted 84% officers	77% overall 75% enlisted 85% officers	
	Ignoring the situation	Active Component SOFS-A	26% overall 27% enlisted 20% officers	28% overall 29% enlisted 22% officers	
	Using alcohol or drugs to cope	Active Component SOFS-A	13% overall 14% enlisted 9% officers	15% overall 16% enlisted 12% officers	

[98] The SOFS-A does not define counselor, and may include military and civilian, medical or non-medical, providers.

6. Identify and Support People at Risk				
Example DoD Initiatives • Service Member Gatekeeper and Leadership Interventions • Social Media Training Pilot • Cognitive Behavior Strategies for the Prevention of Suicide Training Pilot • National Guard Bureau Suicide Prevention and Readiness Initiative for the National Guard (SPRING)		**Proximal Outcomes** • Increased Knowledge to Identify and Respond to At-Risk Individuals • Improved Access to Resources and Care		
Metric	**Data Source/ Population**	**Baseline (2018)**	**2019**	**Implication**
Service members reported that suicide prevention training was at least somewhat helpful in identifying behaviors in others.	Active Component SOFS-A	78% overall 81% enlisted 69% officers	75% overall 77% enlisted 68% officers	Suicide prevention training and awareness can result in an increased number of people identified at risk for suicide.

7. Lessen Harms and Prevent Future Risk				
Example DoD Initiatives • Safe Messaging and Reporting on Military Suicide • Postvention Toolkit		**Proximal Outcomes** • Improved Responsible Reporting of DoD Suicide • Increased Access to Postvention Care		
Metric	**Data Source/ Population**	**Baseline (CY 2018)**	**CY 2019**	**Implication**
A representative sample of military suicide news articles was compiled, evaluated, and rated for how compliant they were with safe reporting guidelines.[99]	DSPO (2021)[100]	On average, articles reporting on military suicide from the fourth quarter of 2018 were 74% compliant with safe reporting guidelines. Most of the news articles violated about five out of 18 guidelines (World Health Organization, 2017). Guidelines such as *providing help or prevention resources* and *educating the public about suicide* were most likely to be violated.	On average, articles reporting on military suicide from the fourth quarter of 2019 were 74% compliant with safe reporting guidelines. Most of the news articles violated about five out of 18 guidelines. Guidelines such as *providing help or prevention resources* and *educating the public about suicide* were most likely to be violated. The average compliance score across the sample of articles for the entire calendar year was 75%. This indicates that the majority of articles in the sample were in compliance with the majority of (but not all) safe reporting practices.	Reducing the number of media outlets that violate Safe Reporting on Suicide Guidelines will increase compliance and will improve responsible reporting and potentially decrease contagion of suicide behavior.

[99] Media coverage of suicide can negatively impact behavior by contributing to contagion or can positively encourage help-seeking (Bohan & Wang, 2012).
[100] Defense Suicide Prevention Office (DSPO). *Media Scoring Project: Media Coverage of Military Suicide—Compliance with Safe Reporting Practices: CY 2019: Quarter 3 & 4—Year End Report*. May 3, 2021.

Appendix K: Research Collaborations and Data Sharing

The science and practice of suicide prevention depends on a broad community of interdisciplinary researchers in collaboration with each other to draw out the best of government, academia, and industry. Robust collaborations on suicide prevention research and data sharing continued in CY 2020. The following pages are examples of research collaborations and data sharing that occurred in CY 2020 across the Department and beyond. Any listing of or reference to a nonfederal entity does not imply or constitute an endorsement of that entity by the Department of Defense.

	Example Collaborators (not exhaustive)	Across DoD	VA	Other Federal Agencies	Academia	NGOs
Executive Order 13822 – Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life: Interagency effort to develop and implement a Joint Action Plan to ensure seamless access to mental health care and suicide prevention resources for transitioning Service members and Veterans during their first year after retirement or separation from the military.	• DoD • Military Services • VA • DHS	✓	✓	✓	✓	

	Example Collaborators (not exhaustive)	Across DoD	VA	Other Federal Agencies	Academia	NGOs
Executive Order 13861 – President's Roadmap to Empower Veterans and End a National Tragedy of Suicide: Interagency effort, along with state, local, and private sector organizations, to develop and implement a national, comprehensive roadmap to prevent suicide among our Veterans and all Americans, including our military community.	• Department of Defense (DoD)[101] • Military Services[102] • Department of Veterans Affairs (VA) • Department of Health and Human Services (HHS)[103] • Department of Labor (DOL) • Department of Education (ED) • Department of Homeland Security (DHS) • Harvard University • University of Oxford • American Foundation for Suicide Prevention (AFSP)	✓	✓	✓	✓	✓
Executive Order 13625 – Improving Access to Mental Health Services for Veterans, Service Members, and Military Families: Interagency effort to ensure that Veterans, Service members, and their families have access to needed mental health services and support; included the development of the National Research Action Plan.	• DoD • VA • HHS	✓	✓	✓	✓	
Suicide Prevention Research Impact Network (SPRINT): Collaborative network of VA and non-VA researchers dedicated to conducting high-	• DoD • VA • HHS	✓	✓	✓	✓	

[101] DoD could include the Defense Suicide Prevention Office (DSPO), Defense Health Agency (DHA), Office of Force Resiliency (OFR), Defense Human Resources Activity (DHRA), Uniformed Services University of Health Sciences (USUHS), Psychological Heath Center of Excellence (PHCoE), Military Community and Family Policy (MCFP), Office of People Analytics (OPA), Defense Equal Opportunity Management Institute (DEOMI), and Military Operational Medicine Research Program (MOMRP), among others.

[102] The Military Services may include the Army, Navy, Marine Corps, Air Force, National Guard, and Reserve Components. At this time, references to the Air Force include Space Force unless otherwise stated.

[103] The CDC and the National Institutes of Health (NIH) fall under HHS.

	Example Collaborators (not exhaustive)	Across DoD	VA	Other Federal Agencies	Academia	NGOs
quality, high-priority, and high-impact suicide prevention services research.	• University of Michigan					
The National Action Alliance for Suicide Prevention: Brings together more than 250 national partners from public and private sectors to advance the National Strategy for Suicide Prevention, including sharing of the latest research findings and potential research opportunities.	• DoD • VA • HHS • Tragedy Assistance Program for Survivors (TAPS) • Kaiser Permanente	✓	✓	✓	✓	✓
DoD/VA Suicide Prevention Conference: DoD and VA host a biennial suicide prevention conference, representing the only national conference that specifically addresses suicide in the military and Veteran populations. The conference provides an opportunity for the public and private sectors to share their expertise and learn about the latest research and promising practices for preventing suicide among our military and Veteran communities. The most recent conference took place in CY21, with the next upcoming edition scheduled for CY23.	• DoD • Military Services • VA • HHS • SAMHSA • Multiple Universities • TAPS • Psych Armor • National Shooting Sports Foundation • Elizabeth Dole Foundation • Education Development Center • Military Family Advisory Network	✓	✓	✓	✓	✓
Assessing Social and Community Environments with National Data (ASCEND): ASCEND is a Veteran suicide prevention project supported by a Federal partner engagement team (National Institute of Mental Health, CDC, Substance Abuse and Mental Health Services Administration, DSPO, VA and DoD Study to	• DoD • VA • HHS • Military Services • University of Michigan • Harvard University	✓	✓	✓	✓	

	Example Collaborators (not exhaustive)	Across DoD	VA	Other Federal Agencies	Academia	NGOs
Assess Risk and Resilience in Service Members (STARRS)). Goals include establishing a nationally representative survey of Veterans (not just those enrolled with VA), using community-based participatory methods to engage Veterans, leveraging the surveys as a national surveillance system, and estimating the impact of social and community risk and protective factors on Veteran suicidal thoughts and behaviors.						
Federal Reporter (DoD Suicide Prevention): This database maintains information on suicide prevention research projects sponsored by various Federal agencies. Sharing this information with the public, researchers and agencies allows the scientific community to maintain awareness of past and ongoing research projects and identify gaps for future investigations, facilitates interagency collaboration, reduces redundancies of effort, and ultimately accelerates scientific discovery.	• DoD • VA • Multiple universities	✓	✓	✓	✓	
DoD and VA Military Mortality Database: This database is the only existing mortality database that includes all causes of death for individuals with a history of military service, merging existing data from DoD and VA with death records acquired by CDC. DoD and VA jointly manage access to this database for DoD and VA researchers.	• DoD • VA • HHS • Multiple universities	✓	✓	✓	✓	
Military Suicide Research Gaps Analysis CY 2019 –2020: A large-scale analytic project to	• DoD • VA	✓	✓		✓	

	Example Collaborators (not exhaustive)	Across DoD	VA	Other Federal Agencies	Academia	NGOs
identify and prioritize gaps in military suicide research. Key collaborative contributions to the prioritization process have been made by 19 external subjects matter experts across DoD, VA, and academic institutions.	• Multiple universities					
National Institute of Mental Health (NIMH) Suicide Prevention Database: National Action Alliance for Suicide Prevention Research Prioritization Task Force, led by NIMH, developed a prioritized research agenda that aimed to determine how recently funded U.S. studies could be leveraged. The Research Prioritization Task Force collected information from Federal (including DoD, VA, National Institute of Health, CDC, and others) and non-Federal funders to categorize and characterize suicide prevention research studies and conduct a portfolio and gap analysis.	• DoD • HHS • VA • AFSP	✓	✓	✓		✓
Study to Assess Risk and Resilience in Service Members–Longitudinal Study (STARRS-LS): This DoD-funded longitudinal research study is focused on creating practical, actionable information on risk reduction and resilience-building for suicide, suicide-related behavior, and other mental and behavioral health issues in the military. The study is led by the Uniformed Services University of the Health Sciences and University of California-San Diego. A Federal Government steering committee, made up of DoD, VA, NIMH, and military Service	• DoD • VA • HHS • Military Services • University of California-San Diego • University of Michigan • Harvard University	✓	✓	✓	✓	

	Example Collaborators (not exhaustive)	Across DoD	VA	Other Federal Agencies	Academia	NGOs
members, oversees the project goals and objectives. The VA joined as a full partner in 2020 and began incorporating VA records to support analyses of data on study cohort members who are now Veterans.						
Military Suicide Research Consortium (MSRC): This consortium integrates and synchronizes DoD and civilian research efforts to implement a multidisciplinary research approach to suicide prevention. The consortium is funded by the Defense Health Program, managed by the Military Operational Medicine Research Program, and operated by Florida State University and the Denver Veterans Affairs Medical Center.	• DoD • Military Services • HHS • VA • Florida State University • University of Denver	✓	✓	✓	✓	
Military Operational Medicine Research Program Review Panel: Oversees and makes recommendations on planning, programming, and execution of a large portfolio of psychological health research studies, to include suicide, behavioral health, family, resilience, and violence prevention.	• DoD • Military Services • HHS • Academia • VA • CDC	✓	✓	✓	✓	
Prevention Program Evaluation Toolkit: A step-by-step guide to help program managers adapt, implement, and evaluate violence prevention programs. Support was received from the Marine Corps, Naval Operations, and academic partners.	• Military Services • Academia	✓			✓	
National Guard Bureau (NGB) and VA Readjustment Counseling Service (RCS) Vet Center Initiative: Provides greater access to behavioral health and support services for	• National Guard Bureau (NGB) • VA	✓	✓		✓	

	Example Collaborators (not exhaustive)	Across DoD	VA	Other Federal Agencies	Academia	NGOs
National Guard members and their families via VA Mobile Vet Centers during drill periods. Numerous Army National Guard state-level programs also share data with VA as part of either their Suicide Prevention Task Force, Mayors' Challenge, Governors' Challenge, or suicide prevention efforts as a whole.						
NGB Data Sharing and Collaboration: Shares data with the Uniformed Services University and Purdue University, in support of the Star Behavioral Health Providers program which trains community-based behavioral health providers in military culture. This collaboration expanded from three states to a regional model that includes 12 states in CY 2019 and is ongoing.	• NGB • Uniformed Services University • Purdue University	✓			✓	
DoD Suicide Event Report (DoDSER)–National Violent Death Reporting System (NVDRS) Database Linkage: DoD is partnering with CDC to link NVDRS data on suicide deaths with DoDSER data, with a key outcome being detailed mapping of suicide deaths by U.S. county (and the characteristics of decedents in these concentrated areas). Identifying areas and localized populations with high suicide rates will help enable the allocation of suicide prevention resources where and to whom they are most needed.	• DoD • CDC	✓		✓		
Use of Advana: Leverage technology platform that houses a collection of DoD enterprise data to develop SPRINGboard, which is a data-driven tool	• DoD • NGB	✓				

	Example Collaborators (not exhaustive)	Across DoD	VA	Other Federal Agencies	Academia	NGOs
to help National Guard leaders make more informed decisions about the health and well-being of Service members. Advana is in use by other DoD agencies, including the Office of Force Resiliency (OFR). OFR is employing Advana to ingest multiple risk and protective factor data sets to inform Force-wide command climate reporting.						
Army National Guard (ARNG) Resilience Program: Collaboration between ARNG and Defense Health Agency (DHA) Army Satellite to examine the effectiveness of the ARNG Resilience Program and its impact on Soldier resilience.	• Army National Guard (ARNG) • DoD • SAMHSA • University of Pennsylvania	✓		✓	✓	
Rational Thinking – Emotional Regulation – Problem-Solving (REPS) Training Pilot: Piloting an interactive educational program designed to teach foundational skills to deal with life stressors early in one's military career.	• DoD • Military Services	✓				
Transition Support: Outreach to Service members transitioning to civilian life to promote access to care (e.g., mental health, financial) and encourage help-seeking among Service members and Veterans. Examples are *in*Transition and Solid Start programs.	• DoD • Military Services • VA	✓	✓			
Resources Exist, Asking Can Help (REACH) Training Pilot: A pilot barrier reduction training designed to address the most prevalent help-seeking concerns and perceived barriers of Service members (e.g., career and security clearance loss concerns, loss of	• DoD • Military Services	✓			✓	

	Example Collaborators (not exhaustive)	Across DoD	VA	Other Federal Agencies	Academia	NGOs
privacy/confidentiality, and preference for self-management), and encourage Service members to seek help early on.						
Status of Forces Survey-Active Duty (SOFS-A): Quantitative research effort led by the Office of People Analytics focusing on quality-of-life factors, such as overall satisfaction, retention intention, stress, deployments, financial readiness, and suicide prevention of Active Component Service members.	• DoD • Military Services	✓				
Status of Forces Survey-Reserve (SOFS-R): Quantitative research effort led by the Office of People Analytics focusing on quality-of-life factors such as overall satisfaction, retention intention, stress, deployments, financial readiness, and suicide prevention of Reserve Component Service members.	• DoD • Military Services	✓				
Evidence-Informed Communication Tools on Lethal Means Safety: A suite of evidence-informed communication tools that reinforce the importance, and the positive impact, of safely storing firearms and medications for leaders, Service members, and families. The tools, including a public service announcement video, means safety guide, and firearm retailer toolkit, among others.	• DoD • Military Services	✓				
Defense Equal Opportunity Climate Survey (DEOCS): Quantitative research effort led by the Office of People Analytics that assesses climate	• DoD • Military Services	✓				

	Example Collaborators (not exhaustive)	Across DoD	VA	Other Federal Agencies	Academia	NGOs
factors including the level of connectedness (a known factor in suicide) within a military unit to inform strategies for military leaders to increase connectedness and unit cohesion.						
2020 QuickCompass of Active Duty Members: Survey led by the Office of People Analytics to understand beliefs about safe storage practices and attitudes about firearm ownership among Service members.	• DoD • Military Services	✓			✓	
Star Behavioral Health Providers Program: Trains community-based behavioral health providers in military culture. This 2019 collaboration includes 12 states.	• DoD • NGB • Purdue University	✓			✓	
Counseling on Access to Lethal Means (CALM) Training Pilot: Piloting CALM training for non-medical military providers, such as Military and Family Life Counselors and Military OneSource counselors. In Phase 2 of the pilot, training will be extended to other individuals in the military community, such as spouses.	• DoD • Military Services • SAMHSA	✓		✓		
Recognizing the Signs of Intent to Die by Suicide on Social Media Training Pilot: Training video that educates Service members on the warning signs of suicide on social media, as well as the constructive steps to take to intervene in a crisis and refer to appropriate care.	• DoD • Military Services • University of Utah	✓			✓	
Postvention Toolkit: Comprehensive, evidence-informed guide to providing postvention services and bereavement support to unit members and next-of-kin who survive military suicide loss.	• DoD • Military Services • VA • TAPS	✓	✓			✓

	Example Collaborators (not exhaustive)	Across DoD	VA	Other Federal Agencies	Academia	NGOs
Social Norms for Safe Firearm Storage: Effort to develop and pilot firearm safe storage messaging that encourage adoption of firearm safety practices among Service members.	• DoD • Military Services • University of Colorado • Rutgers University	✓			✓	
Lethal Means Safety Video: Video that educates Service members and families on the importance of storing firearms and medications safely.	• DoD • Military Services	✓				
Longitudinal Study of Suicide Ideation: Longitudinal study led by the Office of People Analytics to assess changes in suicidal ideation, resources used, and the effectiveness of those resources in reducing ideation.	• DoD • Military Services	✓				
Suicide Ideation and Career Outcomes Study: Longitudinal analysis of existing survey and administrative data to understand if suicide ideation and seeking help have an effect on career outcomes of Active Component Service members.	• DoD • Military Services	✓				
Zero Suicide Initiative: The Air Force is collaborating with Pennsylvania State University on the implementation and program evaluation of the Zero Suicide Initiative effort to train medical personnel on suicide risk assessment, safety planning in Air Force hospitals and clinics.	• DoD • Military Services • Pennsylvania State University	✓		✓	✓	
Wingman Connect: Air Force collaborated on research examining risk and protective factors among Airmen, as well as effectiveness of the Suicide Prevention Program with the University of Rochester.	• Military Services • University of Rochester	✓			✓	

	Example Collaborators (not exhaustive)	Across DoD	VA	Other Federal Agencies	Academia	NGOs
PsychArmor: Collaboration with PsychArmor, which provides resources to Americans so they can effectively engage with and support Service members, Veterans, and their families.	• DoD • NGB • PsychArmor	✓			✓	✓
Tragedy Assistance Program for Survivors (TAPS): Partnership with TAPS to provide bereavement counseling, case management, and support to family members of Service members who have died.	• DoD • Military Services • TAPS	✓				✓
Airman's Edge: The Air Force collaborated with the Ohio State University on a peer-to-peer program for suicide prevention. The collaboration is expected to continue until 2021.	• Military Services • The Ohio State University	✓			✓	
LGB Couples Study: The Air Force collaborated on research related to the readiness and resilience of Lesbian, Gay, and Bisexual (LGB) Service members and their same-sex partners in a study led by investigators from Wright State University.	• Military Services • NGB • Wright State University	✓			✓	
Give an Hour: National Guard Warrior Resilience and Fitness partnered with Give an Hour (GAH) to increase access to mental health services for their Service member and families. From 2015 to 2020, GAH providers offered 70,788 hours of free mental health services to Reserve, National Guard, and their families. These mental health services included face to face, telephonic, and telehealth services. Through the Campaign to Change Direction, GAH delivered comprehensive mental health literacy to 76,193 Service members	• DoD • NGB • Give an Hour	✓				✓

	Example Collaborators (not exhaustive)	Across DoD	VA	Other Federal Agencies	Academia	NGOs
and their families, providing resources about Healthy Habits, Five Signs, and how to access GAH services						
RAND Systematic Review of Military Suicide Aftercare FY 2018–2020: Synthesis of the existing evidence on interventions for people who have attempted suicide and their family members after attempted suicide.	• DoD • RAND Corporation	✓				✓
Military and Veterans Advisory Group (MVAG): MVAG was formed in 2019 to support the "Reviewing Effects of Caring Contacts: A Long-Term Follow-Up Study from the Military Continuity Project" study. MVAG members are comprised of suicide experts from DoD, VA, and academia. They support project researchers by fulfilling data requests, problem solving critical issues, and coordinating actions between Federal and academic stakeholders.	• DoD • VA • University of Washington	✓	✓		✓	
Clinical Support Tools for Suicide Prevention: The DoD and VA are actively collaborating on the development of clinical support tools designed to help patients, family members, military leaders, and providers understand and/or implement recommended interventions in the 2019 VA/DoD Clinical Practice Guideline (CPG) for the Assessment and Management of Patients at Risk for Suicide. The CPG provides thorough guidance on evidence-based practices for suicide risk care for military and Veteran patients.	• DoD • VA	✓	✓			

	Example Collaborators (not exhaustive)	Across DoD	VA	Other Federal Agencies	Academia	NGOs
Explosive Ordnance Disposal (EOD) Personnel Suicide Risk: Psychological Health Center of Excellence (PHCoE) completed a retrospective cohort study of EOD personnel to assess the risk for suicide mortality (primary outcome), traumatic brain injury, post-traumatic stress disorder, and other psychological disorders. The study produced a report entitled "Longitudinal Investigation of Diagnosed Psychological Outcomes among EOD Personnel in the U.S. Military."	• DoD	✓				
Reasons for Medical Evacuation from Theater (Africa): AFRICOM is working with the Armed Forces Health Surveillance Branch (AFHSB) to monitor reasons for medical evacuation from Africa, focusing especially on mental health reasons. This informs theater entry policies, including waiver requirements for mental health conditions, as well as inform practices and policies of Commanders on the ground to educate troops and provide support.	• DoD • Military Services	✓				
Recruit Sustainment Program Resilience Training Study: Collaboration with the Defense Health Agency (DHA) Army Satellite to examine the effectiveness of the ARNG Resilience Program to impact Soldier resilience. The study measures psychological resilience of Recruit Sustainment Program (RSP) Soldiers who receive resilience training, evaluates whether their resilience changes over their career, and	• NGB • Defense Health Agency (DHA) Army Satellite	✓		✓		

	Example Collaborators (not exhaustive)	Across DoD	VA	Other Federal Agencies	Academia	NGOs
measures the cost effectiveness of the training. This collaboration is expected to be completed in CY 2023.						
Medical Technology Enterprise Consortium (MTEC): MTEC is a non-profit enterprise partnership in collaboration with industry and academia. The USAMRDC MOMRP has engaged DoD, Service and Component stakeholders to develop and release an MTEC focused on Cross-Cutting Prevention research that will develop, test, and deliver solutions focused on optimizing health promotion via prevention initiatives for the military that provide education and skills, protective environments, and healthy climates and relationships in efforts to prevent various forms of violent, abusive, or harmful acts. Solutions must have cross-cutting impacts on more than one area of interest, including suicide ideation and behaviors.	• DoD • Military Services • Various academic institutions • Various industry partners	✓			✓	✓
Millennium Cohort Program (MCP): A DoD-based longitudinal research study designed to evaluate the health of Service members and their families both during and after their military service. Launched in CY 2001, the MCS has tracked the health of a cohort of more than 200,000 Service members (and a more recently established cohort of 10,000 spouses). It examines factors associated with acute- and long-term physical and psychological health, including suicide and related behaviors. The Millennium Cohort External	• DoD • Military Services • VA	✓	✓		✓	✓

	Example Collaborators (not exhaustive)	Across DoD	VA	Other Federal Agencies	Academia	NGOs
Advisory Board includes distinguished researchers and subject matter experts from academia, DoD, VA, and Veteran Service Organizations.						
Individual and Community and Organizational Factors for Suicide Risk in the USAF: The Air Force collaborated on research examining risk and protective factors among Airmen, as well as effectiveness of the Suicide Prevention Program with the University of Rochester. This collaboration began in CY 2016 and concluded in CY 2020.	• Military Services • University of Rochester	✓				✓
Ask, Care, Escort–Suicide Intervention Curriculum Update and Evaluation: The Army G-1 and Army Public Health Center and National Guard Bureau (NGB) are collaborating with the Walter Reed Army Institute of Research (WRAIR), Army Public Health Command (APHC), and Army Resilience Directorate (ARD) on research and evaluation of the new Ask, Care, Escort–Suicide Intervention (ACE-SI) curriculum for the Army, designed to train personnel to intervene in a suicidal crisis. The ACE-SI curriculum will be executed across all three components, and the National Guard and Reserve Command have been partners in its development, evaluation, and implementation.	• DoD • Military Services • NGB	✓				
Interagency Suicide Prevention Research Working Group: Initiated in 2017, the Interagency Suicide Prevention Research	• DoD • VA • HHS	✓	✓	✓		

	Example Collaborators (not exhaustive)	Across DoD	VA	Other Federal Agencies	Academia	NGOs
Working Group helps research funding organizations to maintain interagency awareness of planned initiatives, identify potential collaborations to synergize efforts and maximize resources and investments, and share advances as well as lessons learned. Participating organizations include DoD, VA, and NIH (NIMH, NIAAA). All aspects of suicide prevention research are discussed in this forum.						
Virtual Reality Suicide Prevention Training: The Air Force collaborated with Air Mobility Command and Moth & Flame to develop and test a Suicide Prevention Virtual Reality training. The virtual reality training allows DAF personnel to practice the Ask, Care, Escort intervention with an avatar.	• Military Services • Moth and Flame					✓

Appendix L: Acronyms and Abbreviations

AFMES – Armed Forces Medical Examiner System

ARNG – Army National Guard

ASR – Annual Suicide Report

CALM – Counseling on Access to Lethal Means

CDC – Centers for Disease Control and Prevention

CY – Calendar Year

DEERS – Defense Enrollment Eligibility Reporting System

DEOCS – Defense Organizational Climate Survey

DEOMI – Defense Equal Opportunity Management Institute

DHA – Defense Health Agency

DHS – Department of Homeland Security

DMDC – Defense Manpower Data Center

DoD – Department of Defense

DoDI – Department of Defense Instruction

DoDSER – Department of Defense Suicide Event Report

DOE – Department of Education

DOL – Department of Labor

DSPO – Defense Suicide Prevention Office

FY – Fiscal Year

HHS – Department of Health and Human Services

MC&FP – Office of Military Community and Family Policy

MFLC – Military and Family Life Counselors

MMDB – Military Mortality Database

NDAA – National Defense Authorization Act

NDI – National Death Index

NGB – National Guard Bureau

NIH – National Institutes of Health

NIMH – National Institute of Mental Health

NVDRS – National Violent Death Reporting System

OCONUS – Outside Continental United States

OPA – Office of People Analytics

OSD – Office of the Secretary of Defense

PHCoE – Psychological Health Center of Excellence

QPR – Question-Persuade-Refer

RCS – Readjustment Counseling Service

REACH – Resources Exist, Asking Can Help

REACH-S – Resources Exist, Asking Can Help–Spouse

REPS – Rational Thinking – Emotional Regulation–Problem-Solving

SELRES – Selected Reserve

SOFS-A – Status of Forces Survey of Active Duty Members

SOFS-R – Status of Forces Survey of Reserve Component Members

SOS – Signs of Suicide

SPRING – Suicide Prevention and Readiness Initiative for the National Guard

STARRS-LS – Study to Assess Risk and Resilience in Service Members–Longitudinal Study

TAP – Transition Assistance Program

TAPS – Tragedy Assistance Program for Survivors

USARMDC – U.S. Army Medical Research and Development Command

VA – Department of Veterans Affairs

WISQARS – Web-Based Injury Statistics Query and Reporting System

Appendix M: Terms and Definitions

Unless otherwise noted, these terms and their definitions are for the purpose of this Annual Suicide Report.

Active Component: Per the Office of the Deputy Chief Management Officer, the Active Component is "the portion of the armed forces as identified in annual authorization acts as 'active forces,' and in Section 115 of Title 10 U.S. Code as those active duty personnel paid from funds appropriated for active duty personnel."

Active Duty: Full-time duty in the active military service of the United States. This term includes full-time training duty, annual training duty, and attendance, while in active military service, at a school designated as a Service school by law or by the Secretary of the Military Department concerned. Active duty is prescribed by Title 10 U.S. Code.

Armed Forces Medical Examiner System: The system within the Defense Health Agency that provides worldwide comprehensive medico-legal services and investigations, as well as tracks all deaths subject to its jurisdiction (active duty status deaths; see **Active Duty**), their determination, and other relevant information.

Contagion: A phenomenon whereby susceptible persons are influenced toward suicidal behavior through knowledge of another person's suicidal acts. Closeness to an individual, group, or individuals within a specific organization may increase the risk of contagion.

Data Sharing: The exchange of data or results of research between agencies, consistent with Federal laws.

Death by Suicide: Synonymous with a manner of death classification of suicide.

Defense Eligibility Enrollment System (DEERS): A computerized database of military sponsors (active duty, retired, or member of the Reserve Component) and their eligible family members. DEERS registration is required for certain military benefits including TRICARE.

DoDSER Annual Report: This report is the Department's official source for DoDSER suicide and suicide attempt data (e.g., including medical and behavioral health factors, military-related factors, psychosocial and lifestyle stressors, known cases of suicide ideation). It seeks to enhance the Department's understanding of suicidal behavior as well as further inform future research, program development, and policy efforts.

Evidence-Based: A conclusion based on rigorous research that has demonstrated effectiveness in achieving the outcomes that it is designed to achieve.

Fiscal Year (FY): Begins October 1 and ends September 30 each year.

Gatekeeper: Can include anyone who is strategically positioned to recognize and refer someone at risk for suicide (e.g., parents, friends, neighbors, teachers, coaches, caseworkers, police officers) to care.

Intervention: A strategy or approach that is intended to prevent an outcome or alter the course of an existing challenge or stress; also known as "secondary prevention."

Manner of Death: The legal classification of death. There are five manners of death: suicide, homicide, accident, natural, and undetermined.

Means: How the injury was inflicted (i.e., how the person was hurt). The classification by mechanism characterizes the external agents or particular activities that caused the injury (e.g., motor vehicle, firearm, submersion, fall, and poisoning).

Means Safety: Programs and policies aimed at making lethal means less available or safer and thereby reducing the overall lethality of suicide attempts.

Mental Health: The capacity of individuals to interact with one another and the environment in ways that promote subjective well-being, optimal development, and use of mental abilities (cognitive, affective, and relational).

Mental Illness: A diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with an individual's cognitive, emotional, or social abilities.

Military Community: A broad term, equivalent to "the community' in the 2012 National Strategy for Suicide Prevention ecological model, designed to capture applicable members of the Total Force and military family members, as well as to describe the general surroundings in which they live and work (e.g., unit, base, station).

Military Family Members (or Military Dependents): Military Family Members (also known as Military Dependents) are those who are sponsored by the Military Service member, are enrolled in the Defense Eligibility Enrollment System (DEERS), and meet the requirement for a military dependent as defined by Title 10 U.S. Code, Section 1072 (2).

Military Treatment Facility (MTF): A military hospital or clinic on or near a military base.

National Death Index (NDI): The NDI is a centralized database of death record information on file in state vital statistics offices. The CDC's National Center for Health Statistics works with state offices to establish the NDI as a resource to aid epidemiologists and other health and medical investigators with their mortality ascertainment activities. In this report, the NDI was used to supplement DoD data sources in the identification of family member suicides.

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

Prevention: A strategy or approach that reduces the risk or delays the onset of adverse health problems, or reduces the likelihood that an individual will engage in harmful behaviors. Also known as "primary prevention."

Protective Factors: Skills, strengths, or resources that help people deal more effectively with stressful events. Protective factors enhance resilience and help to counterbalance risk factors. Protective factors may be personal (e.g., attitudes, values, and norms prohibiting suicide) or external or environmental (e.g., strong relationships, particularly with family members).

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

Reserve Component: The Armed Forces of the United States Reserve Component consists of the Army National Guard of the United States, Army Reserve, Navy Reserve, Marine Corps Reserve, Air National Guard, Air Force Reserve, and the Coast Guard Reserve.

Resilience: The ability to withstand, recover, and grow in the face of stressors and changing demands.

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

Safety Plan: Written list of warning signs, coping responses, and support sources that an individual may use to avert or manage a suicide crisis.

Screening: Administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment.

Screening Tools: Instruments and techniques (e.g., questionnaires, checklists, and self-assessment forms) used to evaluate individuals for increased risk of certain health problems.

Selected Reserve (SELRES): Drilling and training members of the National Guard and Reserve, Individual Mobilization Augmentees, and full-time support Active Guard and Reservists. This excludes members of the Individual Ready Reserve (IRR) and Inactive National Guard (ING).

Service Member: A person appointed, enlisted, or inducted into a branch of the Military Services, including Reserve Components (e.g., National Guard), cadets, or midshipmen of the Military Service Academies.

Statistically Significant: A comparison is considered statistically significant if the probability of not observing that difference, or a more extreme difference, is less than 5%.

Stigma: Negative perception by individuals that seeking mental health care or other supportive services will negatively affect or end their careers.

Suicidal Behaviors: Behaviors related to suicide, including preparatory acts, as well as suicide attempts and deaths.

Suicide Ideation: Thinking about, considering, or planning suicide.

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

Suicide Attempt: A non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior; might not result in injury.

Suicide Crisis: A suicide crisis, or potential suicide, is a situation in which a person is attempting to kill him or herself or is seriously contemplating or planning to do so. It is considered a medical emergency, requiring immediate suicide intervention and emergency medical treatment.

Suicide Event Status (Pending and Confirmed):

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

- **Confirmed Suicide:** A designation by AFMES when assigning suicide as the final determination of the manner of death.
- **Suicide Rate:** The average number of deaths by suicide in a fixed population per unit of time. As suicide is relatively rare, the suicide rate is commonly standardized to deaths per 100,000 persons per year. A suicide rate is calculated by dividing the number of deaths by suicide in the unit of time (in DoD, typically a calendar year) by the exposed population (in DoD, the average of 12 monthly end-strengths).

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