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*DEPARTMENT OF THE NAVY SUICIDE  
INCIDENT REPORT (DONSIR):  
SUMMARY OF 1999 FINDINGS*

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# **Department of the Navy Suicide Incident Report (DONSIR): Summary of 1999 Findings**



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## Abstract

This report presents key findings from the first year (1999) of implementation of the Department of the Navy Suicide Incident Report (DONSIR). The DONSIR represents the first systematic attempt to collect epidemiological and risk factor data on all suicides that occur among active-duty Navy and Marine Corps personnel. This is the first in a planned series of annual reports that summarize DONSIR data. The intent is to provide line and medical personnel with information on suicide trends within Department of the Navy and to assist leaders in improving local suicide prevention efforts. In 1999, 40 Navy and 26 Marine Corps personnel died by suicide. This report includes all 1999 DONSIRs received by Navy Personnel Command and Headquarters Marine Corps by 31 March 2000. Data were entered into a database created and maintained by the Naval Health Research Center. Findings are summarized according to demographics, military career information, casualty data, medical and psychological status, and major risk factors. This report concludes with information on special issues pertaining to the DONSIR, and recommendations for further action.

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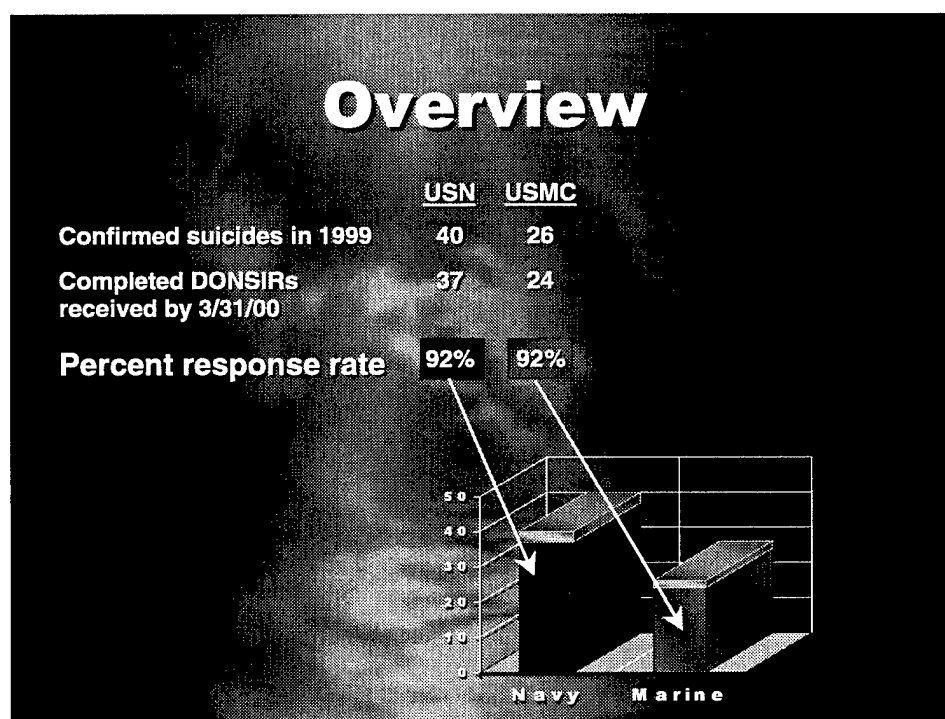
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## **Department of the Navy Suicide Incident Report (DONSIR): Summary of 1999 Findings**

### **Overview**

This report presents key findings from the first year (1999) of implementation of the Department of the Navy Suicide Incident Report (DONSIR). The DONSIR represents the first systematic attempt to collect comprehensive epidemiological and risk factor data on all suicides that occur among active-duty US Navy (USN) and Marine Corps (USMC) personnel. This is the first in a planned series of annual reports summarizing DONSIR data. The intent is to provide line and medical personnel with information on suicide trends within the Department of the Navy (DON) and to assist leaders in improving local suicide prevention efforts.

In 1999, 40 Navy and 26 Marine Corps personnel (N=66) died by suicide. This report includes all 1999 DONSIRs received by Navy Personnel Command and Headquarters Marine Corps by 31 March 2000. Given the complexity of suicide investigations, the DONSIR response rate for both services was a robust 92% (37 USN, 24 USMC; n=61). Data were entered into a database created and maintained by the Naval Health Research Center (NHRC).<sup>1</sup> Findings are summarized according to demographics, military career information, casualty data (including time and place information), medical and psychological status, and major potential risk factors. The report concludes with information on special issues pertaining to the DONSIR, and recommendations for further action.



## **Background**

In 1998, the Department of Defense (DoD) requested that all Services respond to a draft directive mandating the completion of psychological autopsies for deaths attributable to suicide or undetermined causes. Due to the relative expense, questionable reliability, lack of standardized procedures, and limited usefulness of psychological autopsies experienced in prior civilian and military studies, DON designed an alternative data collection instrument, the DONSIR, and sponsored a pilot test of its implementation. The purpose of DONSIR is to provide DON with the same type of information gathered in the psychological autopsy (PA) but collected in a standardized, structured format to accelerate access to the information and reduce sources of bias in the data collection process. DONSIR focuses on timely military sources of data only, thus avoiding further emotional burden on deceased servicemembers' family and friends.

## **Methods**

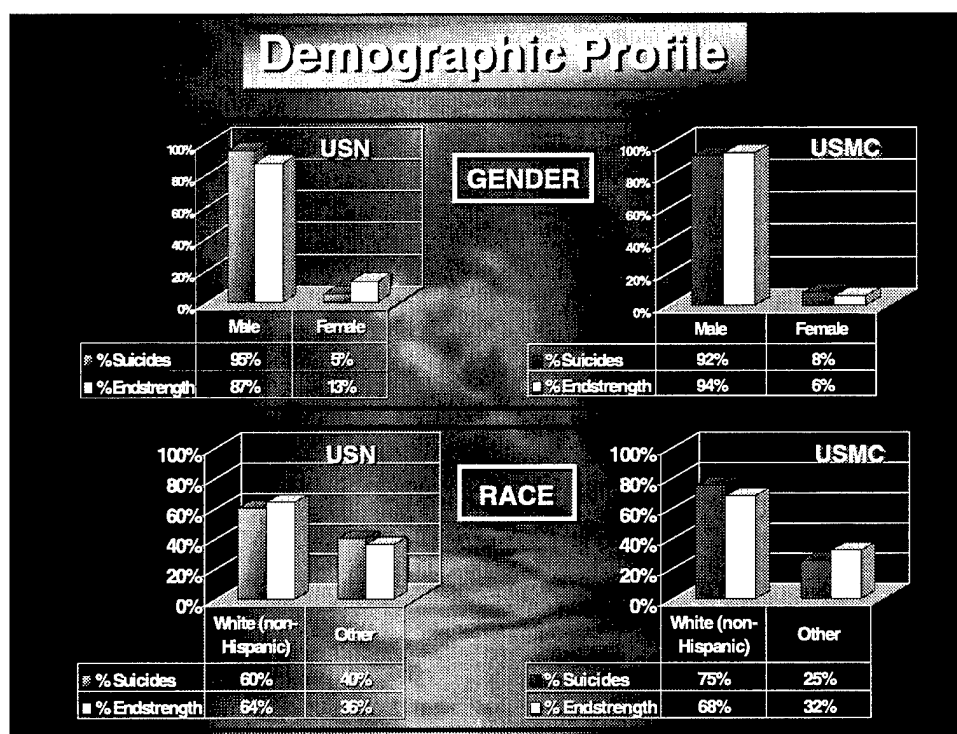
The DONSIR was constructed in consultation with psychologists affiliated with Navy Personnel Command (NPC), Headquarters Marine Corps (HQMC), Naval Criminal Investigative Service (NCIS), American Association of Suicidology, and NHRC. Input regarding suicide data collection in the military was also obtained from investigators in the Air Force Epidemiology Service, Walter Reed Army Institute for Research, and the National Institute of Mental Health. DONSIR incorporated all known suicide risk factors and suggested classes of variables recommended for inclusion in a PA, with emphasis on factors relating to the individual's military life.<sup>2</sup> The DONSIR form is divided into broad content areas including demographic information, command assessment of incident, incident information, military service information, background factors, personnel/civil information, medical information, use of services, situational factors, and report status/feedback. To ensure that potential risk factors covered by a PA would be covered by DONSIR items, six representative PAs from the period 1992-1998 were provided by NCIS for review. Draft DONSIRs were coded from information contained in the PAs and DONSIR items were added as indicated. The Air Force suicide data collection instrument was also reviewed to ensure that its content was included on the DONSIR form. The DONSIR format was designed to support direct data entry into an electronic database.

In preparation for DONSIR data collection NPC and HQMC Suicide Prevention Program Managers disseminated NPC and HQMC military instructions and provided informational cover letters to DONSIR points of contact (POCs). Program managers were available for telephone consultation to answer questions about the data collection process. DONSIR also solicited feedback on the process of its use from POCs via open-ended questionnaire items regarding accessibility of information, time to complete the instrument, command concerns about using DONSIR, and suggestions for improving the data collection process. POCs were asked to complete the DONSIR within three weeks of a suicide, brief their commands on their findings, and forward the form to the corresponding Navy/Marine Corps program manager. Program managers forwarded copies of all DONSIRs received to NHRC for data entry. Data were entered

with a double-data-entry reliability-checking scheme into an Access® database. Excel® pivot tables were created to allow for on-line query capability and automated reporting.

### Quantitative Analysis\*

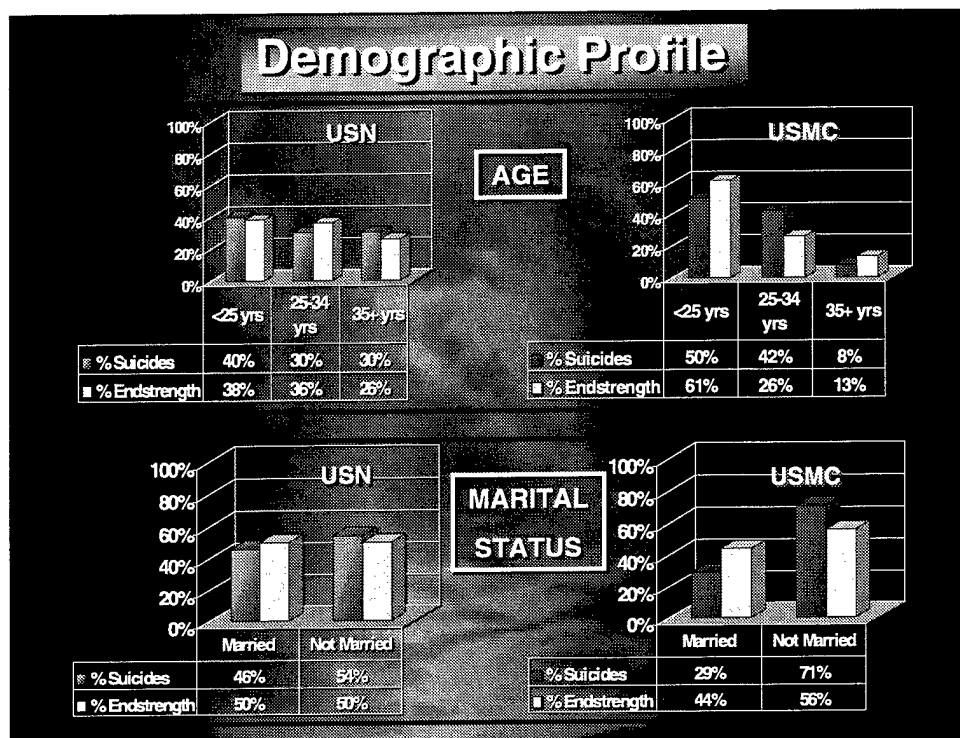
**Demographic Profile.** Fifty-seven (93%) of the suicides occurred among males and four (7%) among females. Most suicides (66%) occurred among Caucasians. This is consistent with the higher national rates observed for white males in the civilian sector.<sup>3</sup> Although suicides by females and nonwhites were infrequent, there was a slight trend toward a greater proportion of suicides to occur among Marine Corps females and Navy nonwhite personnel than would be expected given the distribution of these sub-groups in the Navy and Marine Corps populations as a whole. This finding is consistent with earlier research suggesting a potentially higher suicide risk in the military than in the civilian sector for these small demographic (female and nonwhite) groups.<sup>4,5</sup> In terms of age demographics, Navy and Marine Corps suicides were consistent with the Services population distributions. Navy suicides tended to be older and have higher education levels than those in the Marine Corps. The highest risk groups appeared to be Sailors over 34 years old and Marines between 25 and 34 years old.



Note: USN n=37, USMC n=24 (3 USN and 2 USMC DONSIRs not received by time of data analysis); missing data excluded. Endstrength data from DMDC as of 2/00.

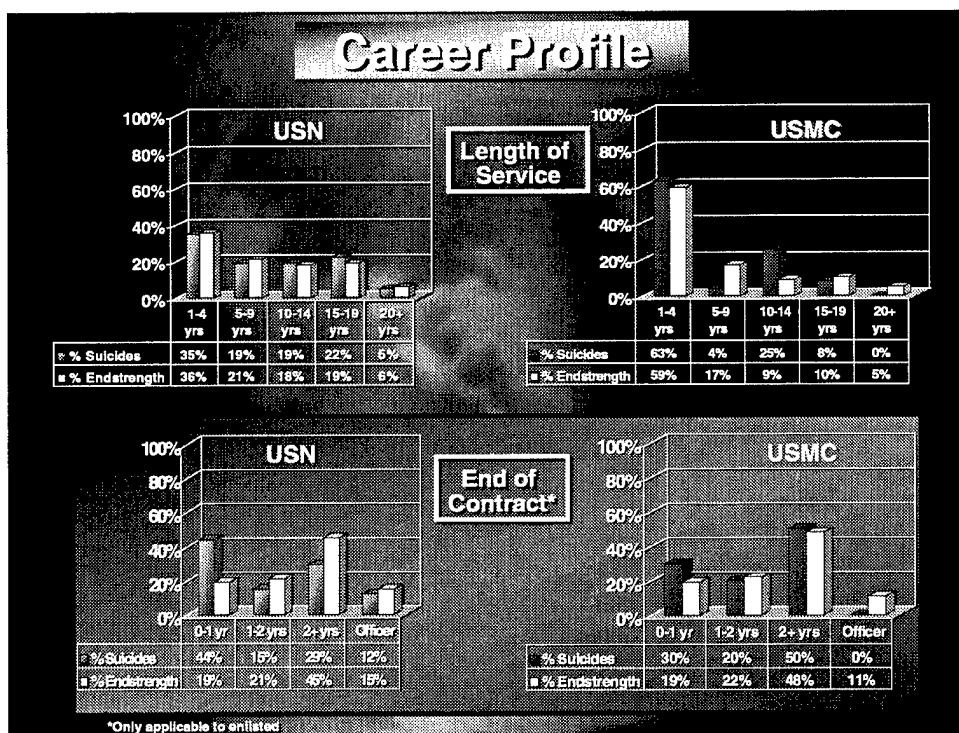
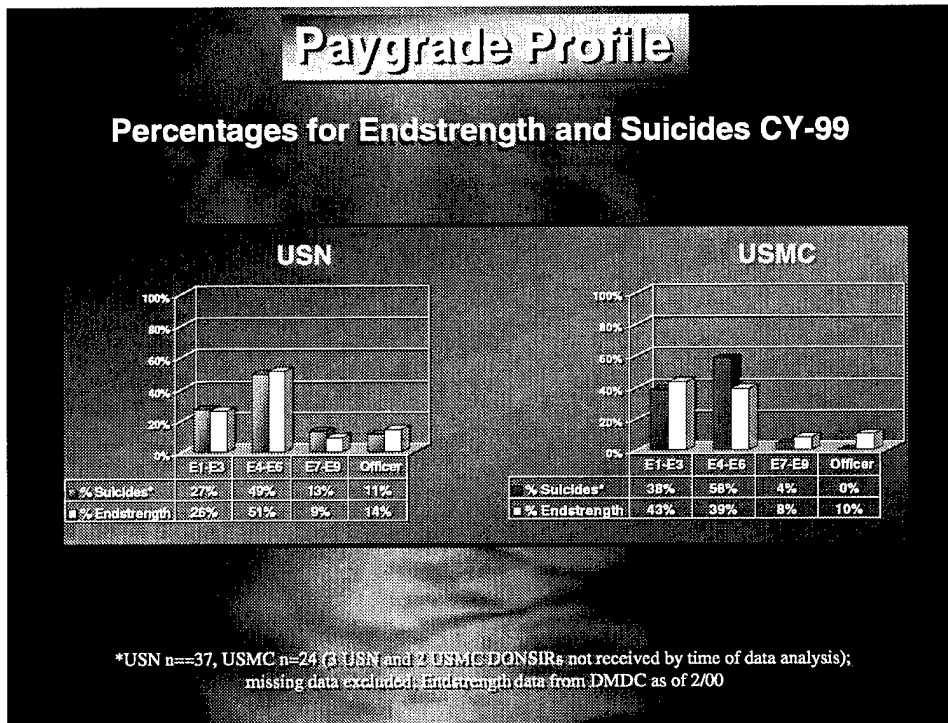
\* All quantitative data have been analyzed by branch of service with SPSS-PC, Version 9.0. Value categories for some variables were collapsed to minimize the number of cross-tabulation cells with less than five observations. Chi-square tests of significance were conducted on all cross-tabulations by branch. Because of small cell sizes, only a few tests of association were statistically significant; nonsignificant values are not reported. The likelihood of observing statistically significant differences will increase as the number of cases in the database increases. Thus, data presented herein are descriptive only, and caution should be taken in making generalizations.

Also, as in the civilian literature, nonmarried active-duty personnel are at greater risk for suicide than married personnel are.



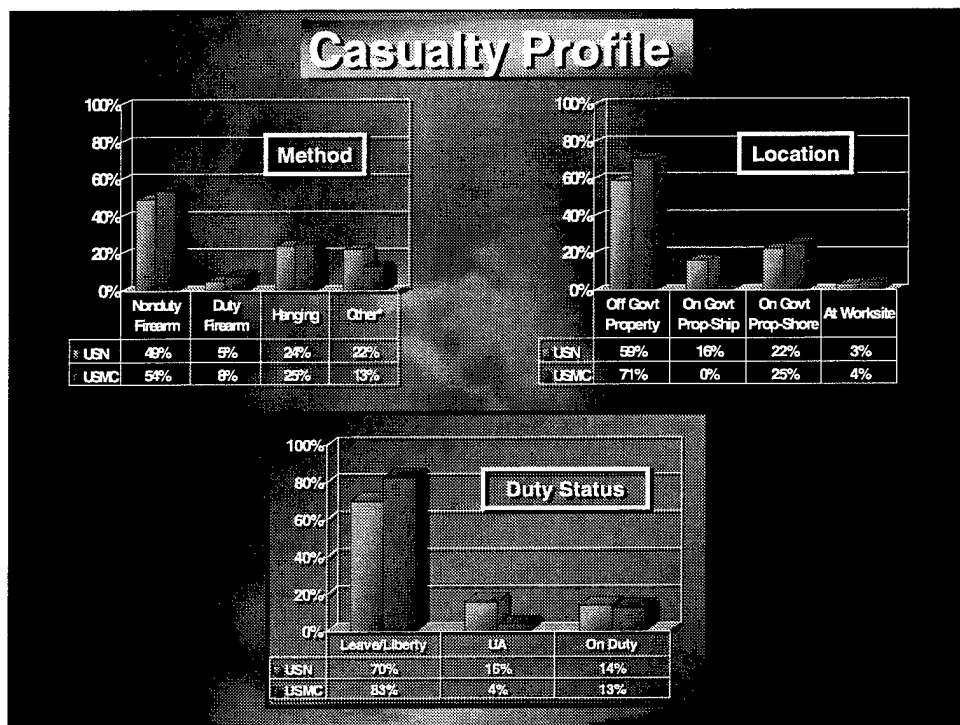
Note: USN n=37, USMC n=24 (3 USN and 2 USMC DONSIRs not received by time of data analysis); missing data excluded. Endstrength data from DMDC as of 2/00.

**Military Career Profile.** Among Marines, midlevel enlisted personnel (E-4 – E-6) were at highest risk for suicide. Among Navy personnel, senior enlisted personnel (E-7 – E-9) were at highest risk. Most Marine suicides took place within the first four years of service, whereas Sailors who had served 10-20 years were at greatest risk. Most enlisted Navy and Marine Corps members were at highest risk within a year of their expiration of active obligated service (EAOS)--usually a four-year contract. About one third of the cases had completed some type of hazardous duty or combat assignment sometime during their career. Only two of the 61 cases had a below-average rating on their most recent performance evaluation, and only three cases had not been recommended for promotion or were considered less than promotable. Among DON suicides, two had failed selection and two others had been demoted.



Note: USN n=37, USMC n=24 (3 USN and 2 USMC DONSIRs not received by time of data analysis); missing data excluded. Endstrength data from DMDC as of 2/00.

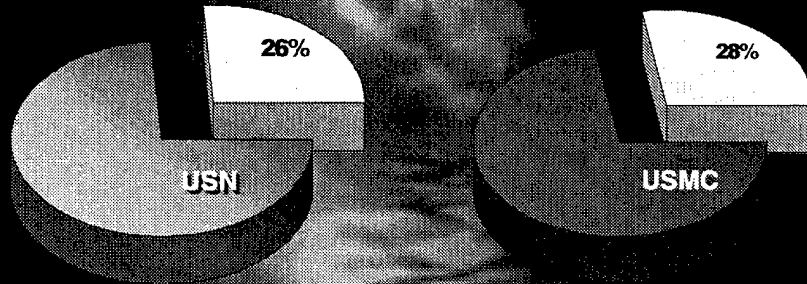
**Casualty Profile.** The most frequent location for suicide among both Navy and Marine Corps personnel was at home, and most often while on liberty. Only two of the 61 suicides occurred at the work site. Firearms were used in most suicides (57%), with Sailors more likely to use their own handguns and Marines more likely to use privately owned rifles or shotguns. The use of alcohol was suspected or confirmed in 26% of both Navy and Marine Corps suicides. Five suicides (8%) were accompanied by acts of violence. Three of these suicides were Navy and two were Marine. Two Sailors and one Marine committed homicide prior to their suicide; in all 3 homicides, the victim was the spouse or significant other. Inconsistent with the published civilian literature, the majority of the present cases did not communicate intent prior to the suicide.<sup>6</sup> Marines were significantly less communicative (only 9% communicated intent) than Sailors (49% communicated intent). The majority of suicides in both Services occurred when or where no one was likely in range to intervene and their bodies were most often found by someone who was not a family member or co-worker.



Note: Navy "Other" method includes 3 ingestions and 1 each of carbon monoxide, jumping from height, suffocation, strangulation, and drowning; Marine Corps "Other" method includes 1 ingestion, 1 carbon monoxide, and 1 vehicular.

## Casualty Profile

About one fourth of both USN and USMC suicides used alcohol at time of suicide

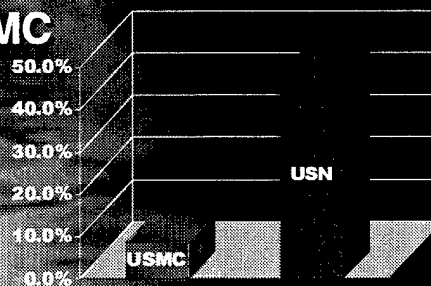


## Casualty Profile

A quarter of the suicides in both Services, occurred in close enough proximity for someone to intervene.



Almost half (n=18) of USN suicides and 9% (n=2) of USMC suicides recently communicated suicide intent.



In 1999, autumn months were the most frequent time of suicide for Navy personnel; whereas most Marine suicides occurred in the spring. Sundays were higher risk for Marines, with approximately one third of their suicides occurring on that day, whereas Navy's suicides were more evenly distributed across the days of the week. Marines were more likely to commit suicide in the evening-to-dawn hours and Sailors during the day. Long term trends in timing of suicides cannot be determined from a single year's data sample.

None of the Marine Corps and only 22% of Navy suicides occurred outside the continental US (OCONUS). San Diego (California) and Camp Lejeune (North Carolina) had the greatest number of suicides for Navy and Marine Corps, respectively, reflecting their relatively large concentrations of personnel.

### Where and When Suicides Occurred: Service Differences in 1999 Cases\*

- Autumn had the greatest number of USN suicides; spring had the greatest number of USMC suicides.
- USN suicides occurred most frequently during daytime hours on Saturdays (n=4); USMC suicides occurred most frequently on Sunday nights (n=5).
- San Diego had the greatest number of USN suicides (16%); Camp Lejeune for USMC (13%).
- 70% USN suicides occurred in echelon PAC or LANT; 31% USMC suicides in PAC or LANT \*\*
- 30% of USN suicides were assigned to ships; 26% of USMC were assigned to GCE units.
- 8 (22%) USN suicides occurred OCONUS; none of USMC.

\* 3 USN and 2 USMC DONSRs not received by time of report; missing data excluded.

\*\*Other frequencies of reported echelons for USMC suicides: 3 HQMC, 3 MCCDC, 2 RESFOR, 1 MCAS, 1 MCRD, 1 MEU, 1 squadron, 1 battalion.

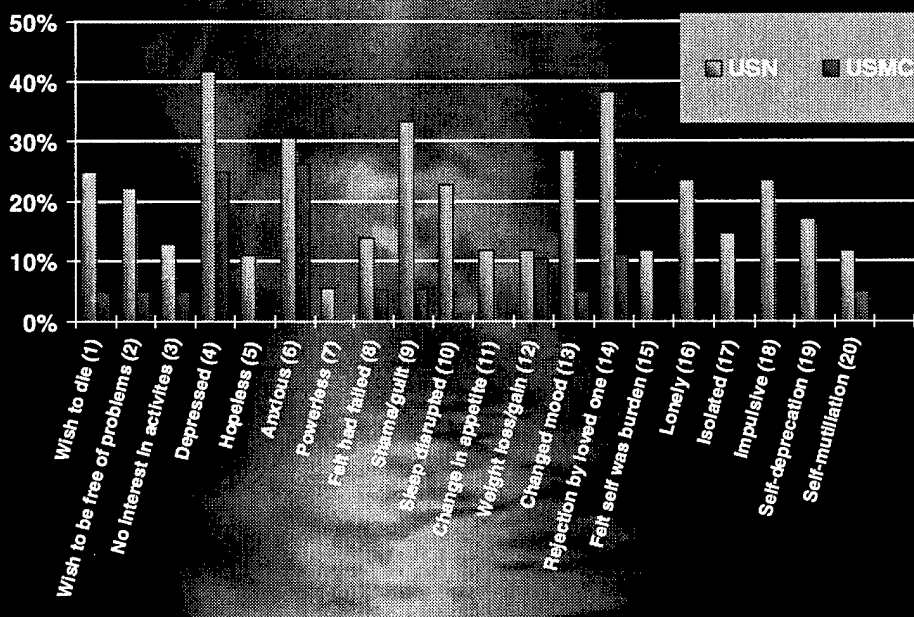
*Medical and Psychological Status.* Navy suicides were significantly more likely than Marine Corps suicides to have had 3 or more outpatient medical visits in the prior year, to have been on prescribed medications, or to have had a major or chronic medical problem. These findings held after stratifying by age, suggesting that the older age of Navy personnel alone did not account for the effects. Navy suicides also had higher proportions than Marine Corps suicides of cases with a reported family history of suicide, depression, or substance abuse, a personal history of physical or sexual abuse, and evaluation or treatment for a psychiatric condition. However, these inter-Service differences did not reach statistical significance. A majority of suicides in both Services showed evidence of at least one of 20 psychological symptoms. Sailors who committed suicide tended to show evidence of depression or feeling rejected, and Marines tended to show depression and anxiety. About one half of suicides in each Service were rated as having had a lack of social support.

## Medical/Psychological Status Among 1999 USN and USMC Suicides\*

	USN (N=37)		USMC (N=24)	
	N	%	N	%
Had 3 or more outpatient medical service visits in prior year†	19	54	4	21
On prescribed medication†	14	40	2	11
Major or chronic medical problem†	12	33	2	9
Family history of suicide, depression, substance abuse	11	44	3	20
Ever evaluated or treated for psychiatric condition	11	31	3	16
Previous suicide attempt or gesture	6	17	3	13
Ever hospitalized for psych condition	5	16	1	6
Victim of physical or sexual abuse	3	9	0	0
Evidence of pre-service psych problem	1	3	3	14

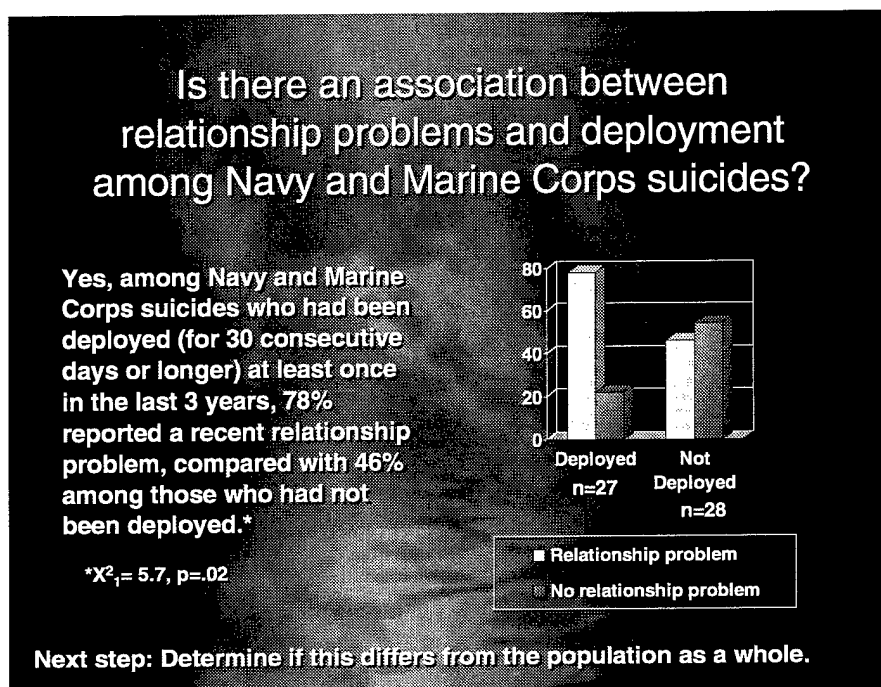
\*3 USN and 2 USMC DONORS not received by time of data analysis; missing data excluded; † applies to differences between services.

## Psychological Symptoms



**Major Potential Risk Factors.** The most frequently reported potential risk factor for both Services in this study's data was a recent relationship problem (61%). Suicides that had been deployed for 30 consecutive days or longer in the last three years were more

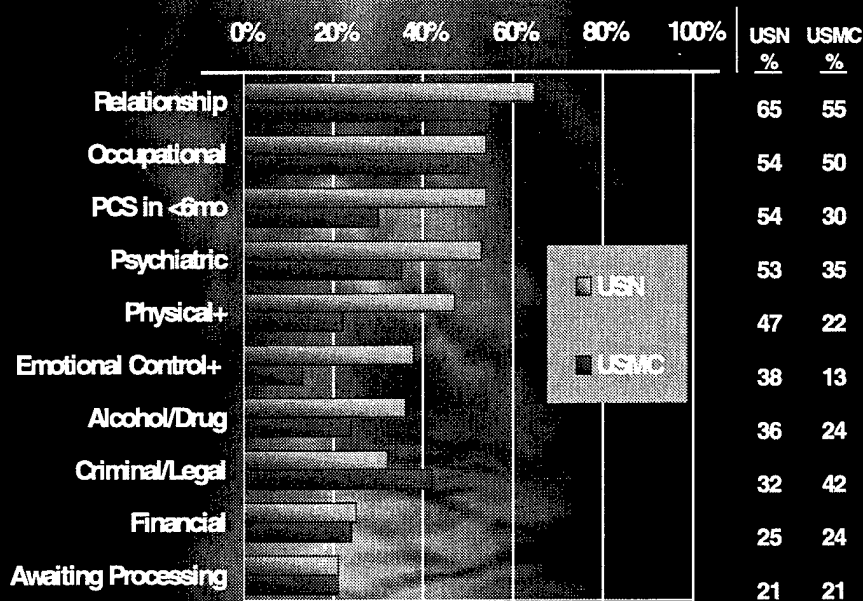
likely to have a recent history of relationship problems. Among 27 Navy and Marine Corps suicides who had been deployed in the prior three years, 78% reported a recent relationship problem compared with 46% among those who had not been deployed.



At least half of Navy and Marine Corps suicides showed evidence of some type of work-related issue or problem with the military. One third (31%) of Navy cases and 23% of Marine Corps cases reported job assignment dissatisfaction or a desire to leave the military. One third of Marine suicides and half of Navy suicides were within six months of a permanent change of station (PCS). Navy cases were somewhat more likely to have had any physical or psychiatric problem, and Marine cases had a slightly higher proportion of cases with a criminal or legal problem. There was evidence of serious financial problems, such as bankruptcy and bill collectors, in about one quarter of the cases in each Service. About one out of five (21%) suicides in each Service were on temporary status (e.g., awaiting Medical Evaluation Board or administrative processing) at the time of the suicide. (See Appendix I for definitions of major risk factor variables.)

Other potential risk factors include command characteristics or situational factors that may contribute to job stress. The majority of commands in which a suicide occurred had experienced some type of change in command climate, such as a new commanding officer, deployment, high operational tempo, or reorganization. However, such command climate changes may be just as prevalent among commands that did not experience suicides. Nearly half of the commands (25 out of 56) had experienced a prior suicide or attempt within the year, and 71% of suicides had attended some form of suicide awareness training within the prior year.

## Major Potential Risk Factors\*



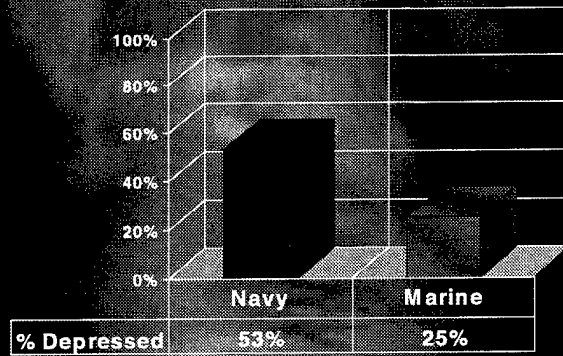
\* See appendix for variable definitions.  
+ p<.05 for differences between services.

## Selected Potential Contributing Factors to USN and USMC Suicides, 1999\*

	USN (N=37)		USMC (N=24)	
	n	%	n	%
Had top secret clearance	5	15	0	0
Received waiver to enter service	11	31	3	14
Had been exposed to hazardous duty or combat	11	31	7	30
Expressed or demonstrated at least 1 of 20 psychological symptoms	28	78	10	50
Had less than average social support	16	46	11	52
Used any medical or counseling services in prior 3 months	23	64	9	41
Had avg. to below avg. on last overall performance rating	11	33	9	43
Had change in command climate	29	78	19	86
Previous command suicide or attempt	17	47	7	33

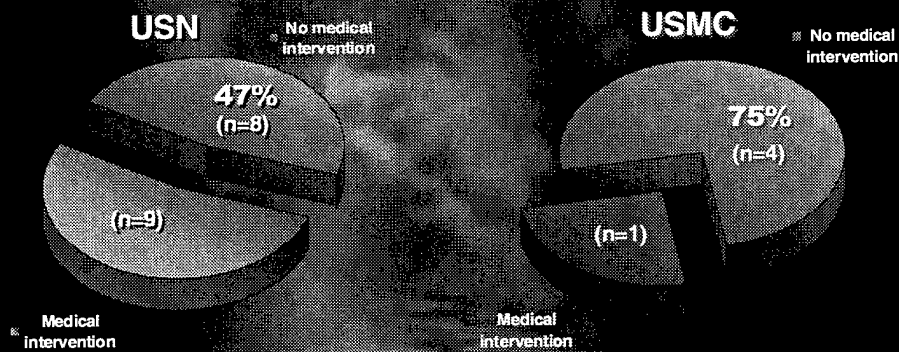
\* 3 USN and 2 USMC DONSIRs not received by time of data analysis; missing data excluded.

## Percent Appearing Depressed\* Prior to Suicide



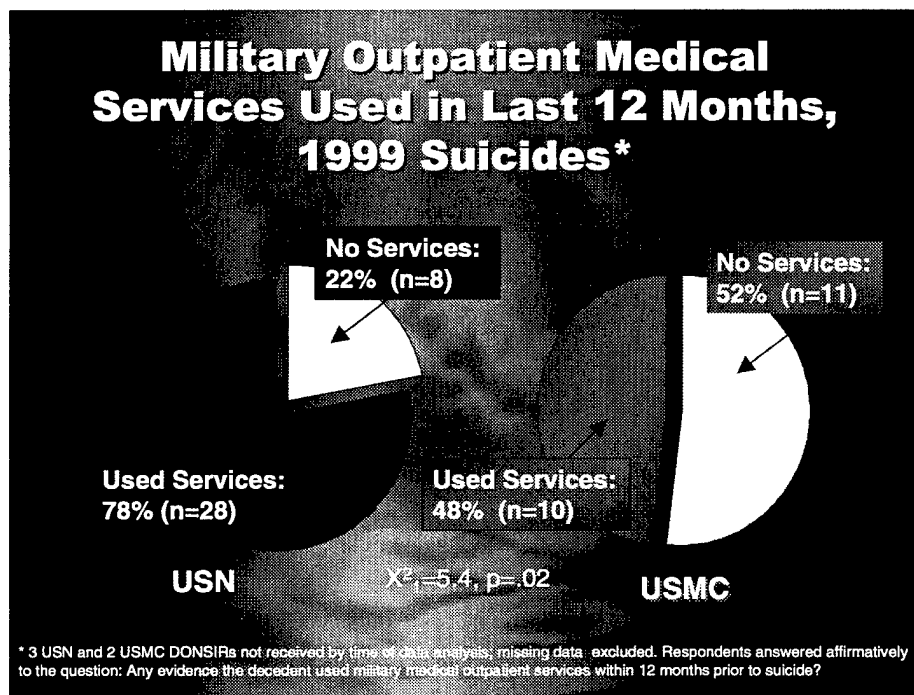
\* Expressed or demonstrated feelings of depression or desire to die.

## Proportion Suicides Appearing Depressed\* Who Received No Medical Intervention



\* Expressed or demonstrated feelings of depression or desire to die.

*Use of Services.* Among Navy suicides who had expressed any feelings of depression or desire to die, about half had been evaluated or treated. Among Marine suicides expressing feelings of depression, only 25% had received evaluation or treatment. Only 20% of Sailors and 6% of Marines in the year prior to their suicide used individual counseling services such as mental health, substance abuse, financial counseling, stress management, anger management, Family Advocacy Program, Family Service Center, or chaplain. However, use of medical evaluation and services were fairly frequent: 83% of Navy and 57% of Marine Corps cases had had at least one medical appointment or contact within the prior year. In terms of recent medical appointments, 50% of Navy cases and 43% of Marine Corps cases saw a medical provider during the three months prior to their suicide. Navy suicides were significantly more likely than Marine Corps suicides to have had a military outpatient visit in the prior year. A greater proportion of Marine Corps decedents (17%) than Navy decedents (8%) had visited a civilian medical treatment facility in the year prior. There was a tendency for Sailors to have used mental health services and Marines to have used the Family Services Center, Chaplain Services, and financial counseling.



### Content Analysis\*

*Lessons Learned and Recommendations for Command Action.* Many of the "lessons learned" by commands from the suicide incident were prevention-oriented. These

\* Content analyses were conducted on selected narrative and open-ended items of the DONSIR. The content-analysis method used can be summarized by the following steps that were applied to each item separately: (1) the narrative response was summarized into as many key ideas as were identified by the analyst; (2) these key ideas were grouped across respondents into categories based on similar concept; (3) each concept was assigned an arbitrary, unique code number; (4) each key idea was then assigned the code number of the corresponding category; and (5) the percentage of respondents per category was computed.

lessons included items such as recommending that all threats should be taken more seriously, noting that undermanning of ships creates stress, suggesting more attention be given to mental health issues, wanting more follow up on referrals, and recommending continued suicide prevention training (see Appendix II for detailed results). Marine Corps commands were somewhat more likely to suggest increased awareness and discussion. The majority (60%) of Marine Corps commands made the recommendation for command action to conduct or continue suicide awareness training, compared with 31% of Navy commands (see Appendix II). Across both Services, suggestions for prevention steps beyond the annual awareness training included strategies toward individuals with a known problem or setback, but most suggestions concerned strategies applicable prior to awareness of a personal problem. Overall, more than one third of the POCs indicated the suicide was unpredictable.

**“What are specific ‘Lessons Learned’  
by the command from this incident?”**

Categories: <u>Lessons Learned</u>	Respondents					
	USN (n=33)		USMC (n=17)		Total (n=50)	
	n	%	n	%	n	%
Suicide is unpredictable and unpreventable.	12	36	5	29	17	34
Command could take prevention steps (other than awareness training).	11	33	4	23	15	30
Command could use damage-control steps (after suicide).	7	21	8	47	15	30
Take special steps for members dealing with set-backs & problems.	6	18	4	23	10	20
Suicide awareness/training is important/necessary to prevention.	5	15	2	12	7	14
Anyone is susceptible to suicide.	2	6	2	12	4	8
None	1	3	0	0	1	2
(blank)	4	*	7	*	11	*

\* 18% of 61 respondents (37 USN and 24 USMC) left the item blank; those cases are excluded from computation of tabled percent values. Due to multiple responses per item, values sum to more than 100%.

*Suicide Stressors.* Stressors were categorized both by the POC’s narrative assessment of the stressors involved in the case and quantitative analysis of the specific risk factors identified on the DONSIR. POC’s provided short narrative responses to open-ended questions such as, “What were the significant stressors/events surrounding this suicide?” and “Secondary or associated factors include: [fill in the blank].” These narrative responses were similar to the ranked major risk factors obtained from the quantitative analyses. Interpersonal loss or problem was cited by the most respondents, followed by job stressors. One or the other or both were reported in over 50% of suicides. Coping impairment, legal problem, physical pain/impairment, and financial/convenience hardship were other important stressors identified. Significant stressors were more difficult to determine in Marine Corps suicides; 28% reported no known stressors.

### **DONSIR Administration Feedback**

The largest proportion of commands completing the DONSIR reported no difficulties or concerns with the report and/or did not offer suggestions for improving the process of data collection. Of those that did, most were concerned about duplication of effort with other investigations or about insufficient time to access records and other information sources. Suggestions for improvement included allowing additional time to complete the DONSIR, allowing commands to retain records until the DONSIR is completed, tailoring the Judge Advocate General (JAG) investigation to obtain DONSIR information, increasing DONSIR awareness, and making the report electronic and/or Internet-based (see Appendix II).

Other investigations that were occurring either prior to or during completion of the DONSIR included JAG, NCIS, and/or civilian authorities (see full-page table). The proportion of suicides pending final confirmation at the time of DONSIR completion was the same (17%) for each Service. JAG and/or NCIS investigations were completed, ongoing, or planned in 82% of the suicides in both Services. However, DONSIRs on Navy suicides were more likely to report that the pending investigation was by NCIS. Navy administrators were also more likely to report feedback comments indicating redundancy between DONSIR and other investigations, as shown in the content analysis (see Appendix II).

Non-medical personnel administered 100% of Marine Corps DONSIRs and 70% of Navy DONSIRs. In both Services POCs primarily accessed the casualty report, military service and medical records, and selected individuals for interview (see table). POCs for Marine DONSIRs tended to be lower ranking than POCs for Navy DONSIRs. Marine Corps DONSIRs had significantly more missing data than Navy DONSIRs ( $F=8.7$ ,  $df=58$ ,  $p=.005$ ). Marine POCs were less likely to have access to medical records and frequently commented that the records had been forwarded to headquarters within 5 days per BUPERSINST 1770.3. Navy POCs were twice as likely to use interviews as sources of DONSIR information and to consult mental health professionals as were Marine Corps POCs. In both Services, co-workers, supervisors, CACOs, and top-level command officers were the most frequently consulted resources in completing the DONSIR.

POC time involvement to complete the DONSIR was 5-16 hours for most (63%) POCs, with Marine POCs completing the DONSIR in about half the average time (USN average = 15 hours, USMC average = 8 hours) as did Navy POCs.

### **Special Topics**

*Medical Versus Line Officer POC Comparisons.\** An issue with regard to fleet implementation of the DONSIR is the potential for limited medical resources to support

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\* Navy POCs in selected geographic areas were asked to complete the DONSIR for the suicides in their areas. Navy POCs were clinical psychologists, psychiatrists, or clinical social workers. Preference for Navy POCs was given to individuals who currently collect clinical suicide data in their area. Navy POCs were identified via psychiatry department heads of area military treatment facilities. Marine Corps POCs were G-1 personnel officers. Marine Corps POCs were identified through their commanding officers via message from Marine Corps Headquarters.

**Table 1. Service Differences in 1999 DONSIR Data Collection**

	USN (N=37)		USMC (N=24)		Test Statistic
	n	%	n	%	
At time of DONSIR data collection					
JAG investigation complete, ongoing, or planned	25	76	9	53	$X^2_3=9.7, p=.02$
NCIS investigation complete, ongoing	27	82	9	45	$X^2_2=10.5, p=.005$
Civilian investigation complete, ongoing	19	58	13	62	
Most cited as used in completing DONSIR*					
Service record	33	89	20	83	
Medical record	31	84	12	50	$X^2_1=8.0, p=.005$
Investigation report	20	54	8	35	
Interviews	31	84	11	48	$X^2_1=8.7, p=.003$
POC considered good source of DONSIR data					
Command interviewees	33	89	18	86	
Noncommand interviewees	22	92	14	100	
Most cited as consulted for DONSIR					
Co-workers	33	89	18	78	
Supervisors	32	87	18	78	
CACO	28	76	16	70	
CO/XO/Command-level	26	70	16	70	
Legal officer	24	65	10	44	
Medical care professional	16	43	11	48	
Chaplain	13	35	11	48	
Mental health professional	13	35	4	17	
Other military	22	60	15	65	
Other nonmilitary	11	30	3	13	
(Family member)	(1)	(3)	(2)	(9)	
Paygrade of DONSIR POC					
E-5 – CWO5	2	6	8	35	$X^2_2=11.1, p=.004$
O-1 – O-3	15	43	11	48	
O-4 – O-6	18	51	4	17	
Hours to complete DONSIR					
1 – 4 hours	4	12	7	35	$X^2_3=7.7, p=.05$
5 – 8 hours	9	26	8	40	
9 – 16 hours	14	41	3	15	
17+ hours	7	21	2	10	

\* By military instruction, service and medical records were to be forwarded to NPC or HQMC within 5 days of death.

DONSIR data collection. Because it was unknown whether the quality of DONSIR data would be contingent on having a medical background to extract required medical and psychological data from records and interviews, a small sub-study was initiated to compare the quality of DONSIR data from mental health service and line officer administrators. BUMED-assigned mental health service officers (psychologists, psychiatrists, social workers, and nurses) who were not necessarily part of the command where the suicide occurred, were assigned as points of contact for 13 DONSIRs; one case not returned from a deployed submarine and one case subsequently ruled an accident were not included in these analyses. Data quality was assessed by the amount of missing data.

When Navy DONSIR data were examined by type of administrator responsible for its completion (i.e., BUMED-assigned mental health services officer vs. command-assigned POC), no statistically significant differences were found. There were no differences between these groups for number of people consulted, number of information-source types accessed, amount of missing data both overall and for key medical-information items, and endorsements of risk factors (i.e., items concerning evidence of situational, medical, or psychological problems). However, BUMED-assigned POCs took an average of seven hours longer to complete the DONSIR.

In reviewing DONSIRs completed by BUMED-assigned mental health officers it was discovered that in four cases DONSIRs were actually completed by a *non-medical* command POC. In addition, there was a further complication in determining the relative value of BUMED-assigned mental health POC versus command-assigned POCs: some suicides occurred in medical commands. This resulted in the command-assigned POC having a medical or nursing background that was in many ways comparable to the health-related background of BUMED-assigned mental health professional. To overcome these complications, a comparison was analyzed based solely on presence or absence of health related background for the DONSIR administrator. Results showed that administrators with a health-related background reported more pre-existing risk factors on the DONSIR than did those without medical backgrounds. Administrators with health related backgrounds also had less missing data in their completed DONSIRs.

Combined results suggest that there is little advantage to an external assignment of mental health POCs who are not a part of the command where the suicide occurred. However, when non-health-related DONSIR administrators are compared to all administrators with health-related backgrounds including those assigned from within the command, the completed DONSIR is more likely to have less missing data and reveal more specific circumstantial stressors. This suggests that administrators from within the command, especially those with some health-related background, may be better equipped to identify specific risk factors as they occur within the operational environment.

*DONSIR versus Psychological Autopsy (PA) Comparison.\** In a recent review of suicide assessment methodologies, strengths of post-suicide assessment instruments, including the DONSIR, were compared to those of the PA.<sup>7</sup> It was concluded that, while appearing to capture similar information, DONSIR data had a broader, more general application in that unlike the PA, it easily permitted quantification and pooling of results to provide ready feedback into intervention and prevention activities or programs. In a final set of analyses in the present study, quality of risk factor data was compared between that obtained on DONSIR and that obtained by PA. Of ten PAs provided by NCIS, six were used in the comparative analyses (excluded were two accident PAs with no DONSIRs and two suicide PAs for which DONSIRs had not been returned as of May 2000).

Results showed that PAs contained more discussion on the potential subjective state of the deceased (often based on family and friend interviews). However, a comparison of specific risk factor data gathered by DONSIRs and PAs revealed that four out of five DONSIRs reported the same external stressors and specific risk factors as PAs. The exception resulted from the comparison of a PA with a DONSIR for which the medical and service records were apparently unavailable at the time the DONSIR was completed. In addition, one of the comparison cases resulted in no identification of external stressors or specific suicide risk factors by the DONSIR. Subsequent NCIS psychological autopsy deemed this death to be a probable accident.

## **Psychological Autopsy (PA) and DONSIR Data Comparisons**

### Method of Analysis:

- 6 1999 PAs used from NCIS: 2 accidents, 4 suicides (3 USN, 3 USMC).
- DONSIR forms completed on the basis of information available from PA.
- Item by item matches and mismatches reviewed and discrepancies identified.
- Discrepancies defined as potential risk factors recorded in only PA or only DONSIR.

### Summary of Results:

- Although PAs reported more emotional symptoms (often based on family and friend interviews), 4 of 5 DONSIRs reported same major stressors as PAs.
- Exception was DONSIR for which the medical and service records were unavailable (had been returned to Division HQ per instruction).
- A DONSIR that reported no stressors was ruled accidental by NCIS.
- In addition to more complete demographic and military-service specific data, one DONSIR included potentially important intervention information that PA did not (i.e., decedent had been denied request for stress management course).

### Conclusions:

- DONSIR data are as comprehensive or more so than PA when DONSIR POC has same access to service and medical records as NCIS or JAG investigator.
- Extend PA data collection to strengthen PA-DONSIR comparative analyses.

\* An NHRC research team member completed a DONSIR form on the basis of information from each available PA (n=6). Research team members compared the PA-based DONSIR with the POC's DONSIR, jointly reviewing, item by item, matches and mismatches. Items were considered discrepant when a potential risk factor was recorded as present in one but not the other.

The DONSIR database format results in more reliable comparisons of information gathered in different reports by different administrators than the narrative psychological autopsy. This results in greater ease and validity in pooling data across multiple DONSIRs than from the narrative text of multiple psychological autopsies. The DONSIR also was more proficient at capturing demographic information and military service information (such as number of prior suicide attempts at the command, frequency of medical and counseling services used, job performance rating, time to PCS). Furthermore, one DONSIR included potentially important command intervention information the PA did not (i.e., decedent had been denied requests for stress management course). These few instances suggest DONSIR data may be as comprehensive or more so than PA information when the DONSIR POC has the same access to service and medical records as do NCIS or JAG investigators. Procedurally steps have been taken in both Services to improve record availability prior to DONSIR completion. In cases of suspected suicide the command is now responsible for ensuring medical record and service record availability until DONSIR completion.

### **Discussion**

Overall comprehensiveness of the DONSIR database, given sufficient cases, allows thorough investigation and analysis of potential modifiable risk factors for suicide in the naval services. As the number of cases in the database increases, specific stressors and problems can be identified and targeted for further examination. Work continues with available data from endstrength databases and Service population studies to compare specific data generated by DONSIR with normative data for Sailors and Marines. In this way specific suicide risk factor comparisons can be made between available normative databases and DONSIR databases. Such comparisons have the potential of reliably identifying key differences between suicidal and non-suicidal naval populations. The statistical power needed to perform more complex analyses will increase as cases accumulate and permit assessment of significant combinations of events and factors leading to a military suicide. Also, although the Services can be expected to differ on many variables given the diversity of their populations, in some cases Service differences may be used to improve respective suicide prevention programs. For example, in the present analyses, Marine Corps suicides appear less likely to have histories of initiating medical care than Navy suicides. If this trend continued and there was a consistent elevation in the Marine Corps suicide rate over Navy, it would be appropriate to suggest an organizational intervention based on continued encouragement of help-seeking behavior. Interventions based on such military-specific factors may be influential in reducing the rate of suicide in the military, and may be operating among cases that did not result in death. Continued DONSIR database maintenance will support further descriptive and analytic research designed to evaluate and improve DON suicide prevention efforts.

### **Conclusions and Recommendations**

1. DONSIR represents a significant advance in the capability of DON to track and analyze suicide data. However, it is important not to draw premature conclusions based only on one year's worth of data. During the initial year of the DONSIR project the high

response rate (92%) and quality of information indicated that the instrument fulfilled its purpose of standardizing the review and reporting process on suicides among active-duty personnel. At the DoD level, all Services are working toward creating common procedures for collecting information on active-duty suicides. It is strongly recommended that DON continue to use DONSIR to improve institutional knowledge about suicides among Sailors and Marines.

2. Present data establish baselines for monitoring significant stressors and problems for Sailors and Marines, such as relationship problems, medical and psychological problems, and alcohol abuse. These data can be used to support identification of risk factors and intervention opportunities. They are also consistent with leadership's continued attention to early intervention for problems contributing to suicide and encouragement of Sailors and Marines to seek help early before problems escalate into crises.

3. To make further use of data collected with DONSIR at the local level, recommend those tasked with completing the DONSIR brief their commanding officers on the results in the invited presence of members of the local support team--including medical, chaplains, supervisors, family advocacy, legal, and counselors. The support team briefing could encourage integration of services and exchange of information among local support staff.

## **Conclusions**

- The DONSIR represents a significant advance in the capability of the DON to track and analyze suicide data.**
- While further work is needed to refine some DONSIR data fields, the response rate (92%) and the quality of information received thus far suggest the DONSIR has fulfilled its purpose of standardizing the review and reporting process on suicides among active-duty personnel.**
- The present data establish baselines for monitoring significant suicide risk factors for Sailors and Marines, including relationship problems, medical and psychological problems, and alcohol abuse.**

## Recommendations

- It is strongly recommended that DON continue to use DONSIR to improve institutional knowledge about suicides among Sailors and Marines.
- These data are consistent with leadership's continued attention to early intervention for problems contributing to suicide and encouragement of Sailors and Marines to seek help before problems escalate into crises.
- To encourage integration of services and exchange of information between the helping staff, formalize DONSIR briefing process to include members of the support team including medical, chaplains, supervisors, family advocacy, legal, and counselors.

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## Appendix I

### Major Risk Factor Variable Definitions

- Physical Problem:** (affirmative response to any of 4 items)  
 Recent catastrophic diagnosis, chronic illness/condition, career-ending injury, or other physical problem (MED1a-d=2,3).
- Relationship Problem:** (affirmative response to either of 2 items)  
 Experienced a recent relationship problem (MIL21L=2,3);  
 Any recent death of loved one, relative, friend, Sailor/Marine (MIL21M=2,3) (excluded 1 USMC suicide).
- Problem with Military:** (affirmative response to any of 12 items)  
 Below-average performance rating in either of last 2 evaluations (MIL6a,7a=3);  
 Decrease over last 2 performance ratings ([MIL7a-MIL6a]);  
 Failed body composition portion of last PRT (MIL8=1);  
 Promotion status on last evaluation was “progressing,” “unsatisfactory,” or “not recommended” (MIL9 = 4,5,7);  
 Recently failed selection or denied reenlistment (MIL10=2);  
 Ever demoted (MIL11a=2,3);  
 Job dissatisfaction, other work problems, documented problems with authority, recent job loss, or military legal or admin problems (MIL21b,c,e,f,g=2,3);  
 Poorer than usual supervisor/co-worker rating of military performance/work behavior (MIL27=1).
- Psychiatric Problem:** (affirmative response to any of 5 items).  
 History of violent/aggressive behavior, problems regulating emotions (MIL21n,o=2,3);  
 Evidence of preservice psychiatric problems (MED11=2);  
 Ever evaluated/treated for psychiatric condition (MED15a=2-4) (exclude case if missing MED15a and negative responses on other items).  
 Used mental health services in past 12 months (USE1e=2-4)
- Criminal/Legal problem:** (affirmative response to any of 4 items)  
 Under investigation for criminal behavior (MIL21h=2,3);  
 Subject of civil legal difficulty (MIL21j=2,3);  
 Awaiting admin separation or other legal judgment/processing (MED18a1,4=2).
- Alcohol/Drug Problem:** (affirmative response to any of 3 items)  
 Any alcohol-related problems within last year (MED4a=2,3) (exclude case if missing MED4a and negative responses on other items);  
 History of substance abuse (other than alcohol or food) (MED7a=2);  
 Used substance abuse services within last year (USE1d=2-4).
- Financial Problem:** (affirmative response to either of 2 items)  
 Evidence of any serious financial problems (MIL21i=2,3) (exclude case if missing MIL21i and negative response to second item);  
 Used financial counseling in last 12 months (USE1f =2-4).
- Awaiting Processing:** (affirmative response to any of 4 items)  
 Awaiting separation, board, or other judgment/processing (MED18a1-4=2).
- PCS Within 6 Months:** (affirmative response to either of 2 items)  
 Experienced PCS within 6 months prior or expected PCS within 6 months following the incident (MIL19,20=2).
- Emotional Control:** (affirmative response to either of 2 items)  
 History of violent/aggressive behavior (MIL21n=2,3);  
 Problems regulating emotions (e.g., anger, anxiety) (MIL21o=2,3).

## Appendix II

### Content Analysis of Select DONSIR Data, 1999 Cases (N=61)

#### DONSIR items analyzed:

- Page 8, #5: "What questions/concerns does the command have about the DONSIR or its process?"
- Page 8, #6: "What suggestions do you or your command have for improving the process of data collection?"
- Page 10, #1a: "What were the significant stressors/events surrounding this suicide?"
- Page 10, #1b: "Secondary or associated factors include:"
- Page 10, #2: "What are specific 'Lessons Learned' by the command from this incident?"
- Page 10, #3: "Based on DONSIR review into this incident, what are the recommendations for command action?"

- Content Analysis Steps:**
1. Summarize each respondent's narrative response into key idea(s). (conducted per item)
  2. Group key ideas across respondents into categories based on similar concept.
  3. Assign each category an arbitrary, unique code number, and code each key idea per respondent.
  4. Compute summary statistics per category code, controlling for same-case code duplication.

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#### Item: "What questions/concerns does the command have about the Suicide Incident Report or process?"

Categories: DONSIR Concerns	Respondents					
	USN (n=28)		USMC (n=15)		Total (n=43)	
	n	%	n	%	n	%
Impact	11	39	2	13	13	30
Timely Record Assess	2	7	4	27	6	14
Item Difficulty	2	7	1	7	3	7
None	13	46	8	53	21	49
(blank)	9	*	9	*	18	*

\* 29% of 61 respondents (37 USN and 24 USMC) left the item blank; those cases are excluded from computation of tabled percent values. Due to multiple responses per item, values sum to more than 100%.

#### Narrative-response Key Idea(s) by Category:

(N = USN decedent; M = USMC decedent)

##### Impact

- N Is DONSIR really useful & necessary? Very painful to review this matter, but if useful in prevention, OK.
- N DONSIR requirement is extremely insensitive to family/friends/co-workers, being received well after the incident & reopening healing wounds. Use medical & service records, CACO message, & SITREP instead.
- N DONSIR seems redundant with other investigations.
- N Duplicates many hours spent on JAG investigation.
- N Collect this data from JAGMAN & NCIS investigations instead.
- N Can the command substitute a copy of the JAGMAN for DONSIR?
- N For JAGMAN cases, would it be possible to forward copy of JAGMAN rather than replicating effort via this report?
- N Concern for interview confidentiality; releasable under FOIA to show death not service-connected for VA benefits.
- N XO interested to see if DONSIR process finds any information to explain this suicide.
- N Would this command receive feedback when research project is over?
- M If no warning signs are discernable, suicide is unpreventable.
- M The Casualty Assistance command is not in best position to answer all these questions --deceased's last command is.
- N Clarify working relationship between medical POC & command POC; who was supposed to do the final submission? --if command POC, why send completed form to medical POC?

##### Timely Record Assess

- M In accordance with MCO, Service, Medical, Dental records sent to HQMC; not available for DONSIR.
- M Incorrect responses occur without benefit of JAG report.
- N Not enough preparation allowed.

- M Turnaround time is insufficient.
- M More time needed to allow gathering accurate info when from outside agencies.
- M Extend deadline to 30 days so can use CACO, coroner, police, & other information sources.
- N 15 days is not enough; 30 more realistic.

**Item Difficulty**

- M DONSIR is too in-depth.
- M No solid answers for many questions.
- N Command would only have knowledge of member's mental state if member had expressed it.
- N Very thorough.

**None**

- M None. LT Jones at HQMC was extremely helpful.
- \* None.
- M N/A.

\* *Multiple respondents, both services.*

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**Item: "What suggestions do you or your command have for improving the process of data collection?"**

Categories: Data Collection	Respondents					
	USN (n=28)		USMC (n=11)		Total (n=39)	
	n	%	n	%	n	%
Information Access	9	32	1	9	10	26
Required Effort	7	25	3	27	10	26
Electronic Version	6	21	1	9	7	18
Determining POC	0	0	2	18	2	5
None	10	36	5	45	15	38
(blank)	9	*	13	*	22	*

\* 36% of 61 respondents (37 USN and 24 USMC) left the item blank; those cases are excluded from computation of tabled percent values. Due to multiple responses per item, values sum to more than 100%.

**Narrative-response Key Idea(s) by Category:**

(N = USN decedent; M = USMC decedent)

**Information Access**

- M Since suicides require command investigation, allow more time.
- N The sooner data are collected, the more readily available information is on the deceased.
- N Allow commands to keep original service/health records until DONSIR completed, or direct them to make copies before forwarding originals.
- N Have BUPERSINST 1770.3 changed to read "Retain records until DONSIR is completed."
- N Glean required info from existing reports --CACO message, Unit SITREP.
- N Await completion of JAGMAN before forwarding DONSIR.
- N Include a block for unknown because the command may not be aware, but that does not mean the problem does not exist.
- N Directions prohibit contacting family; this makes pre-service info collection difficult & subject to speculation.
- N Family members should be interviewed to help with related questions.
- N Delete the interviews to avoid subjecting family & friends to more pain.
- N Think of ways to better assess info from family.

**Required Effort**

- M Reduce amount of information requested.
- M Eliminate duplicate reporting from DONSIR by tailoring JAG investigation to obtain the needed information.
- N Allow substitution of JAGMAN for this report.
- M To ease admin burden on same command providing a CACO, IO for JAG, & IO for DONSIR, make DONSIR part of command's death investigation. The JAG should provide a copy to MRO upon completion of the command investigation.
- N Refer to existing data (on file at NavPersCom or in OPREPS/SITREPS/Command Investigations/NCIS Reports).
- N PERS-601B should provide service-record info (from their microfiche), & BUMED should supply the medical info (since they receive the medical records).
- N Have someone at BUPERS consolidate info from JAG & NCIS reports (since both forwarded there), & limit DONSIR to questions only the command can answer (e.g., pages 7, 10, & #16-18 on page 6).
- N Many at JAG, FSC, FAP, & command were unaware of DONSIR, which complicated & slowed the process. Recommend informing relevant agencies. Perhaps have mental health POC should be present for short DONSIR brief.
- N Introduce DONSIR at regional CACO training so that their awareness of it is raised & commands will be expected to complete it for suicides.
- N Provide advance copy of DONSIR questions.

**Electronic version**

- M Make it electronic.
- N Make this form available in an electronic version.
- N Perhaps provide a disc with the DONSIR to facilitate typing responses.
- N Provide electronic or single-page version to facilitate typing.
- N Provide online web site data entry.
- N Why not make this an internet-based process to cut down in mailing time & costs?
- N Do it via e-mail/electronically.

**Determining POC**

M Investigating officer should complete the DONSIR so that information will be more accurate.

M This OCONUS command is removed from CONUS site of suicide, limiting information access. Recommend the I-I in the incident locality should complete such DONSIRs.

**None**

N None; survey is thorough.

M None—this is a very thorough questionnaire.

N None; seemed thorough, detailed, relevant.

M None at this time. Requested data seem in-depth.

N The DONSIR is a good method for obtaining data on suicides.

N None; Suicide Prevention Program Manager, LCDR Kennedy, was very responsive & available for any questions.

N None at this time.

\* None.

*\* Multiple respondents, both services.*

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**Two Items Combined: “What were the significant stressors/events surrounding this suicide?”**  
**“Secondary or associated factors include: ”**

Primary/Secondary Stressors	Respondents					
	USN (n=35)		USMC (n=18)		Total (n=53)	
	n	%	n	%	n	%
Interpersonal Loss/Problem	27	77	9	50	36	68
Work Stress	19	54	6	33	25	47
Coping Impairment	16	46	5	28	21	40
Legal Problem	12	34	2	11	14	26
Physical Pain/Impairment	9	26	1	6	10	19
Financial/Convenience Hardship	4	11	3	17	7	13
None / Unknown (both items)	1	3	5	28	6	11
(blank –both items)	2	*	6	*	8	*

\* 13% of 61 respondents (37 USN and 24 USMC) left both items blank; those cases are excluded from computation of tabled percent values. Due to multiple responses per item, values sum to more than 100%.

**Narrative-response Key Idea(s) by Category:**

(N = USN decedent; M = USMC; P = Primary stressors; S = Secondary.)

(“...” indicates where a comment was split to accommodate placement in more than one category.)

**Interpersonal Loss/Problem**

- M P Breakup with girlfriend.
- M P Breakup with girlfriend.
- N P Simultaneously broke up with girlfriend & ....
- N P Breakup (1 week prior) with long-time girlfriend.
- M S Recently broke up with girlfriend.
- N P Recent breakup with girlfriend he had hoped to marry.
- N P Anguish over fiancée ending their engagement.
- N P Guilt due to infidelity to fiancée...; fiancée had left previous spouse for infidelity.
- N P Sensed fiancée drifting away, though she & friends denied it.
- N P Recent rejection by a love interest.
- N P Personal relationship with girlfriend. She cheated on him; let him down.
- N S Possible extramarital affair.
- N S Chance of returning to sea with suspicion that wife would continue affair or divorce.
- N P SVM's spouse appears to have been involved with male friend. SNM confronted, shot male friend, shot & killed spouse, went into house, notified security, & killed self.
- N P Anxiety over possible disintegration of marital relationship after his disclosure regarding exposure to STD infection, despite her reassurances.
- N S SNM was ... without secure home-life to comfort him.
- N S The sudden separation/divorce from his wife.
- N P Marital problems with current wife.
- M P Marital problems; separation from spouse.
- N P Marital problems (which had prompted SNM to evict wife & request special liberty).
- N P Marital (discord, separation, infidelity).
- N P Marital discord with divorce likely.
- N P Long-term marital ... problems (domestic violence).
- M P Marital problems? (Wife asked him to move out, to which he agreed, then changed his mind.)
- M P Marital problems.
- N P Recent marriage issues.
- N P An investigation had ensued when, ... the 2 wives disagreed about his divorce status.
- N P Complicated child-custody divorce proceedings.
- N P Problems with mother of his son (stopped child support; son & mom had moved). SNM's Rolodex was open to son's (void?) phone number.
- N P Apprehensive that FAP investigation would result in loss of joint custody of sons....

- N P Lack of contact with son from failed 1<sup>st</sup> marriage.
- M P Lack of access to daughter.
- M P Two failed relationships.
- M P Wife (falsely) reported miscarriage.
- N S Language barrier (--wife is Japanese).
- N P Liked job, but did not cope with (physical) separation from wife well.
- N P Further investigation indicated relationship problems....
- N P Obsession with female officer whom he greatly admired professionally.
- N P Pregnant girlfriend.
- N P Ex-girlfriend pregnant. Wife suspected of affair.
- N P Apparently, he had an argument with his wife immediately prior to the act.
- M S SNM was with ex-girlfriend, who then left.
- N P Grandfather's suicide about three months prior.
- N P SNM's father's death (a few years ago).
- N P His mother was dying of cancer.
- M P Possible serious illness of sister made known just prior to incident.
- N P Childhood experiences of abuse, neglect, abandonment.
- N S Family problems dating from childhood.
- N P History of family problems.
- N S Incident of somewhat aggressive behavior two days prior, witnessed by officer.
- M S Pressure from mother-in-law.
- N P Inability to talk to friends/family about emotional frustrations.
- N S A loner; little social life.
- N S SNM was a loner who never confided his personal issues/problems with anyone.
- N S Social isolation.
- N S Disciplinary problems.
- N P Routinely counseled by Staff Duty Officer that morning for failing to muster for restriction.
- N P SNM's new LCPO.
- N P Increasing anger & frustration with officer leadership.

### **Work Stress**

- N S Pending PCS transfer.
- N S Recent return from deployment.
- N S High operational tempo. Uprooting of squadron (BRAC). Hurricane evacuation days before deployment.
- N S Base relocation very stressful.
- N P Possibly the irregular working hours in unfamiliar environment.
- N P Being placed on restriction pending....
- N P One month prior, SNM had been transferred to a watch schedule.
- N P SNM's internal work reassignment.
- N S Though expressed no job dissatisfaction, SNM was undergoing a job change after lengthy negotiations with supervisors; a possible stressor.
- N S SNM was near retirement without....
- N P He was amidst serious career decisions.
- N P Qualification for ATC suspended one year with poor prognosis of ever being reinstated.
- N P Apprehensive that FAP investigation would ... jeopardize his career.
- M P Heavy workload.
- N P Leadership attrition (due to retirement, PCS, and gapped billets) increased his workload.
- N P Despite dept head's frequent address on leadership transition, SNM did not adjust his personal perceptions.
- N S Desire to do something different & escape job stress was disclosed to wife with increasing frequency & anxiety.
- N P Taking two college courses after work & beginning 2nd job.
- N S Poor performance at "A" school --atrited.
- N S Worry about returning to college after brief attendance earlier in life.
- N S Felt bad about command's negative reaction to his reverse-decision to separate.
- M P Guilt over letting down his fellow marines.
- N S Though cleared of fraternization charges, felt reputation was diminished.
- M P Getting the rescinded sexual-harassment charge out of his record.
- N S Removal of security clearance.
- N S Tension from claimed threats from shipmates convicted at CAPT's Mast, followed by being ostracized by many peers in month prior.
- N P Further investigation indicated ... homosexual issues.

- N S Work discord, lack of command support to attend workshop for stress (given on ship).
- M P SNM did not want to remain in USMC.
- M P Being required to return to Japan against his wishes.
- N P Stressed by difficulty of process when marrying [foreigner?] while in the military.
- N P Possibly recent drastic lifestyle changes (recruit, then new to this command).
- M P New to command.
- M P New school graduate.

### **Coping Impairment**

- N P Alcohol use with history of violent behavior after drinking.
- N S Heavy alcohol use.
- N S History of alcohol problems.
- N S Drank to excess (~10 drinks) the night of the incident; was expecting to meet with his fiancée the following morning after 1 week apart.
- M P Suspected use of alcohol prior to incident.
- N S Alcohol (was used to numb problems).
- M S Prior to incident, SNM had a few beers socially.
- M P Possibly drinking was a stressor.
- N P Drinking problem.
- N P ... for alcohol-use relapse.
- N P Guilt due to infidelity to fiancée during drunken night in Thailand....
- N S Alcohol.
- N P Multiple prescription medicines.
- N P Suspected use of over-the-counter drug bought in Jordan.
- N S Family history of suicide (possibly predisposing him).
- N S History of suicide attempts/gestures.
- M P SNM had gestured suicide before in front of spouse.
- N S Chronic dysthymia with a self-perpetuating fascination with weapons & shooting himself.
- N P SNM's depressive disorder.
- N S Denied SI [suicidal ideation/intent] during FAP assessment, though seemed depressed.
- N S Personal self-esteem issues.
- N P SNM was emotionally unstable, had low self-esteem, especially dealing with females. He disclosed suicide thinking since high school years, & likely considered self-harm as a means to avoid loneliness & unhappiness.
- N P Low self-esteem, especially with women.
- N S Suicide note expressed feeling incapable of making any woman happy.
- N P Diminished self-esteem from loss of physical capabilities....
- N S Emotional & impulsive personality.
- N P Emotional frustrations.
- M P SNM held emotion in until at a breaking point.
- M S He masked his troubles.
- M S Personal confusion.
- M S Pride.
- N P Strong desire to be perfect & for approval.
- N P Recommendation ... created a sense of failure, heightened by brother's success in USN.
- M P I believe he did not want to deal with his responsibilities anymore.
- N P Suicide note stipulates intent to end life due to many unmanageable personal torments.
- N S Lied to parents about being in Secret Unit. High family expectations. Father under impression Navy conspired to kill SNM.
- N P Told close friends that was diagnosed with cancer & that command knew (false). Autopsy showed no cancer.
- N P That morning, checked out medical record (now missing).
- N S Possible spiritual crisis; religious habits stopped when fraternization investigation began.

### **Legal Problem**

- N P Long-term ... legal problems (domestic violence).
- N P Mounting legal troubles with military & civilian authorities.
- M S Civil/criminal legal problems from car accident that resulted in suspended license & dispute with insurance company.
- N P Lengthy ... child-custody divorce proceedings.
- N P Was in legal battle for custody of illegitimate daughter.
- N P Concern that discovery [of wrongdoing] might affect child-custody outcome.

- N P Apprehensive that FAP investigation would result in.... (Neither Investigating Officer nor FAP had yet determined whether SNM's corporal punishment to children during period of joint custody was abusive.)
- N P An investigation had ensued when, after he fabricated a divorce decree & remarried....
- M P Facing standing (civilian) trial on a serious charge (rape).
- N P Raped girlfriend just prior.
- N P Had gone UA for 4 days.
- N P Some unknown problem was troubling him; he went UA.
- N S Prior UA.
- N P ... pending Article 32 hearing.
- N P Recommendation from [previous] Division Officer for Mast/OTH created a sense of failure....
- N P Possibility of Admin Sep for....
- N P Fear of discovery/punishment for unauthorized use of government computer.

#### **Physical Pain/Impairment**

- N P Sought medical treatment for diagnosed back pain.
- N S Chronic back pain....
- N P Chronic pain & disability from right shoulder injury (two MVAs & two surgeries; prescribed Tylenol #3 with Codeine).
- N P Difficulty with physical fitness training & other activities from pain & weakness in right shoulder.
- M P SNM was unable to perform duties due to recent back surgery & numerous medical issues.
- N P Car accident & resulting head injury.
- N P Life-altering cancer with surgery & intensive treatments over long timeframe.
- N P From loss of physical capabilities, including bladder control & sexual function.
- N S Lack of sleep, loss of appetite, difficulty concentrating.
- N P Health problems (skin disorder).
- N P Possibly misunderstanding of glaucoma condition.
- N P Anxiety over possibility of having contracted any STDs after 20Aug99 port visit, despite negative test results.

#### **Financial/Convenience Hardship**

- M P Extreme financial difficulties.
- N P Financial difficulty (substantial credit-card debt).
- N P Financial problems.
- M P Financial.
- N P Sent \$1500. to wife for car problems day of incident.
- M P To him, money ruled the world & drove his life.
- M P Car access barred after recent accident.
- N P Car stolen.
- N P Evicted (reason unknown).

#### **None Identified / Unknown / N/A**

- M P Hours before incident, appeared to be enjoying self with friends.
- N P Perhaps a traumatic event occurred?
- N P Perhaps SNM had hidden problems that reached unbearable proportions?
- M P None noted. SNM was excelling as a Marine. Recommended for merit promotion & NCO of the Quarter.
- N P None identified.
- N S None apparent.
- \* S None known.
- \* S None.
- M P Unknown. The command saw SNM only once a month (on drilling weekends).
- \* P Unknown.
- \* S Unknown.
- M P Not sure.
- M S Not sure.
- N S None known (autoerotic accident was ruled out by counterevidence).
- N S I cannot conclusively state or find any.

\* *Multiple respondents.*

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**Item: "What are specific "Lessons Learned" by the command from this incident?"**

Categories: Lessons Learned	Respondents					
	USN (n=33)		USMC (n=17)		Total (n=50)	
	n	%	n	%	n	%
Suicide with no warning is unpredictable (& unpreventable).	12	36	5	29	17	34
Command can take prevention steps (other than awareness training).	11	33	4	23	15	30
Command can take damage-control steps (after suicide).	7	21	8	47	15	30
Take special steps for members dealing with set-back/problem.	6	18	4	23	10	20
Suicide awareness/training is important/necessary to prevention.	5	15	2	12	7	14
Anyone is susceptible to suicide.	2	6	2	12	4	8
None	1	3	0	0	1	2
(blank)	4	*	7	*	11	*

\* 18% of 61 respondents (37 USN and 24 USMC) left the item blank; those cases are excluded from computation of tabled percent values. Due to multiple responses per item, values sum to more than 100%.

**Narrative-response Key Idea(s) by Category:**

(N = USN decedent; M = USMC decedent)

**Suicide with no warning is unpredictable (& unpreventable).**

- N With some suicides, there are no "lessons learned."
- N Even a strong prevention program is not enough if no evidence presents itself.
- M If a suicidal person seems outwardly okay, can't anticipate suicide.
- M Not all (alleged) suicides show signs of intention.
- M It is apparent that there were no indicators visible to recruit training personnel that SNM would take his own life.
- M No suicidal clues despite evaluation by psychiatrist & visit with SACO prior to leave.
- N The command looked for suicidal signs during the bigamy investigation, but if a member is a liar, suicide is unpreventable.
- N Things are not always as they seem on the surface. Sometimes there are no warning signs.
- N Suicide can strike without warning.
- N Suicide may occur without warning & be unpreventable.
- M Nobody interviewed could have predicted he would harm himself.
- N No one saw this coming.
- N No evidence of ideation or intent; no command intervention opportunity.
- N None; this case appears to have been unpreventable by command.
- N None; did not seem foreseeable.
- N None; the event has no nexus with Navy. Also, no precursor clues.
- N None. SNM appeared to have a good support system & expressed no suicidal ideation/intent. Apparently, a spontaneous decision.

**Command can take prevention steps (other than awareness training).**

- N Need instructional talk on identifying & responding to suicidal intent.
- M Utilize spouses more in dealing with suicide prevention.
- M Marines need to inform unit leadership when problems arise in the civilian community.
- N Members of the military need to ensure as their status changes they update their service record.
- N Screen members for mental health issues or unstable behavior as basis for disqualification from weapons access.
- N Conducted thorough review of man-overboard procedures.
- N Ship's medical did not have portable defibrillator nor anyone on board with authority to use available instruments.
- N SNM was not allowed to attend Stress, Anger, & Communication workshop --he signed up for 2 times in August.
- N Undermanning created stress. (This ship designed for 420 members, but staffed at 306!)
- N Members under stress or suicidal might not discuss issues with chain of command; prevention training should emphasize alternate sources --family, friends, chaplains/church, hotlines.
- N Need CACO instruction (writing now) & local CACO SOP vs. Navy generic. Updating phone listing for CACO numbers with Security Dept.
- M Know Marines beyond "basic knowledge" (i.e., specific details that could lead to a crisis).
- N All suicide threats should be taken seriously, even from an outgoing person who claims to be joking.

- N Chain of command should be informed of such threats [from an outgoing person who claims to be joking].
- N Be alert to shipmate's changes in patterns, attitudes, etc.
- N Speak to shipmates & talk through problems; be observant.
- M Special awareness of individuals is needed in a Reserve Unit.
- N Chain of command stressing to all to talk about problems & concerns can never be overdone.
- N Accountability of all personnel 24 hrs a day is mandatory. Use of Buddy System is a must.
- N Romantic entanglements aboard ship can disrupt order & discipline & end in tragedy.
- N Shipboard life can present high risk for stress & isolation.
- N Navy leadership must not result in destruction of individual's self-esteem, dignity, or desire to live/work productively.

**Command can take damage-control steps (after suicide).**

- N Control rumors by having the command tell everyone what happened as soon as it is known.
- M Useful for command folks who knew decedent to talk about it in informal environment.
- M Interpersonal discussions will be planned.
- M Command will continue to counsel as necessary through our combat stress reduction initiative sponsored by our chaplain & division psychiatrist.
- M We must continue to conduct suicide briefs & interviews.
- M Conduct reinforcement training on suicide awareness.
- M Conduct in-depth suicide awareness training.
- N We must schedule suicide awareness training.
- M Increased/additional awareness training for Marines on duty during emergency situations.
- N Heightened awareness all around.
- N The channel is open for airing problems/issues, & this has been reinforced throughout command.
- M Command took immediate action to locate SNM when he did not report for duty. Based upon SNM's character, command ruled out UA status & immediately began searching for clues of missing person status.
- N Staff & supporting agencies responded in appropriate & timely manner.
- N SPRINT was very helpful.
- N [Recommendations were developed for improved interactions with Mortuary Affairs Officer.]

**Take special steps for members dealing with setback/problem.**

- M People who suffer setbacks need special attention, no matter how well they seem to be coping.
- M Refer marines to marriage counselor.
- M Encourage spouse to attend LINKS/marriage counseling.
- M Treat every domestic incident between member & spouse as if could lead to fatal consequence.
- M Become more inquisitive of experiences associated with marital & other difficulties.
- N Carefully evaluate every request for leave/liberty in conjunction with a known personal problem.
- N Too much emphasis was placed on SNM's alcohol problem which was apparently a symptom of deeper mental-health problems.
- N We referred SNM to medical twice for depression & follow-up, specifically inquiring of SNM whether he had suicidal thoughts.
- N Command suicide policy is inadequate. (Though suicidal ideation was revealed [to MedDept] & depression to Chaplain, referral for care did not follow.)
- N We need the mental health professionals to more closely monitor members with suicidal ideation/gestures, & they need to info the command so we can monitor.
- N Command members have been encouraged to notify chain of command of new members with a history of suicide attempts. This alerts us to possible counseling needs & prompts special attention to signs they otherwise might ignore.
- M The Corps should not assume a Marine under civilian custody will be safe, & should make every attempt to keep someone with him.
- N Ill-advised to return to his workcenter a member who has been identified as suicide risk.

**Suicide awareness/training is important/necessary to prevention.**

- M Important to have training.
- N Continue periodic suicide awareness & prevention training.
- M Command will continue suicide awareness & prevention training.
- N Continue command efforts to educate members on suicide warning signs & prevention measures.
- N Continue to stress suicide prevention & warning signs to all hands & especially managers.
- N Suicide Awareness/Prevention GMTs for CPO Mess & wardroom are just as important for the crew & should continue.
- N All personnel, regardless of rank, need to be able to identify signs of unhappiness/despair & act quickly to help.

**Anyone is susceptible to suicide.**

M Suicide can come from anyone.

M Anyone is susceptible to suicide.

N Anyone is capable of suicide; warning signs are not always obvious/overt.

N Even a person not exhibiting signs of depression can commit suicide.

**None**

N None.

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Item: "Based on the DONSIR review into this incident, what are the recommendations for command action?"

Categories: Recommendations	Respondents					
	USN (n=32)		USMC (n=15)		Total (n=47)	
	n	%	n	%	n	%
Continue/Conduct Prevention Training	10	31	9	60	19	40
Implement New Prevention Practice	11	34	7	47	18	38
Continue Other Prevention Practices	8	25	5	33	13	28
None (without further specification)	8	25	0	0	8	17
(blank)	5	*	9	*	14	*

\* 23% of 61 respondents (37 USN and 24 USMC) left the item blank; those cases are excluded from computation of tabled percent values. Due to multiple responses per item, values sum to more than 100%.

**Narrative-response Key Idea(s) by Category:**  
(N = USN decedent; M = USMC decedent)

**Continue/Conduct Prevention Training; No New Actions**

- M Continue to conduct suicide awareness classes during recruit training.
- N Keep conducting suicide awareness/prevention presentations for crew, CPO Mess, & wardroom.
- N Continue periodic suicide awareness & prevention training.
- M To continue suicide awareness & prevention training.
- M Continue to provide training on suicide.
- M Continue to teach suicide awareness.
- M None; suicide training is consistently provided to the Marines of this squadron.
- N None; I do not believe this could have been foreseen/averted.
- N No command action recommended.
- N In this case, the command really could not have prevented member's actions.
- N No obvious warning signs; no apparent deficiencies in command suicide prevention efforts.
- M I don't know what the command could have done different other than to be more forceful in keeping SNM away from his quarters.
- M Victim gave no outward indication he would take his life; current suicide prevention training is sufficient.
- N With no warning signs, prevention was precluded. Suicide awareness has been made high priority since Jan'99, with additional training & CO focus.
- N Schedule suicide awareness training.
- M Conduct suicide awareness training.
- N [Conduct] Training in appropriate response to suicidal ideation encounter.
- N Afterward, command held suicide awareness training.
- M Conducted suicide awareness training.

**Continue Other Prevention Practices**

- N Afterward...offered special sessions with chaplain for any requesting such.
- M Conducting casualty debrief.
- N Command reviewed this incident with all members.
- N Chain of command reviewed instructor screening process & indoctrination procedures.
- M Continue to provide training on emergency/crisis awareness (pro-active measures).
- N Vigilant awareness to signs that predict suicide.
- M Maintain vigilance of Marines on recruiting duty for suicide indicators.
- N Continue to be watchful over students & faculty, & responsive to any warning signs of suicide. (None noticed by even closest friends.)
- M Continue counseling program for Marines.
- N Conduct suicide prevention counseling on continuous basis. Talk about real-life issues, not just statistics.
- M Through more leadership, discussions, counseling, & lectures, we will heighten special awareness of individuals.
- M Note all counseling sessions.
- N Keep stressing the function of the chain of command in assisting with resolving personal issues that impact readiness.

- N Keep fostering work climate of mutual respect, honesty, & integrity.
- N Updated phone lists.
- M Update & enforce standards of conduct & SOPs in duty binders.
- N None. (NCIS recommended classified inventory of suicide prevention training; all material was 100% accounted for at this command.)
- M Keep chain of command informed.
- N Continue strong discouragement of romantic entanglement among shipmates.

#### Implement New Prevention Practice

- M Conducted extensive risk management training.
- M Regimental chaplain conducted spirituality/attitude session w unit.
- N Counseling was completed by chaplains & a psychiatrist.
- M To counsel as necessary through our combat stress reduction initiative sponsored by our chaplain & division psychiatrist.
- N Held group meetings & discussion on the topic & related issues.
- M Regardless of rank, everyone must be aware of suicide incidents.
- M Conducted combat stress awareness training.
- M Conduct command-level investigation of the cause(s) of this suicide.
- M Conduct more psychological testing of Marines joining their first unit.
- M Be more proactive with the spouses when teaching suicide prevention.
- M I would suggest the Corps make every effort to ensure no Marine is left alone while being held in a civilian facility on a serious legal charge.
- N Increase follow-through on members with reported incidence of alcohol/drug use.
- N Investigate behavior changes (such as cessation of a ritualized habit).
- N It may be helpful to educate senior crew in identifying erratic behavior & moodiness as reasons for immediate referral to medical attention, & on-board medical may consider interviewing peers/co-workers of at-risk sailors to help make thorough assessments, as it seems SNM's peers were well-aware of impulsive, emotionally unstable patterns undisclosed to supervisors.
- N Command needs immediate replacements for suicides. Not only has the division suffered emotional stress, they are left with the extra work of being short-handed.
- N Command will purchase portable defibrillator.
- N Mandatory attendance for members signing up for stress workshops.
- N Have 2-3 people trained in CACO process.
- M Provide specific classroom training for all Marines eligible to stand duty (company & battalion levels).
- M Assign mentors to new joins; show points of interest, assist with check-in process & help in establishing Marine within the company.
- N Recommend overseas-screening interview include more personal questions to determine individual's capacity for the additional stress of life abroad in the context of current difficulty level in personal life.
- N None except to highlight this as an anonymous case in future suicide prevention training.
- N Recommended that the case be used in general military training syllabi to present a perplexing mixture of factors unindicative of suicide.
- M Ensure maximum use of buddy system.
- M Seek professional assistance outside command.
- N Closer coordination between the command & mental health professionals.
- N Be aware of shipmates & look for changes.
- N Medical Dept members & Chaplain should never allow prospect of embarrassment to affect prompt referral of crewmember to appropriate assistance.
- N This ship needs a vigorous suicide prevention program that is integrated into a broadly expanded health promo effort using a multi-disciplinary approach coordinated by Medical Dept, with strong Command interest & monitoring.
- N [Command CACO] SOP [is being] re-done.

#### None (without further specification)

- \* None.

\* Multiple USN-decedent respondents.

**REPORT DOCUMENTATION PAGE**

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14. ABSTRACT This report presents key findings from the first year (1999) of implementation of the Department of the Navy Suicide Incident Report (DONSIR). The DONSIR represents the first systematic attempt to collect epidemiological and risk factor data on all suicides that occur among active-duty Navy and Marine Corps personnel. This is the first in a planned series of annual reports that summarize DONSIR data. The intent is to provide line and medical personnel with information on suicide trends within Department of the Navy (DON) and to assist leaders in improving local suicide prevention efforts. In 1999, 40 Navy and 26 Marine Corps personnel died by suicide. This report includes all 1999 DONSIRs received by Navy Personnel Command and Headquarters Marine Corps by 31 March 2000. Data were entered into a database created and maintained by the Naval Health Research Center. Findings are summarized according to demographics, military career information, casualty data (including time and place information), medical and psychological status, and major risk factors. (Cont'd on reverse side)					
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(Continued from Block 14. Abstract)

The report concludes with information on special issues pertaining to DONSIR and recommendations for further action.