Department of Defense Quarterly Suicide Report

Calendar Year 2017 1st Quarter

Defense Suicide Prevention Office (DSPO)

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The estimated cost of this report or study for the Department of Defense is approximately $6,770 for the 2017 Fiscal Year. This includes $3,940 in expenses and $2,830 in DoD labor.
Generated on 2017Jul17 RefID: 8-979D8D4

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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 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 dedicated to fostering collaboration and cooperation to develop suicide prevention efforts among all stakeholders, including the Military Departments; federal agencies; public, private, and non-profit organizations; 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. DPSO then applies this method to areas that will make death by suicide more likely (risk factors) or less likely (protective factors) within the specific military aspects of a person, a community, military life, the unit, or an environment. [1]

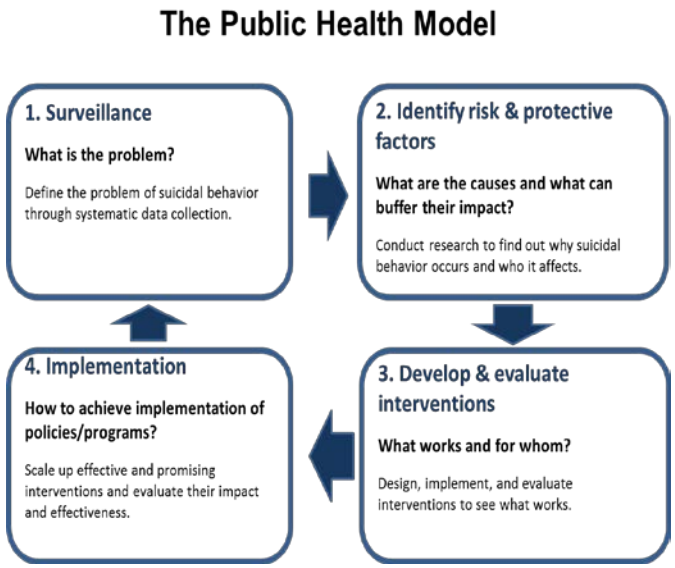

Figure 1: World Health Organization Public Health Model

DSPO develops the Quarterly Suicide Report (QSR) to collect and report objective and consistent quantitative data to share with appropriate stakeholders. The QSR is the Department of Defense (DoD)-level quarterly publication,

[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)

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

- **Accurate**: Historical counts are revised as the underlying data are 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 90 days after 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, firearms) used in suicide death, but the quantitative data provided inform the development of public health approaches to suicide prevention.

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. The primary data surveillance function of the QSR is to identify the number of individuals that die by suicide within each DoD Service and Component. However, the Department understands 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, law, military, and economics. Data surveillance outcomes help

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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 the Individual Ready Reserve (IRR) and Inactive National Guard (ING), 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…or the cause or manner of death is unknown…" (10 USC 1471).

generate hypotheses that target research efforts. Thus, the power of the QSR data resides in the accuracy and timeliness of its data. Continued tracking and analysis will promote in-depth research for more effective implementation of suicide prevention efforts. Over time, the numbers can be analyzed for patterns and trends which can direct the focus of intervention efforts.

For the first quarter of 2017, the military services reported the following:

- 71 deaths by suicide in the Active Component
- 20 deaths by suicide in the Reserves
- 31 deaths by suicide in the National Guard

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

Patterns and Trends

This QSR indicates differences in the total number of deaths by suicide across the Services and Components. This difference is largely 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.

There may be 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. Recent research suggests that there may not be a direct association between suicide and deployment or combat exposure.[5] However, other research suggests that certain types of combat exposure may be associated with a greater sense of acquired capability for self-harm, and could be a risk factor.[6] Research on combat exposure shows that community support and connectedness, while in-theater, can be a protective factor against suicide.[7, 8] These factors often contribute to differences in the number of deaths by suicide across Services and Components and further research into these factors may be warranted.

Research on civilian suicide has shown that transitions can be a risk factor for suicide. [9] [10] Military Service members often experience transitions that can disrupt social and interpersonal structure and relationships.[11] Transitions may magnify feelings of thwarted belongingness and burdensomeness. Further research is necessary to better understand the interplay of risk and

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[5] Reger et al. (2015). Risk of Suicide Among US Military Service Members Following Operation Enduring Freedom or Operation Iraqi Freedom Deployment and Separation From the US Military, JAMA Psychiatry, 72(6):561-9.
[6] Blosnich & Bossarte, R. (2013). Suicide acceptability among U.S. Veterans with active duty experience: Results from the 2010 General Social Survey. Archives of Suicide Research. 17(1), 52–57.
[7] Bryan et al. (2010). Combat experience and the acquired capability for suicide. Journal of Clinical Psychology, 66(10), 1044 -1056.
[8] Nock et al. (2013). Suicide Among Soldiers: A Review of Psychosocial Risk and Protective Factors. Psychiatry. 76(2): 97–125.
[9] Van Orden et al. (2010). The Interpersonal Theory of Suicide. Psychology Review, 117(2): 575–600.
[10] Ursano et al. (2016). Risk Factors, Methods, and Timing of Suicide Attempts Among US Army Soldiers. JAMA Psychiatry. 73(7).
[11] Brenner L. & Barnes (2012). Facilitating Treatment Engagement During High-Risk Transition Periods: A Potential Suicide Prevention Strategy. American Journal of Public Health. 102, Supplement 1:S12-4.

protective factors and the impact of transitions. The development of unit-level, community support, and training interventions that have the potential of mitigating negative aspects of frequent transitions is warranted.

Everyone Can Play a Positive Role in Suicide Prevention

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

- ***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 the Military Crisis Line.

> "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*

Research shows that depending on the way media portrays suicide, it can either increase the risk of dying by suicide for vulnerable individuals, or, can encourage those at risk to seek help.[12] 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.

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[12] *Preventing Suicide: A Resource for Media Professionals (2008). Department of Mental Health and Substance Abuse, World Health Organization; International Association for Suicide Prevention.*

- Include crisis hotline contact information and other resources that provide help.

Access to Lethal Means for Suicide

Research shows suicidal thoughts and behaviors are fluid.[13] Putting time and distance between a person who is having thoughts of suicide and lethal means, such as a gun or prescription drugs, can help save their life. Family and friends can take steps to ensure that lethal means are stored safely and securely, especially during times of crisis.

- ***Recognize if someone may be suicidal.*** Look for warning signs, such as someone talking about being better off dead.
- ***Make sure all firearms are secure inside your home.*** Store the gun unloaded in a secured and locked location, different from where the ammunition is stored. Consider using a gun lock or removing the firing pin.
- ***Explore options to temporarily store guns outside of your home.*** In times of crisis, consider storing weapons at a family member, friend, or neighbor's house in a locked box, at the local armory, or at the local police department, until the person no longer feels suicidal. Please note that some local and state laws require weapon registration for legal storage; always follow the law in your jurisdiction.

Social Media

Individuals who are experiencing suicidal thoughts often do not explicitly state that they want to die or that they have taken steps to end their life. Often times there may be other indicators of suicidal intent, for example, phrases such as, "my family would be better off without me" or "I can't take this anymore." Suicidal intent may also be evident in social media posts. Dr. Craig Bryan, at the University of Utah, in collaboration with The Defense Personnel and Security Research Center, recently conducted an analysis of social media posts of Service members who died by suicide (manuscript in preparation). They found that posts expressing lack of purpose and meaning, self-criticism, sudden interest in alcohol, and/or no longer mentioning loved ones increased before death. If you see signs similar to these, it is important to reach out by offering support and letting the person know you care. Not sure how to start the conversation? Take free online training at the Columbia Lighthouse Project website at http://cssrs.columbia.edu/training/training-options/. If you have other questions on how to approach someone with suicidal thoughts, the National Suicide Prevention Lifeline 1-800-273-8255 can help walk you through several actions you can take.

Peer-to-Peer Assistance

DoD launched the new "Be There" program, which offers confidential peer coaching to Active Duty Service members, including National Guard and Reserve members and their families, through 24/7 chat, phone, and text. The DoD "BeThere" Peer Support Call and Outreach Center is staffed by peer coaches, who are Veteran Service members and family members of Veterans,

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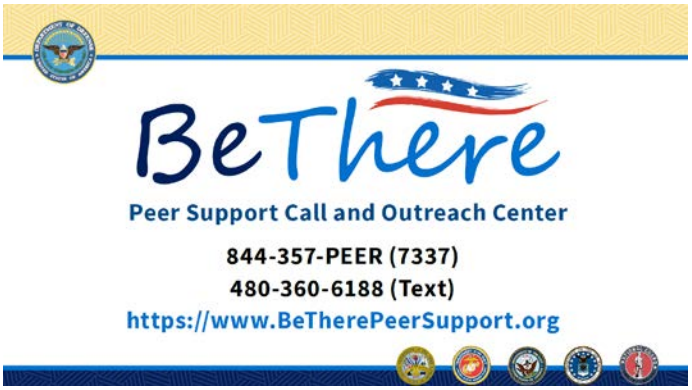
[13] *Rudd, M.D. (2006). Fluid Vulnerability Theory: A Cognitive Approach to Understanding the Process of Acute and Chronic Suicide Risk.*

and aims to provide support for everyday problem solving, such as career and general life challenges.

Service members' families who would like to learn more about the "BeThere" Call and Outreach Center or connection with a peer may visit www.betherepeersupport.org, call 844-357-PEER (7337), or text 480-360-6188.



Conclusion

Suicide continues to be a significant public health issue nationally and 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 will use the knowledge gained over time to develop and promote research-informed suicide prevention policies, practices, and programs to most effectively address the specific factors attributed to military suicide. Additionally, the Department will employ an inclusive approach, by deepening existing relationships and cultivating new ones with relevant stakeholders, to contribute to ongoing research, data surveillance, policy development, education, and outreach efforts related to military suicide prevention.

Attachment A

DoD Service and Component	CY2012 Total	CY 2013					CY 2014					CY 2015				
		Q1	Q2	Q3	Q4	Total 2013	Q1	Q2	Q3	Q4	Total 2014	Q1	Q2	Q3	Q4	Total 2015
Active Component	**321**	**67**	**61**	**70**	**58**	**256**	**73**	**70**	**58**	**73**	**274**	**60**	**71**	**72**	**63**	**266**
Air Force	**50**	7	14	15	12	**48**	19	11	13	19	**62**	14	17	16	17	**64**
Army	**165**	33	28	33	27	**121**	27	31	31	35	**124**	33	28	32	27	**120**
Marine Corps	**48**	11	12	**14**	9	**46**	11	9	6	8	**34**	3	12	13	11	**39**
Navy	**58**	16	7	8	10	**41**	16	19	8	11	**54**	10	14	11	8	**43**
Reserve Component	**204**	**55**	**56**	**53**	**56**	**220**	**46**	**34**	**48**	**42**	**170**	**42**	**53**	**72**	**45**	**212**
Reserve	**72**	**27**	**16**	**23**	**20**	**86**	**24**	**14**	**20**	**21**	**79**	**13**	**21**	**37**	**17**	**88**
Air Force Reserve	**3**	1	2	5	3	**11**	2	1	3	4	**10**	1	1	3	4	**9**
Army Reserve	**50**	21	11	15	12	**59**	13	4	15	10	**42**	9	17	21	7	**54**
Marine Corps Reserve	**11**	4	1	2	4	**11**	4	5	1	2	**12**	1	1	8	1	**11**
Navy Reserve	**8**	1	2	1	1	**5**	5	4	1	5	**15**	2	2	5	5	**14**
National Guard	**132**	**28**	**40**	**30**	**36**	**134**	**22**	**20**	**28**	**21**	**91**	**29**	**32**	**35**	**28**	**124**
Air National Guard	**22**	2	2	6	4	**14**	6	2	4	2	**14**	8	5	5	3	**21**
Army National Guard	**110**	26	38	24	32	**120**	16	18	24	19	**77**	21	27	30	25	**103**

DoD Service and Component	CY2016					CY2017	
	Q1	Q2	Q3	Q4	Total 2016	Q1	Total 2017
Active Component	**62**	**55**	**82**	**77**	**276**	**71**	**71**
Air Force	10	15	14	22	**61**	19	**19**
Army	31	20	41	35	**127**	31	**31**
Marine Corps	12	11	8	6	**37**	7	**7**
Navy	9	9	19	14	**51**	14	**14**
Reserve Component	**56**	**51**	**46**	**50**	**203**	**51**	**51**
Reserve	**18**	**24**	**18**	**20**	**80**	**20**	**20**
Air Force Reserve	5	2	1	2	**10**	2	**2**
Army Reserve	6	13	11	11	**41**	11	**11**
Marine Corps Reserve	4	6	5	4	**19**	5	**5**
Navy Reserve	3	3	1	3	**10**	2	**2**
National Guard	**38**	**27**	**28**	**30**	**123**	**31**	**31**
Air National Guard	5	5	1	3	**14**	2	**2**
Army National Guard	33	22	27	27	**109**	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 31 March, 2017.

Indicates a change from the previous QSR based on updated information.