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Updated October 2, 2019

Military Suicide Prevention and Response

Background

When a servicemember dies by suicide, those close to the member often experience shock, anger, guilt, and sorrow. As such, a servicemember's suicide may adversely impact the wellbeing of his or her family and friends. Further, it may affect the morale and readiness of his or her unit. The military's response to suicidal thoughts (ideation), attempts, and deaths involves coordinated efforts among command and unit leadership, medical professionals, counselors, and others across the military community.

Under the authority given to Congress in Article 1, Section 8 of the U.S. Constitution, to raise and support armies; provide and maintain a navy; and provide for organizing, disciplining, and regulating them, Congress strives to understand the scope of this issue as it pertains to the military, the efforts previously taken to address it, and the considerations for confronting it in the future.

Defense Suicide Prevention Office

The Defense Suicide Prevention Office (DSPO), established in 2012, is the office responsible for "advocacy, program oversight, and policy for Department of Defense (DOD) suicide prevention, intervention and postvention efforts to reduce suicidal behaviors in servicemembers, civilians and their families." The office also manages a 24-hour Military Crisis Line, produces an annual DOD Suicide Event Report (DoDSER), and compiles quarterly DOD military suicide reports.

Prevalence Rates

In calendar year (CY) 2018, DOD reported 541 servicemember suicide deaths. There were 325 suicides in the Active Component (AC), 81 in the Reserves, and 135 in the National Guard. While suicide remains a low incidence event, Active Component suicide rates have trended upwards since 2013. In CY2018, the active Marine Corps and Army had the highest rates among the services. While overall National Guard and Reserve rates have not shown a discernable trend since 2013, Army National Guard suicide rates have been consistently higher than the other services and components (see **Table 1** for rates across components).

In terms of demographics, over 90% of military suicide deaths are men, and approximately half of reported suicides are junior enlisted personnel (E1-E4).

Comparison to the General Population

According to Centers for Disease Control and Prevention (CDC), the suicide mortality rate for the U.S. general population was 14.0 per 100,000 in 2017: markedly lower than the 2017 AC rate of 21.9 per 100,000. However, comparisons between military and civilian populations can be misleading because of differences in suicide reporting methods used by CDC and DOD. Also, these populations greatly differ in terms of age and sex. The military services are disproportionately comprised of younger individuals and more males—sub-populations at higher risk for suicide.

For CY2018, DOD found that after adjusting for age and sex, the suicide rates for Active and Reserve members are close to what would be expected if the military had the same age and sex composition as the U.S. general population. However, DOD has reported that the rate of suicide for the National Guard is higher than expected relative to the general population.

Table 1. Unadjusted Suicide Mortality Rates by Service and Component, 2013-2018
(rate per 100,000 personnel)

Service	2013	2014	2015	2016	2017	2018
Active Total	18.5	20.4	20.2	21.5	21.9	24.8
Army	22.5	24.6	24.4	27.4	24.3	29.5
Air Force	14.4	19.1	20.5	19.4	19.6	18.5
Navy	12.7	16.6	13.1	15.9	20.1	20.7
Marine Corps	23.1	17.9	21.2	20.1	23.4	31.4
Reserve Total	22.8	21.6	24.7	22.0	25.7	22.9
Army Reserve	29.6	21.4	27.7	20.6	32.1	25.3
Air Force Reserve	nr	nr	nr	nr	nr	nr
Navy Reserve	nr	nr	nr	nr	nr	nr
Marine Corps Reserve	nr	nr	nr	nr	nr	nr
Natl Guard Total	28.9	19.8	27.5	27.3	29.1	30.6
Army Guard	33.7	21.8	29.8	31.6	34.6	35.3
Air Guard	nr	nr	19.9	nr	nr	nr

Source: Compiled by CRS from Annual Suicide Reports and DOD Suicide Event Reports.

Notes: Rates for subgroups with fewer than 20 suicides are not reported (nr) by DOD due to statistical instability.

Military-Specific Suicide Risk Factors

While military servicemembers are already a high-risk population for suicide due to the demographic composition,

the exposure to unique demands of military service are also associated with greater risk factors for this population:

Mental Health Conditions and Disorders. Exposure to combat and high-stress environments is associated with higher rates of mental health diagnoses, such as depression, anxiety disorders, and Post-Traumatic Stress Disorder (PTSD). Rates of these conditions and disorders among military servicemembers rose steadily from 2005 to 2015, according to the DOD Deployment Health Clinical Center.

Head Trauma/Traumatic Brain Injury (TBI). Research shows increased suicide ideation, attempt, and death rates among people who have experienced head trauma. Deployed military members may sustain concussive injuries as a result of explosive blasts. According to the Defense and Veterans Brain Injury Center, 17,841 servicemembers were diagnosed with TBI in 2017.

Substance Abuse and Associated Disorders. Evidence indicates elevated risk of death by suicide among people with substance-use disorders, including heavy alcohol use. While illicit drug use is not prevalent in the military, surveys have shown that a higher percentage of military personnel report heavy alcohol use compared to similar civilian cohorts. Among servicemembers, drug and alcohol overdoses are the most common methods for suicide *attempts*.

Access to Firearms. Studies have shown that access to firearms is associated with increased risk of death by suicide. Servicemembers generally have more exposure to firearms than the civilian population and are more likely to own a personal firearm. Firearms are the most common method of suicide death among military populations, accounting for 69.6% of all CY2018 suicides in the National Guard, 61.7% in the Reserves, and 60.0% in the Active Component.

Funding

Congress funds DOD suicide prevention programs and research through its annual defense appropriation. Suicide prevention research is primarily funded through the Defense Health Program and, in the past, has received additional funds through the Congressionally Directed Medical Research Program (CDMRP). In FY2019, Congress appropriated $125 million for the CDMRP's psychological health and TBI research portfolio, which includes the Military Suicide Research Consortium. In FY2019, the Psychological Health Center of Excellence (PHCoE) was appropriated $1.42 million. PHCoE focuses on conducted research and integrating evidence-based treatments to address mental health conditions, including suicide.

The President's FY2020 Budget Request includes $9.3 million to fund DSPO, up from $8.7 million in FY2019. The military services, components, and activities, also fund suicide prevention and resiliency activities, as part of family and community support programs, through their Operation and Maintenance budget (e.g., the Army's Ready and Resilient Campaign or the Special Operations Command Preservation of the Force and Family initiative).

Legislative Actions

Congress has taken actions to enhance and expand DOD suicide prevention policies and programs (see **Table 2**). These actions have included strengthening DOD oversight and increasing data collection, reporting, and analysis. Other legislation has sought to improve outreach, awareness, and resiliency, particularly among certain military communities deemed to be at high risk for suicide.

Table 2. Selected Legislation, FY2011-FY2019

Authority	Action
FY2011 NDAA (P.L. 110-417)	Required DOD to establish a task force to examine suicide prevention and develop a comprehensive suicide prevention policy.
FY2012 NDAA (P.L. 112-81)	Required DOD to enhance its suicide prevention program in cooperation with other government stakeholders and to include suicide prevention information in pre-separation counseling.
FY2013 NDAA (P.L. 112-239)	Established a DOD oversight position for suicide prevention and resilience programs and expanded programs to RC members and their families. Amended Section 1062 of the FY2011 NDAA to allow a member's health professional or commanding officer to inquire if the member owns or plans to acquire any weapons if reasonable belief exists that the member is at high risk for suicide or harm to others.
FY2015 NDAA (P.L. 113-291)	Required DOD to prescribe standards for data collection and reporting related to suicides and suicide attempts to include reporting for military dependents, and directed DOD to conduct a review of suicide prevention programs for Special Operations Forces (SOF).
FY2016 NDAA (P.L. 114-92)	Authorized DOD to develop a policy to coordinate its efforts with non-governmental suicide prevention groups and expanded outreach to separating servicemembers.

Source: CRS consolidation of relevant legislation.

Considerations for Congress

Oversight questions for Congress with regard to military suicide and resiliency may include:

- How can research be better disseminated and brought into practice?
- On what aspects of the issue should future congressionally funded research efforts focus?
- What gaps, if any, remain in DOD, service-level, or interagency suicide prevention programs?
- What factors contribute to differences in suicide rates among the services and components?
- Are high-risk military members and communities being identified and do they have access to appropriate and/or tailored services?

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