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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 its constitutional authority to organize and regulate the military, Congress has oversight over this issue and may consider policy interventions to mitigate suicide risk factors.

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

According to DOD reports, in calendar year (CY) 2019 (the most recently available data), 498 servicemember died by suicide; including 344 deaths in the Active Component (AC), 65 in the Reserves, and 89 in the National Guard. (See **According to DOD analysis, when calculating military suicide rates to account for demographic disparities between the military and civilian populations, adjusted military suicide rates are higher than, but comparable to CDC-reported civilian suicide rates (i.e., the differences between these rates are not statistically significant).**

Table 1.) While suicide remains a low incidence event, Active Component suicide rates have trended upwards since 2013. In 2019, suicide rates in the National Guard showed a statistically significant decrease from the previous year; however, in the longer term there are no discernable trends.

In terms of demographics, over 90% of military suicide deaths are men, and approximately half of reported suicides are junior enlisted personnel (E1-E4). While 42.7% of the total military population in CY2019 were enlisted men under the age of 30, this demographic accounted for 61% of the suicide deaths.

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 14.2 per 100,000 in 2018; markedly lower than the 2018 AC rate of 25.9 per 100,000. However, direct comparisons between the general civilian population and the military can be deceiving, as the military services are disproportionately comprised of younger individuals and more males. These sub-populations at higher risk for suicide.

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Table 1. Unadjusted Suicide Mortality Rates by Service and Component, CY2014-2019
(rate per 100,000 personnel)

Service	2014	2015	2016	2017	2018	2019
Active Total	**20.4**	**20.2**	**21.5**	**22.1**	**24.9**	**25.9**
Army	24.6	24.4	27.4	24.7	29.9	29.8
Marine Corps	17.9	21.2	20.1	23.4	30.8	25.3
Navy	16.6	13.1	15.9	20.1	20.7	21.5
Air Force	19.1	20.5	19.4	19.6	18.5	25.1
Reserve Total	**21.6**	**24.7**	**22.0**	**25.7**	**22.9**	**18.2**
Army Reserve	21.4	27.7	20.6	32.1	25.3	18.9
Air Force, Navy, and Marine Corps Reserve rates are not reported (nr) by DOD when the suicide count is less than 20 due to statistical instability.						
Natl Guard Total	**19.8**	**27.5**	**27.3**	**29.8**	**30.6**	**20.3**
Army Guard	21.8	29.8	31.6	35.5	35.3	22.3
Air Guard	nr	19.9	nr	nr	nr	nr

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

Note: Changes in suicide rates from CY2018 to CY2019 are not statistically significant for the active component, but are significantly lower for the National Guard.

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, moral injury, and Post-Traumatic Stress Disorder (PTSD).

Military Culture. Aspects of military culture that value toughness and resiliency may discourage help-seeking behavior. Studies have shown that some servicemembers perceive a stigma attached to seeking mental health care, and express concerns that seeking care will harm their career opportunities.

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.

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.

Access to Firearms. Studies have shown that having a loaded firearm in the home increases the risk of suicide death by four to six times. 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 78.7% of all CY2019 suicides in the National Guard, 66.2% in the Reserves, and 59.6% in the Active Component.

Funding

Congress funds DOD suicide prevention programs, oversight and research through its annual defense appropriation. The Defense Health Program account primarily funds most of DOD's suicide prevention research and, in the past, has received additional funds through the Congressionally Directed Medical Research Program (CDMRP).

In FY2021, Congress appropriated $175 million for the CDMRP's psychological health and TBI research portfolio, which includes the Military Suicide Research Consortium. The Psychological Health Center of Excellence (PHCoE) and the Traumatic Brain Injury Center of Excellence (TBICoE) received nearly $0.5 million in appropriations. PHCoE conducts research and integrates evidence-based treatments to address mental health conditions, including suicide. TBICoE conducts research and integrates evidence-based treatments to address mild to severe TBI. DSPO was funded at $13.6 million in FY2021.

The military services, components, and activities, also fund suicide prevention and resiliency activities as part of family and community support programs through Operation and Maintenance accounts (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-FY2021

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 programs and expanded programs to RC members and their families. Allowed 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 a review of suicide prevention programs for Special Operations Forces.
FY2016 NDAA (P.L. 114-92)	Authorized DOD to coordinate its efforts with nongovernmental organizations and expanded outreach to separating members.
FY2020 NDAA (P.L. 116-92)	Authorized a pilot suicide prevention program for the National Guard using a mobile application.
FY2021 NDAA (P.L. 116-283)	Made RC prevention and resiliency programs permanent and required a multidisciplinary review of suicide events.

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 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?
- How does DOD measure program effectiveness?

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