Department of Defense
Quarterly Suicide Report

Calendar Year 2016 1st Quarter
Defense Suicide Prevention Office
(DSPO)

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DEFENSE SUICIDE
PREVENTION OFFICE

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Introduction

The Defense Suicide Prevention Office (DSPO) integrates a holistic approach to suicide prevention, intervention, and postvention utilizing a range of medical and non-medical resources. DSPO is taking a responsible, measurable, and deliberative approach in its efforts to combat death by suicide through data surveillance and analysis; research and program evaluation; advocacy; plans and policy oversight; outreach; and training and oversight. It is through these efforts that we will build a steady and resilient force that encompasses Service members, civilians, and their families.

DSPO is committed to fostering collaboration and cooperation to develop suicide prevention efforts among all stakeholders including the Military Services; federal agencies; public, private, and non-profits; international entities; and institutions of higher education.

DSPO partners with other leading organizations (i.e., Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Disease Control and Prevention (CDC), National Institute of Mental Health (NIMH), United States Department of Veterans Affairs (VA)) and leverages the existing knowledge and expertise in suicide prevention to support a "whole-of-life" approach and apply it to the specifics of the military: aspects of a person, a community, military life, the unit, or an environment that will make death by suicide[1] more likely (risk factors) or less likely (protective factors).

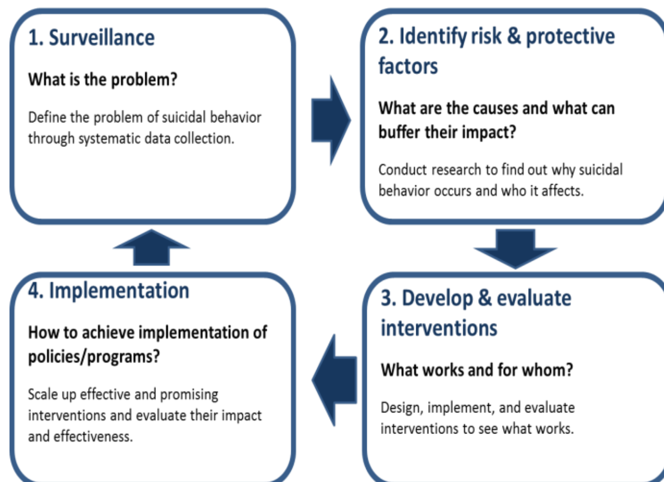

Figure 1: World Health Organization Public Health Model

DSPO develops the Quarterly Suicide Report (QSR) to collect and report objective and consistent quantitative data and disseminates those data to appropriate stakeholders. The QSR is

[1] *The term "suicide" is defined as "Death caused by self-directed injurious behavior with an intent to die as a result of the behavior" (Reference: CDC-http://www.cdc.gov/violencePrevention/suicide/definitions.html)*

the DoD-level, quarterly publication with the most up-to-date suicide data for the Active Component[2] (Army, Marine Corps, Navy, Air Force) and the Reserve Component (Reserve, National Guard).[3] DSPO partners with the Office of the Armed Forces Medical Examiner System (AFMES)[4], which provides worldwide comprehensive medico-legal services and investigations, and the Services to develop and distribute the QSR. The QSR is accurate, clear, timely, and inclusive:

- **Accurate**: Historical counts are revised as the underlying data gets updated (deaths by suicide are confirmed or new cases are reported) so the current QSR can be considered the best "on time" data source for suicide in the DoD. In addition, the Services verify the duty status of all deaths by suicide in the QSR.
- **Clear**: Information is self-contained, transparent, and concise. It is not advisable to compare QSR data to other publications as different reporting and confirmation mechanisms might apply.
- **Timely**: Data are published within 90 days of the end of every quarter. There is no other public DoD report with more timely information on deaths by suicide.
- **Inclusive**: All the Services and the Reserve Component are included in the report.

Data surveillance is used to demonstrate the scope of military suicide, determine distribution trends and patterns, monitor changes, generate hypotheses, and stimulate research efforts. The QSR does not include the means (e.g., medication, firearm) used in suicide death but the quantitative data it provides inform the development of public health approaches to suicide prevention, such as lethal means safety.

DSPO's data surveillance is based on a collaborative effort with the Services and AFMES. These efforts promote strategic alignment and integration of suicide prevention into military, civilian, and family policies and programs.

The QSR Data

The QSR provides the number of deaths by suicide. Over time, these numbers can provide insight into patterns and trends and be indicative of underlying protective or risk factors that

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[2] Active Component: Full-time members of the U.S. Armed Forces and Cadets/Midshipmen at the designated military academies.

[3] Reserve Component: Reserve Component personnel in this report are members of the Selected Reserves (SELRES). SELRES are drilling and training members of the National Guard and Reserves, Individual Mobilization Augmentees, and full-time support Active Guard and Reservists, regardless of duty status at time of death. The report excludes reserves not on Active Duty (Active Component and Reserve Component on active duty), namely the Individual Ready Reserve (IRR) and Inactive National Guard (ING). Also excluded: Military retirees and members in Temporary or Permanent Disability Retired Lists (TDRL, PDRL), to avoid double-counting Department of Veterans Affairs data.

[4] AFMES may conduct a forensic pathology investigation to determine the cause or manner of death of a deceased person if such an investigation is determined to be justified under circumstances…" such as "…it appears that the decedent was killed or that, whatever the cause of the decedent's death, the cause was unnatural…the cause or manner of death is unknown…" (10 USC 1471)

either mitigate or increase the likelihood of suicide. The primary data surveillance function of the QSR is to identify the "who", however we understand that suicide is complex, and must be approached in a holistic manner. The complexity of suicide prevention entails risk and protective factors spanning the fields of medicine, epidemiology, sociology, psychology, criminology, education, legal, military, and economics. Data surveillance outcomes help generate hypotheses that target research efforts. Thus, the power of the QSR data resides in the accuracy and timeliness of those data. Continued tracking and analysis will promote in-depth research for more effective implementation of suicide prevention efforts.

In the first quarter of 2016, the military services reported the following:

- 58 deaths by suicide in the Active Component
- 18 deaths by suicide in the Reserves
- 34 deaths by suicide in the National Guard

Please refer to Appendix A for a detailed breakdown of the number of deaths by suicide within each Service and Component.

Patterns and Trends

When looking at the QSR, it is apparent that there are differences in the total number of deaths by suicide across the Services and Components. A significant factor resulting in this difference is due to the total population of each Service and Component. For instance, the Army has the largest population and, correspondingly, has the largest number of total deaths by suicide. However, there may also be other Service or Component-specific risk factors that could influence the number of deaths by suicide. Examples of two potential risk factors are deployment and combat exposure, which have been a subject of military suicide research over the last year.

Research suggests that there may not be a direct association between suicide and deployment. However, deployment does represent a time of transition that can disrupt social and interpersonal structure and relationships. There is likely an interplay of feelings of belongingness, connectedness, and acquired capability (the concept that repeated exposure to painful or fearsome experiences results in a higher tolerance for pain) that is influenced by deployment transitions. Research on civilian suicide has shown that transitions such as these can be a risk factor for suicide.

The interplay between belongingness, connectedness, and acquired capability may also influence the impact of combat exposure on the risk of dying by suicide. For instance, research shows that community support and connectedness while in-theater can be a protective factor, and there may be differences between Services and Components that influence that level of support. Recent research has also suggested that certain types of combat exposure may be associated with a greater sense of acquired capability. These factors may contribute to differences in the number of deaths by suicide across Services and Components. Further research is necessary to better understand the interplay of risk factors, and to develop unit-level and community support and training interventions that increase the protective aspects of military culture.

Everyone Plays a Positive Role In Suicide Prevention

Communities, peers, close individuals, and the media are critical in preventing death by suicide. If you are concerned about a friend or loved one:

> "Communities play a critical role in suicide prevention. They can provide social support to vulnerable individuals and engage in follow-up care, fight stigma and support those bereaved by suicide."
>
> *World Health Organization, 2014*
> *Preventing Suicide: A Global Imperative*

- ***Be direct***. Talk openly and matter-of-factly about suicide.
- ***Be willing to listen***. Allow expressions of feelings. Accept the feelings.
- ***Be non-judgmental.*** Don't debate whether suicide is right or wrong, or whether feelings are good or bad. Don't lecture about the value of life.
- ***Get involved.*** Become available. Show interest and support.
- ***Don't dare*** him/her to do it.
- ***Don't act shocked.*** This will put distance between you.
- ***Don't be sworn to secrecy***. Seek help.
- ***Offer hope*** that alternatives are available, but do not offer general reassurances such as, "it will get better" or "it could be worse."
- ***Get help*** from persons or agencies specializing in crisis intervention and suicide prevention, such as Military Crisis Line.

Research shows that the way suicide is portrayed in the media can either increase the risk of dying by suicide in vulnerable individuals, or can encourage those at risk to seek help. To ensure a positive impact when reporting, please follow these recommendations:

- Inform your audience of the issue without sensational headlines or claims.
- Be careful not to describe death by suicide numbers as an "epidemic" or "skyrocketing." More investigation is always required to understand patterns and trends in data surveillance.
- Help your audience understand that suicide is a public health issue, not a crime.
- Provide your audience with the understanding that suicide is preventable, and that community connectedness is an important part of suicide prevention.
- Include crisis hotline contact information and other resources that provide help.

Conclusion

Suicide continues to be a significant public health issue in the military. Suicide is a complex problem that requires a public health approach and data surveillance is key to these efforts. Over time, tracking data will uncover existing patterns and reveal trends that will help better understand and prevent deaths by suicide. The Department of Defense will use the knowledge gained over time to develop and promote research-informed suicide prevention policies, practices and programs to most effectively address the specifics of military suicide. Additionally, DSPO will employ an inclusive approach, by deepening existing relationships and cultivating new ones with relevant stakeholders, to contribute to ongoing education and outreach about military suicide prevention.

Attachment A

DoD Service and Component	CY2012	CY2013					CY2014					CY2015					CY2016	
	Total	Q1	Q2	Q3	Q4	Total 2013	Q1	Q2	Q3	Q4	Total 2014	Q1	Q2	Q3	Q4	Total 2015	Q1	Total 2016
Active Component	**321**	**67**	**61**	**69**	**58**	**255**	**73**	**70**	**57**	**73**	**273**	**60**	**71**	**72**	**63**	**266**	**58**	**58**
Air Force	50	7	14	15	12	**48**	19	11	13	19	**62**	14	17	16	17	**64**	9	**9**
Army	165	33	28	33	27	**121**	27	31	31	35	**124**	33	28	32	27	**120**	29	**29**
Marine Corps	48	11	12	13	9	**45**	11	9	6	8	**34**	3	12	13	11	**39**	12	**12**
Navy	58	16	7	8	10	**41**	16	19	7	11	**53**	10	14	11	8	**43**	8	**8**
Reserve Component	**204**	**55**	**56**	**53**	**56**	**220**	**46**	**34**	**48**	**42**	**170**	**42**	**53**	**72**	**45**	**212**	**52**	**52**
Reserve	**72**	**27**	**16**	**23**	**20**	**86**	**24**	**14**	**20**	**21**	**79**	**13**	**21**	**37**	**17**	**88**	**18**	**18**
Air Force Reserve	3	1	2	5	3	**11**	2	1	3	4	**10**	1	1	3	4	**9**	5	**5**
Army Reserve	50	21	11	15	12	**59**	13	4	15	10	**42**	9	17	21	7	**54**	6	**6**
Marine Corps Reserve	11	4	1	2	4	**11**	4	5	1	2	**12**	1	1	8	1	**11**	4	**4**
Navy Reserve	8	1	2	1	1	**5**	5	4	1	5	**15**	2	2	5	5	**14**	3	**3**
National Guard	**132**	**28**	**40**	**30**	**36**	**134**	**22**	**20**	**28**	**21**	**91**	**29**	**32**	**35**	**28**	**124**	**34**	**34**
Air National Guard	22	2	2	6	4	**14**	6	2	4	2	**14**	8	5	5	3	**21**	5	**5**
Army National Guard	110	26	38	24	32	**120**	16	18	24	19	**77**	21	27	30	25	**103**	29	**29**

Note: All figures above may be subject to change in future publications as updated information becomes available.
Suicide counts are current as of March 31, 2016.