United States Government Accountability Office

Report to Congressional Committees

April 2022

SUICIDE PREVENTION

DOD Should Enhance Oversight, Staffing, Guidance, and Training Affecting Certain Remote Installations

Accessible Version

GAO-22-105108

GAO Highlight

Highlights of GAO-22-105108, a report to congressional committees

April 2022

SUICIDE PREVENTION

DOD Should Enhance Oversight, Staffing, Guidance, and Training Affecting Certain Remote Installations

Why GAO Did This Study

In 2020, DOD recorded 384 active component suicide deaths, representing a 33.5 percent increase in the suicide rate since 2016. Some of these servicemembers were stationed at remote OCONUS installations, defined by GAO as meeting DOD criteria involving factors such as harsh living conditions and limited resources.

In response to a provision in the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021, this report examines, among other objectives, the extent to which DOD and the military services have, in relation to remote OCONUS installations (1) collected required suicide incident data, and what is known about the incidence of suicide and related risk factors among servicemembers during 2016-2020; (2) established and ensured implementation of policies, programs, and activities that address suicide prevention; and (3) established guidance and training for key personnel for responding to suicide deaths and attempts. GAO analyzed data, policies, and guidance; reviewed installation-level documents; and interviewed officials from DOD, the military services, and four installations.

What GAO Recommends

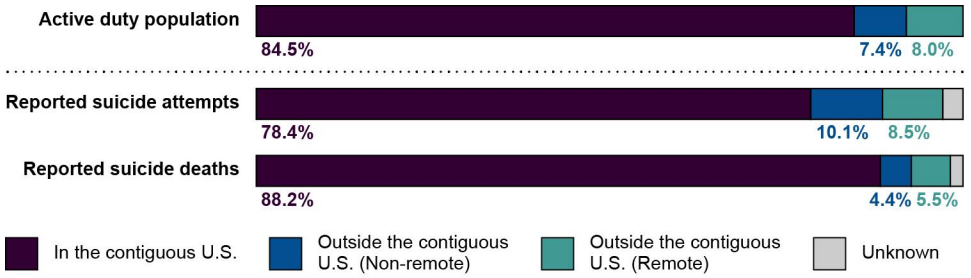
GAO is making 14 recommendations, including that DOD establish a process to assess suicide risk at remote OCONUS installations, three services establish oversight of installations, and DOD improve guidance and training for commanders. DOD generally concurred with the recommendations and described related actions. GAO believes the recommendations are valid, as discussed in the report.

View GAO-22-105108. For more information, contact Brenda S. Farrell at (202) 512-3604 or farrellb@gao.gov.

What GAO Found

The Department of Defense (DOD) and the military services have collected statutorily required suicide data for servicemembers and dependents, including those assigned to remote installations outside the contiguous United States (OCONUS). GAO's analysis suggested that these remote installations accounted for a slightly higher proportion of reported suicide attempts, but a lower proportion of reported suicide deaths relative to the proportion of servicemembers assigned to these locations in 2016-2020 (see figure). DOD officials stated that although access to non-military firearms is limited at installations outside the U.S., remote OCONUS installations can present risk factors like less access to mental health services and increased social isolation. However, DOD has not fully assessed suicide risk at these installations. Establishing a process to do so could enhance related suicide prevention efforts.

Average Proportions of Reported Servicemember Suicide Deaths and Attempts Compared to Active-Duty Population by Geographic Category, 2016 through 2020



Source: GAO analysis of Department of Defense Suicide Event Report data, Armed Forces Medical Examiner Tracking System data, and service population data systems. | GAO-22-105108

Accessible Data Table for Highlight Figure

Percentage	In the contiguous U.S.	Outside the contiguous U.S. (Non-remote)	Outside the contiguous U.S. (Remote)	Unknown
Active duty population	84.5	7.4	8.0	0.1
Reported suicide attempts	78.4	10.1	8.5	3.0
Reported suicide deaths	88.2	4.4	5.5	1.9

Note: Due to data limitations, GAO was unable to identify a geographic category for 2.9 percent of reported suicide attempts, 1.8 percent of reported suicide deaths, and less than one percent of active duty personnel. These proportions are not adjusted for sex or age. Suicide attempts may be under- or inconsistently reported. These limitations could affect comparisons across geographic categories.

DOD and the military services have established suicide prevention policies, programs, and activities—such as counseling and efforts to encourage lethal means safety—for servicemembers and dependents, including those assigned to remote OCONUS installations. However, gaps exist in implementation. For example, the Army, the Navy, and the Marine Corps have not ensured implementation of key prevention activities, such as designating key prevention

personnel. As a result, these services lack reasonable assurance that such activities are implemented across all installations, including remote OCONUS locations, and cannot ensure access to key suicide prevention resources.

DOD and the military services have established some suicide response guidance and training for key personnel, but gaps exist. For example, DOD has established guidance that fully addresses commanders' response to suicide deaths, but not suicide attempts. Further, DOD has not established statutorily required training for commanders on responding to suicide deaths and attempts. By establishing comprehensive suicide response guidance and training for commanders, DOD can better ensure that commanders are prepared to provide support to suicide attempt survivors and the bereaved.

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Abbreviations

CONUS	inside the contiguous United States
DHA	Defense Health Agency
DOD	Department of Defense
DODSER	DOD Suicide Event Reporting
DSPO	Defense Suicide Prevention Office
HIPAA	Health Insurance Portability and Accountability Act of 1996
OCONUS	outside the contiguous United States

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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April 28, 2022

The Honorable Jack Reed
Chairman
The Honorable James M. Inhofe
Ranking Member
Committee on Armed Services
United States Senate

The Honorable Adam Smith
Chairman
The Honorable Mike Rogers
Ranking Member
Committee on Armed Services
House of Representatives

In 2020, the Department of Defense (DOD) recorded 384 confirmed or pending suicide deaths among active component servicemembers, representing a 33.5 percent increase in the suicide death rate since 2016, from 21.5 to 28.7 per 100,000 servicemembers. In addition, in 2019, DOD recorded 202 military dependent suicide deaths.[1] Among these servicemembers and dependents, some were stationed at remote installations outside of the contiguous United States (OCONUS), which may have harsh living conditions and limited access to community resources. For example, a concentration of five suicide deaths of servicemembers at U.S. Army Garrison Alaska, Fort Wainwright, from May 2018 to March 2019, prompted concerns and an internal epidemiological study to identify opportunities to mitigate risks and promote health among servicemembers at the installation. Despite these efforts, media reports have cited a continued increase in suicides among servicemembers in Alaska, and in 2021, Secretary of Defense Lloyd J.

[1]These were the most recent dependent suicide death data available as of February 2022. DOD reports suicide death data for spouses and dependent children (minor and non-minor) who are eligible to receive military benefits under Title 10, U.S. Code, and who are registered in the Defense Enrollment Eligibility Reporting System. Department of Defense (DOD), *Annual Suicide Report Calendar Year 2020* (Sept. 3, 2021).

Austin III expressed concern about suicide rates among servicemembers in Alaska and across the force.[2]

The William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 included a provision for us to review DOD and military service suicide prevention efforts for servicemembers and dependents stationed at remote OCONUS installations.[3] This report examines the extent to which DOD and the military services have (1) collected required data regarding suicide incidents among servicemembers and dependents, and what is known about the incidence of suicide deaths and attempts and related risk factors among servicemembers stationed at remote OCONUS installations during 2016 through 2020; (2) established and ensured the implementation of policies, programs, and activities that address suicide prevention among servicemembers and dependents stationed at remote OCONUS installations; (3) established privacy protections for servicemembers and dependents seeking suicide prevention care and integrated suicide prevention into the delivery of primary care at remote OCONUS installations; and (4) established guidance and training for key personnel for responding to suicide deaths and attempts at remote OCONUS installations.

For our first objective, we compared DOD's collection of suicide incident data and its assessment of related risks against statutory and DOD policy requirements to determine the extent to which DOD has met requirements to collect data on servicemember and dependent suicide incidents and identify suicide risk factors.[4] We obtained and analyzed data from the Armed Forces Medical Examiner Tracking System and the DOD Suicide Event Reporting (DODSER) system for active-duty servicemember suicide deaths and attempts during calendar years 2016

[2]The National Defense Authorization Act for Fiscal Year 2022 required DOD to conduct an independent review of suicide prevention and response at military installations, including at least one remote OCONUS installation. Pub. L. No. 117-81, § 738 (2021). In March 2022, the Secretary of Defense announced the establishment of the Suicide Prevention and Response Independent Review Committee and the selected installations to be reviewed. According to the Secretary's memo, the installations were selected to increase DOD's understanding of the needs of various geographies, including geographically isolated areas and OCONUS installations.

[3]Pub. L. No. 116-283, § 752 (2021).

[4]National Defense Authorization Act for Fiscal Year 2020, Pub. L. No. 116-92, § 741. Department of Defense (DOD) Instruction 6490.16, *Defense Suicide Prevention Program* (Nov. 6, 2017) (incorporating change 2, Sept. 11, 2020).

through 2020. We determined the risk assessment component of *Standards for Internal Control in the Federal Government* was significant to this objective, along with the underlying principle that management should identify, analyze, and respond to risks related to achieving the defined objectives.[5]

DOD does not have a general definition for what constitutes a remote installation.[6] For the purposes of this review, we defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote or isolated for the purpose of morale, welfare, and recreation funding; 2) identified as a hardship duty pay location where living conditions are substantially below those found in the continental United States; or 3) has a less than standard tour length due to quality-of-life factors, such as extreme weather and isolation, or absence of family support facilities.

To determine the proportion of reported suicide deaths and attempts among installations inside the contiguous United States (CONUS), remote OCONUS installations, and non-remote OCONUS installations relative to the proportion of active-duty servicemembers assigned to those locations, we obtained geographical population data for active-duty servicemembers from each military service. We then coded suicide death and attempt records by geographic category. We calculated proportions by dividing the number of reported suicide deaths, reported suicide attempts, and active-duty servicemembers by the total number of reported suicide deaths, reported suicide attempts, and active-duty servicemembers in each geographic category for each year. We then averaged the yearly proportions to obtain an average proportion across the 5-year period.

We assessed the reliability of DOD suicide incident and military service population data by reviewing the data for errors, omissions, and

[5]GAO, *Standards for Internal Control in the Federal Government,* GAO-14-704G (Washington, D.C.: September 2014).

[6]In our prior work, we found that DOD's process for designating installations as remote or isolated for morale, welfare, and recreation funding does not consider other installation support services—such as medical care and housing—and recommended that DOD develop policy for designating installations in the United States as remote or isolated that includes a process for considering such support services. GAO, *Military Installations: DOD Should Consider Various Support Services when Designating Sites as Remote or Isolated,* GAO-21-276 (Washington, D.C., July 29, 2021).

inconsistencies; reviewing documentation on data collection procedures and systems; interviewing cognizant officials; and administering questionnaires on data collection and synthesis. We determined that these data were sufficiently reliable to provide counts of suicide deaths and attempts by service and by geographic category for calendar years 2016 through 2020. In addition, we determined the data were sufficiently reliable to describe the proportion of suicide deaths and attempts relative to the proportion of population across during 2016 through 2020 among CONUS, remote OCONUS, and non-remote OCONUS installations, while noting limitations as appropriate.

For our second objective, we compared DOD suicide prevention policies against related statutory requirements and reviewed the military services' suicide prevention policies to identify required suicide prevention activities. We reviewed rosters of suicide prevention program personnel against program requirements to determine the extent to which related staffing requirements had been met at 57 remote OCONUS installations we identified using the previously described selection criteria. From these remote OCONUS installations, we selected the installation for each service that had the highest number of reported suicide deaths and the installation that had the highest number of reported suicide attempts during 2016 through 2020. For those eight installations, we reviewed documentation to determine the extent to which other required suicide prevention activities had been implemented. We also assessed service-level oversight mechanisms for installation-level responsibilities against DOD and service requirements.[7] We determined that the control environment and control activities components of *Standards for Internal Control in the Federal Government* were significant to this objective, along with the underlying principles that management should establish an organizational structure, assign responsibility, and delegate authority to achieve the entity's objectives; design control activities to achieve objectives and respond to risks; and implement control activities through policy.[8]

For our third objective, we examined DOD policies governing privacy protection and integration of mental health care into primary care in

[7]DODI 6490.16. Army Regulation 600-63, *Army Health Promotion* (Apr. 14, 2015). OPNAV Instruction 1720.4B, *Suicide Prevention Program* (Sept. 18, 2018). Air Force Instruction 90-5001, *Integrated Resilience* (Jan. 25, 2019) (incorporating Change 1, Oct. 21, 2021). Marine Corps Order 1720.2A, *Marine Corps Suicide Prevention System (MCSPS)* (Aug. 2, 2021).

[8]GAO-14-704G.

relation to the content of DOD's suicide prevention policies. In addition, we assessed DOD and military service procedures, resources, and training to determine the extent to which privacy protection was addressed. From the eight selected remote OCONUS installations that had the highest number of reported suicide deaths and attempts during 2016 through 2020, we also requested information and documentation related to procedures and training for privacy protection for the purpose of providing illustrative examples of installation-level efforts. In addition, we assessed DOD staffing activities against *A Model of Strategic Human Capital Management*.[9]

For our fourth objective, we reviewed DOD and service guidance and training to assess the extent to which they address commanders' and suicide prevention program managers' responses to suicide deaths and attempts.[10] Specifically, we compared DOD policies and guidance against a statutory requirement for establishing suicide response guidance and training for commanders. We reviewed relevant policies, guidance, and training identified by officials from each military service to assess the extent to which these documents met statutory and DOD requirements.[11] We also assessed service-level oversight mechanisms for ensuring completion of the required suicide prevention program manager training. We determined the control activities and monitoring components of *Standards for Internal Control in the Federal Government* were significant to this objective, along with the underlying principles that management should design control activities to achieve objectives and respond to risks and remediate identified internal control deficiencies on a timely basis.[12]

[9]GAO, *A Model of Strategic Human Capital Management,* GAO-02-373SP (Washington, D.C.: Mar. 15, 2002).

[10]Each military service uses a different title for the command- or installation-level position intended to meet the DOD requirement for a suicide prevention program manager. Specifically, these personnel are referred to as suicide prevention program managers in the Army, suicide prevention coordinators in the Navy, violence prevention integrators in the Air Force, and suicide prevention program officers in the Marine Corps. For the purpose of this report, we refer to these personnel as suicide prevention program managers.

[11]National Defense Authorization Act for Fiscal Year 2013, Pub. L. No 112-239, § 582 (2013). DOD Instruction 6400.09, *DOD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm* (Sept. 11, 2020).

[12]GAO-14-704G.

For all objectives, we interviewed DOD and military service officials regarding suicide prevention policies, activities, and oversight mechanisms, including for remote OCONUS installations. We interviewed personnel from four remote OCONUS installations—the remote OCONUS installation for each military service that had the highest number of reported suicide deaths during 2016 through 2020.[13] Specifically, we interviewed suicide prevention program managers, medical personnel, commanders, senior non-commissioned officers, and other personnel with responsibilities for suicide prevention.

We also conducted literature reviews to identify what is known about suicide prevention among servicemembers and dependents stationed at remote OCONUS installations, as well as populations indigenous to such locations, based on academic research (see app. I). Appendix II provides additional details about our objectives, scope, and methodology.

We conducted this performance audit from March 2021 to April 2022 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

DOD Roles and Responsibilities for Suicide Prevention

Several entities share responsibility for implementing and overseeing the department's suicide prevention efforts. Specifically, the Defense Suicide Prevention Office (DSPO) is responsible for leading, guiding, and overseeing the department's suicide prevention program. For example, DSPO assists in the development of DOD non-clinical suicide prevention programs, develops and implements strategic communications to promote effective suicide prevention messaging, and oversees the

[13]Army and Air Force officials stated that their services' installations implement suicide prevention requirements—such as a designated individual to oversee suicide prevention activities—for the entire installation. Conversely, Navy and Marine Corps officials explained that Navy and Marine Corps installations implement the suicide prevention program at the command level, including for each installation's command and permanent tenant commands at the installation.

military services' compliance with non-clinical suicide prevention activities in accordance with DOD policy. In addition, DSPO produces DOD's Annual Suicide Report, which serves as the official source for annual suicide counts and rates.

The Defense Health Agency (DHA) is responsible for integrating the use of evidence-based programs and strategies related to suicide prevention and clinical intervention across the military health system and evaluating DOD clinical suicide prevention programs. Within DHA:

- The Office of the Armed Forces Medical Examiner verifies and reports suicide deaths of active component servicemembers to the military services, DSPO, and the Psychological Health Center of Excellence.[14]
- The Psychological Health Center of Excellence uses suicide-related data reported by the military services and the Office of the Armed Forces Medical Examiner to track suicide deaths and attempts and, for some services, suicidal ideations.[15] These data are maintained in the DODSER system and reported in the DODSER Annual Report.
- The Primary Care Behavioral Health Program—intended to provide services in primary care settings to improve patient access to behavioral health care—sets standards and responsibilities and provides training for personnel within this program. In addition, Primary Care Behavioral Health program managers are responsible for providing oversight and management of program training, implementation, sustainment, and evaluation at military treatment facilities.

In addition, the Army, the Navy, the Air Force, and the Marine Corps each develop and implement their own suicide prevention efforts that are required to incorporate department-wide suicide prevention policy and requirements. For example, each military service has established training

[14]The Armed Forces Medical Examiner also verifies and reports suicide deaths of reserve component servicemembers when in an active-duty status. The Armed Forces Medical Examiner provides DOD and other federal agencies comprehensive forensic investigative services, including medical mortality surveillance. The Armed Forces Medical Examiner System, together with input from the military services, provides DOD with suicide mortality data.

[15]DOD defines suicide as death caused by self-directed injurious behavior with an intent to die as a result of the behavior. DOD defines a suicide attempt as a non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior. DOD defines a suicidal ideation as thinking about, considering, or planning suicide. See DOD Instruction 6490.16.

and guidance related to suicide prevention and conducted surveillance of suicide data to identify any trends or risk factors of concern. Each service has also identified required suicide prevention activities to be implemented at the command or installation level. These activities include the designation of suicide prevention program managers that are responsible for implementation and oversight of the suicide prevention program; the establishment of suicide prevention teams; and the development of suicide prevention policies, procedures, or plans tailored to address command- or installation-level needs.

The department has established a governance structure to foster formal collaboration for suicide prevention among clinical and non-clinical officials at the department- and military-service levels through the Suicide Prevention General Officer Steering Committee—which includes senior executive leaders, general officers, and flag officers—and the Suicide Prevention and Risk Reduction Committee, a complementary action-officer level committee.[16]

Suicide Prevention Strategies

Several strategies have informed the department's suicide prevention efforts over the last decade:

- **2012 National Strategy for Suicide Prevention.** In June 2014, DOD adopted as its interim strategy the Department of Health and Human Services' 2012 National Strategy for Suicide Prevention.[17] The 2012 National Strategy identified four strategic directions for suicide prevention: (1) healthy and empowered individuals, families, and

[16]The Suicide Prevention General Officer Steering Committee leads the department's suicide prevention efforts. According to DSPO officials, its members include representatives from DOD and the military services such as the Director of DSPO, the Director of Air Force Resilience, and the Director of the Navy's 21st Century Sailor Office, among others. Additionally, the Suicide Prevention and Risk Reduction Committee is responsible for coordinated implementation of the guidance provided by the Suicide Prevention General Officer Steering Committee. Members of this committee include representatives from DOD and the military services such as the military service suicide prevention program managers, a research psychologist with the Psychological Health Center of Excellence, and the Director of Mental Health and Policy and Oversight within the Office of the Assistant Secretary of Defense for Health Affairs, among others.

[17]Department of Health and Human Services, Office of the Surgeon General and National Action Alliance for Suicide Prevention, *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action* (Washington, D.C.: September 2012).

communities; (2) clinical and community preventive services; (3) treatment and support services; and (4) surveillance, research, and evaluation. The strategy identifies 13 goals and 60 underlying objectives across its four strategic directions.

- **Defense Strategy for Suicide Prevention.** In December 2015, DOD published the Defense Strategy for Suicide Prevention, which retained the strategic directions, goals, and objectives identified in the 2012 National Strategy for Suicide Prevention, while adapting the terminology used in the goals and underlying objectives to be suitable for DOD.[18] The strategy is intended to reduce suicide in DOD through education of military community members about suicide risk and related behaviors; promote health, resilience, and help-seeking behavior; foster research, development, and delivery of effective programs and services; and remove all barriers to care.
- **Centers for Disease Control and Prevention's seven strategies for suicide prevention.** In 2017, the Centers for Disease Control and Prevention issued guidance establishing seven strategies for suicide prevention: (1) strengthen economic supports, (2) strengthen access and delivery of suicide care, (3) create protective environments, (4) promote connectedness, (5) teach coping and problem-solving skills, (6) identify and support people at risk, and (7) lessen harms and prevent future risk.[19] In September 2020, DOD established an integrated violence prevention policy that requires the department's suicide prevention policies and efforts to incorporate these strategies.[20]

Clinical and Non-clinical Suicide Prevention Efforts

DOD's suicide prevention efforts are guided by the aforementioned Defense Strategy for Suicide Prevention. This approach includes both clinical and non-clinical efforts intended to reduce the risk of suicide.

[18]Department of Defense, *Department of Defense Strategy for Suicide Prevention* (December 2015).

[19]Centers for Disease Control and Prevention, *Preventing Suicide: A Technical Package of Policies, Programs, and Practices* (Atlanta, Ga.: 2017).

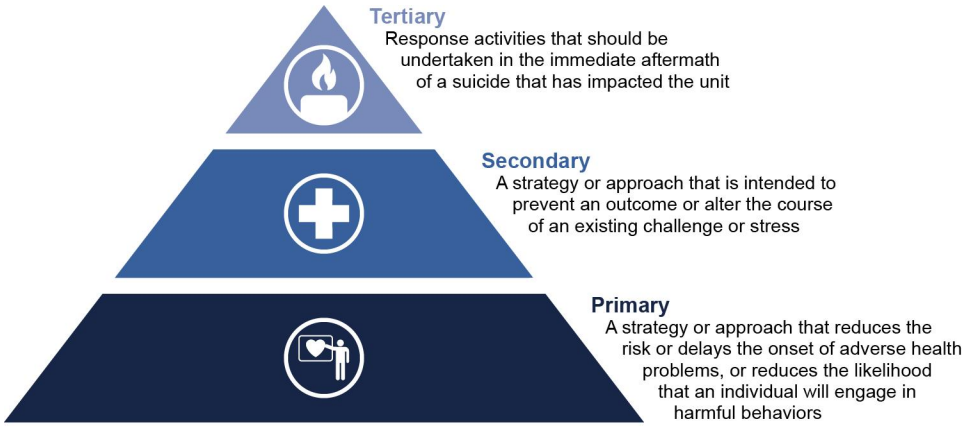
[20]DOD Instruction 6400.09, *DOD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm* (Sept. 11, 2020). According to DSPO officials, the department's suicide prevention strategy also aligns with these seven strategies.

Clinical efforts include, for example, depression and suicide-specific screening in primary care and during annual periodic health assessments.[21]

Non-clinical efforts include activities such as facilitating training for servicemembers in problem-solving, coping skills, and financial literacy; educating commanders and media outlets about safe and effective messaging and reporting regarding suicide and seeking help; and disseminating fact-based suicide-related information, such as the connection between access to lethal means of suicide and incurred risk of dying by suicide.

Suicide prevention efforts can address categories of primary, secondary, or tertiary prevention (see fig. 1).

Figure 1: Suicide Prevention Categories



Source: Department of Defense. | GAO-22-105108

DOD Collected Suicide Data, but Has Not Fully Assessed Risk at Remote OCONUS Locations

DOD and the military services have collected statutorily required suicide data for servicemembers and dependents, including those assigned to

[21]DOD and the Department of Veterans Affairs developed joint clinical practice guidelines for the assessment and management of patients at risk for suicide. See Department of Defense and Department of Veterans Affairs, *Assessment and Management of Patients at Risk for Suicide (2019)*.

remote OCONUS installations. Our analysis of these data suggested that remote or non-remote OCONUS installations accounted for a slightly higher proportion of reported suicide attempts, but a lower proportion of reported suicide deaths, relative to the proportion of servicemembers assigned to those locations during 2016 through 2020.[22] Separately, DOD has taken steps to assess suicide risk broadly, but has not comprehensively assessed risk factors for suicide and related challenges at remote OCONUS installations.

DOD and the Military Services Have Collected Required Suicide Data

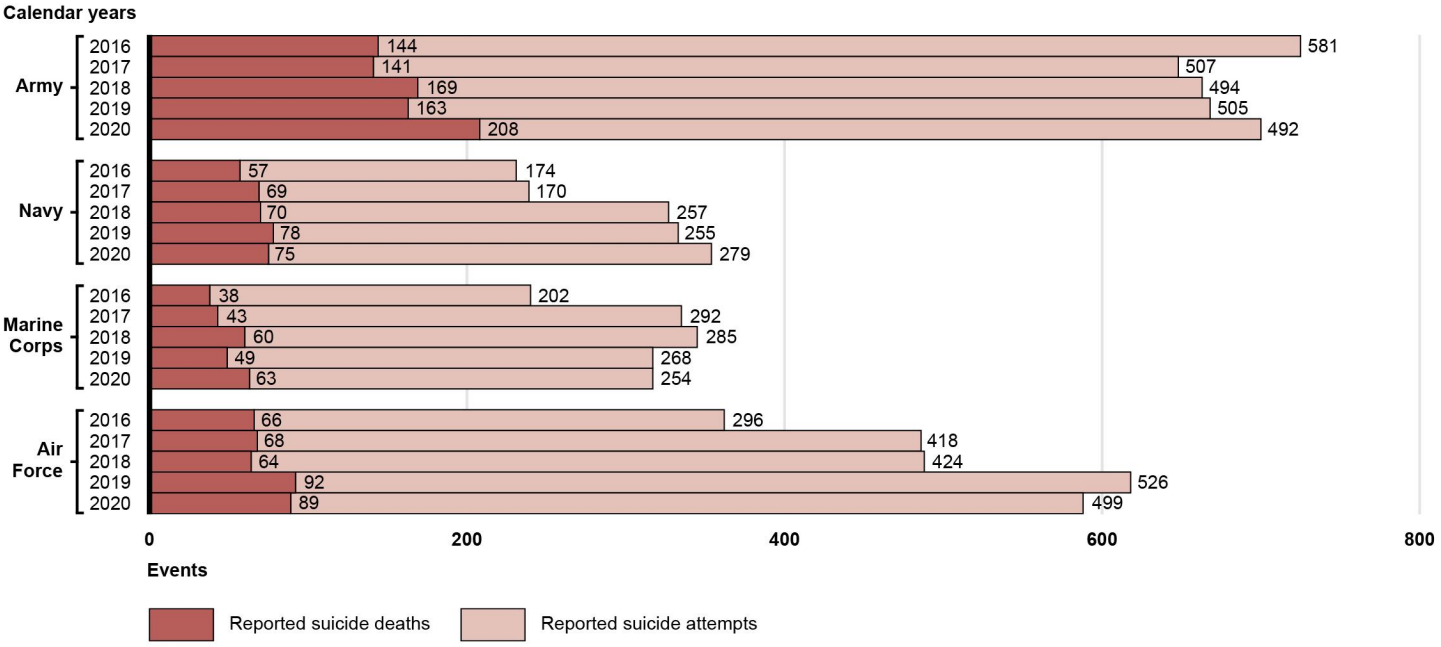
DOD and the military services have collected statutorily required suicide data for servicemembers and dependents, including those assigned to remote OCONUS installations. Specifically, the Armed Forces Medical Examiner records manner of death determinations for active-duty deaths, including suicides. In addition, the Psychological Health Center of Excellence, through the military services, has collected data on reported servicemember suicide deaths, attempts, and ideations, and associated risk factors using the DODSER system.[23] These data are reported annually in two reports, DOD's DODSER Report and its Annual Suicide Report.

[22]We were unable to determine whether these differences are statistically significant given the available DOD data. These proportions are not adjusted for differences in sex or age that may exist across geographic categories, due to limitations of the military service location-based population data. In addition, suicide attempts may be underreported or reported inconsistently. These limitations could affect any comparison of the extent of suicide deaths and attempts across geographic categories. In addition, according to DOD officials, a disproportion between the population of military servicemembers and the subpopulation of those who died by suicide does not equate to higher or lower suicide risk within that population.

[23]Pub. L. No. 113-291, § 567 and Pub. L. No. 116-92, § 741. DOD defines suicide as death caused by self-directed injurious behavior with an intent to die as a result of the behavior. DOD defines a suicide attempt as a non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior. DOD defines a suicidal ideation as thinking about, considering, or planning suicide. See DOD Instruction 6490.16.

According to our analysis of DOD data, during 2016 through 2020, DOD recorded 1,806 suicide deaths and 7,178 reported suicide attempts among active-duty servicemembers, as illustrated in figure 2.[24]

Figure 2: Number of Reported Active-Duty Servicemember Suicide Deaths and Attempts by Military Service, 2016 through 2020



Source: GAO analysis of Department of Defense Suicide Event Report data and Armed Forces Medical Examiner Tracking System data. | GAO-22-105108

[24]According to officials from DOD's Psychological Health Center of Excellence, the 1,806 suicide deaths includes 135 deaths recorded by the Armed Forces Medical Examiner, for which no DODSER data was available. Our analysis included records of suicide deaths and reported suicide attempts of reserve component members serving on active duty at the time of the suicide death or attempt. DOD has published its Annual Suicide Report since 2018.

Accessible Data Table for Figure 2

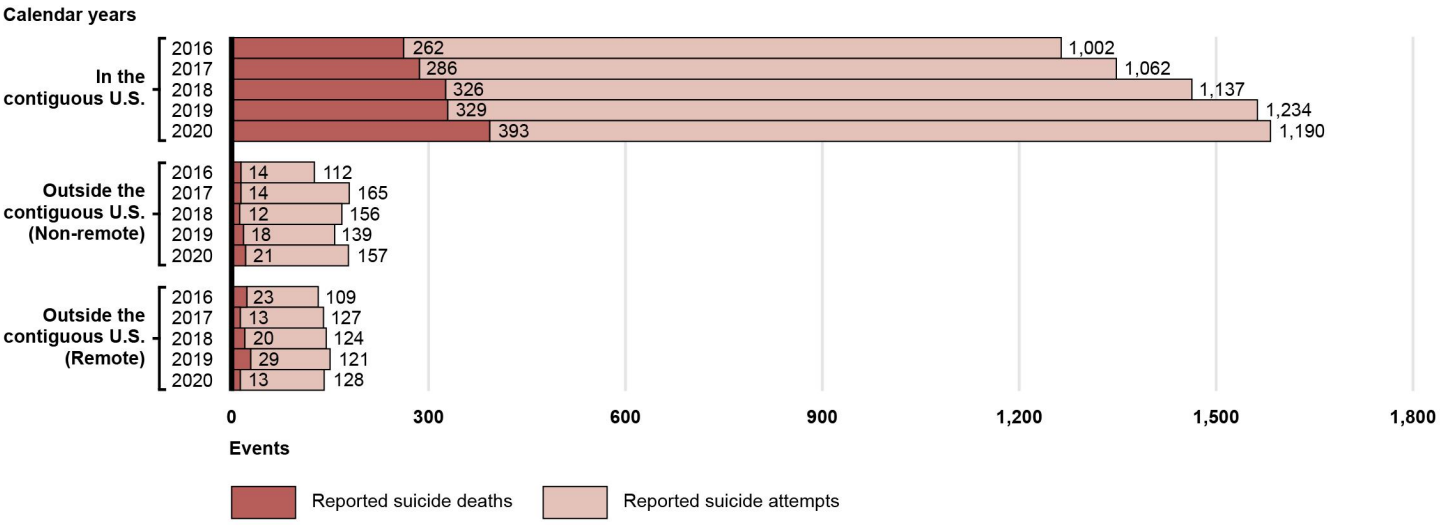
	Calendar years	Reported suicide deaths	Reported suicide attempts
Army	2016	144	581
	2017	141	507
	2018	169	494
	2019	163	505
	2020	208	492
Navy	2016	57	174
	2017	69	170
	2018	70	257
	2019	78	255
	2020	75	279
Marine Corps	2016	38	202
	2017	43	292
	2018	60	285
	2019	49	268
	2020	63	254
Air Force	2016	66	296
	2017	68	418
	2018	64	424
	2019	92	526
	2020	89	499

Notes: Reported suicide attempts may be underreported, or be reported inconsistently, which could affect comparisons.

The Department of Defense (DOD) defines suicide as death caused by self-directed injurious behavior with an intent to die as a result of the behavior. DOD defines a suicide attempt as a non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior.

Figure 3 provides the count of reported suicide deaths and attempts by geographic category during 2016 through 2020.[25]

Figure 3: Count of Reported Active-Duty Servicemember Suicide Deaths and Attempts by Geographic Category, 2016 through 2020



Source: GAO analysis of Department of Defense Suicide Event Report data and Armed Forces Medical Examiner Tracking System data. | GAO-22-105108

[25]DOD does not have a general definition for what constitutes a remote location. For the purposes of this review, we defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote or isolated for the purpose of morale, welfare, and recreation funding; 2) qualifies for hardship duty pay; or 3) has a less than standard accompanied or unaccompanied tour length.

Accessible Data Table for Figure 3

	Calendar years	Reported suicide deaths	Reported suicide attempts
In the contiguous U.S.	2016	262	1002
	2017	286	1062
	2018	326	1137
	2019	329	1234
	2020	393	1190
Outside the contiguous U.S. (Non-remote)	2016	14	112
	2017	14	165
	2018	12	156
	2019	18	139
	2020	21	157
Outside the contiguous U.S. (Remote)	2016	23	109
	2017	13	127
	2018	20	124
	2019	29	121
	2020	13	128

Notes: Reported suicide attempts may be underreported or be reported inconsistently, which could affect comparisons of the distribution by geographic category of suicide deaths and attempts.

Due to data limitations, GAO was unable to identify a geographic category for 215 of 7,178 (2.9 percent) reported suicide attempts and 33 of 1,806 (1.8 percent) reported suicide deaths. These reported suicide deaths and attempts are excluded from the figure.

In the absence of a Department of Defense (DOD) definition, GAO defined remote installations outside the contiguous United States as those located in Alaska, Hawaii, or outside the United States that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship-duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

DOD defines suicide as death caused by self-directed injurious behavior with an intent to die as a result of the behavior. DOD defines a suicide attempt as a non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior.

Since 2017, DSPO has also collected required data for military dependents' suicide deaths, reporting suicide counts of 182 in 2017, 191

in 2018, and 202 in 2019.[26] According to DOD's *Calendar Year 2020 Annual Suicide Report*, the 2019 military family suicide rates were statistically comparable to those in 2017 and 2018. Specifically, the suicide rate of military spouses per 100,000 population was 11.6 in 2017, 12.2 in 2018, and 12.6 in 2019. The suicide rate of military dependents—typically under age 23—per 100,000 population was 3.7 in 2017, 4.0 in 2018, and 4.5 in 2019.[27]

According to DOD's *Calendar Year 2020 Annual Suicide Report*, visibility of dependent suicide deaths is limited because the majority of military dependents are civilians whose deaths frequently occur outside of military installations, and no single data source provides a full accounting of suicide deaths among military dependents. To address this challenge, DOD obtains and analyzes dependent suicide death data from multiple data sources, including the Defense Enrollment Eligibility Reporting System, the Centers for Disease Control and Prevention's National Center for Health Statistics National Death Index, and military service casualty data systems. According to DOD, this multi-pronged approach allows the Department to ensure it captures the most complete information possible from military and civilian data sources.

In April 2021, we found that DOD had not required the use of standard definitions for suicide-related terms—such as suicide attempt—potentially leading to inconsistent data reporting.[28] We recommended that DOD develop consistent suicide-related definitions to be used across the department. In December 2021, the Under Secretary of Defense for Personnel and Readiness signed a memorandum directing the adoption

[26]For the purpose of DOD's reporting, dependents include spouses and dependent children—including biological, step-, foster, ward, pre-adoptive, and domestic partner children—who are eligible to receive military benefits under Title 10, U.S. Code, and are registered in the Defense Enrollment Eligibility Reporting System. Department of Defense (DOD), *Annual Suicide Report Calendar Year 2020* (Sept. 3, 2021).

[27]These rates reflect spouses and dependents of servicemembers across the department, including active component, Guard, and Reserve members.

[28]GAO, *Defense Health Care: DOD Needs to Fully Assess Its Non-clinical Suicide Prevention Efforts and Address Any Impediments to Effectiveness*, GAO-21-300 (Washington, D.C.: Apr. 26, 2021). The DOD Office of Inspector General also reported on issues related to DOD's suicide data reporting in 2014 and made 16 recommendations to improve the quality and completeness of DODSER data, which the DOD Office of Inspector General has tracked as 33 distinct recommendations for follow-up purposes. According to DOD Office of Inspector General officials, eight of the 33 recommendations remained open as of January 2022. DOD Office of Inspector General Report 2015-016, *Department of Defense Suicide Event Report (DoDSER) Data Quality Assessment,* (Nov. 14, 2014).

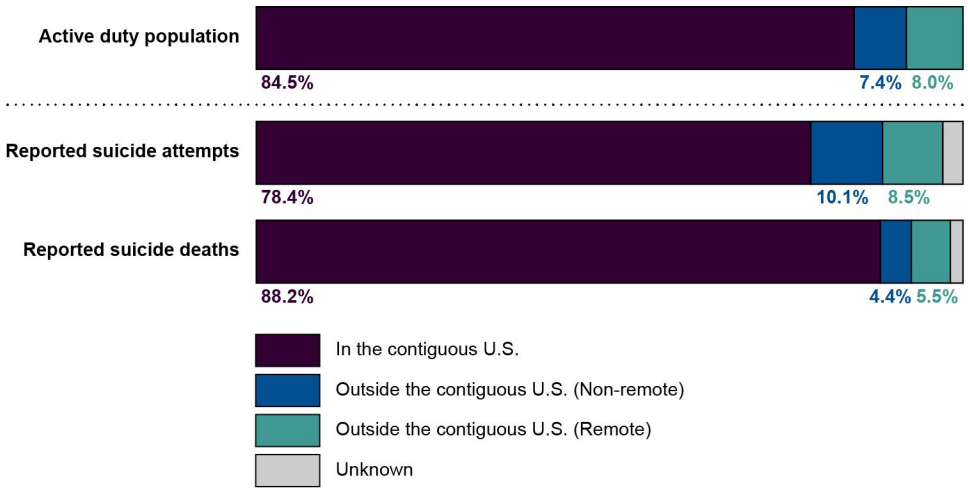
of consistent definitions for suicide, suicide attempt, and suicidal ideation across DOD and the military services. The memo noted that DSPO and the military services will continue to collaborate on standardizing additional suicide prevention terms in advance of the reissuance of DOD's suicide prevention program guidance. As a result, we closed the recommendation as implemented.

Remote OCONUS Installations Accounted for a Slightly Higher Proportion of Reported Suicide Attempts, but a Lower Proportion of Deaths

Our analysis of DOD suicide and population data from 2016 through 2020 suggested that remote OCONUS installations accounted for a slightly higher proportion of reported suicide attempts among assigned servicemembers, but a lower proportion of reported suicide deaths, relative to the proportion of servicemembers assigned to those locations. Specifically, we found that servicemembers assigned to remote OCONUS installations accounted for 8 percent of the active-duty population, but 8.5 percent of reported suicide attempts, and 5.5 percent of reported suicide deaths during 2016 through 2020 (see fig. 4).[29]

[29]These proportions are not adjusted for differences in sex or age that may exist across geographic categories, due to limitations of the military service location-based population data. In addition, suicide attempts may be underreported or reported inconsistently. These limitations could affect any comparison of the extent of suicide deaths and attempts across geographic categories. In addition, according to DOD officials, a disproportion between the population of military servicemembers and the subpopulation of those who died by suicide does not equate to higher or lower suicide risk within that population.

Figure 4: Average Proportions of Reported Servicemember Suicide Deaths and Attempts Compared to Active-Duty Population by Geographic Category, 2016 through 2020



Source: GAO analysis of Department of Defense Suicide Event Report data, Armed Forces Medical Examiner Tracking System data, and service population data systems. | GAO-22-105108

Accessible Data Table for Figure 4

Percentage	In the contiguous U.S.	Outside the contiguous U.S. (Non-remote)	Outside the contiguous U.S. (Remote)	Unknown
Active duty population	84.5	7.4	8.0	0.1
Reported suicide attempts	78.4	10.1	8.5	3.0
Reported suicide deaths	88.2	4.4	5.5	1.9

Notes: Average proportions were calculated as the average of the annual proportions of reported suicide deaths and attempts by geographic category over 5 years because servicemembers may change location from year to year. The associated numbers of personnel and reported suicide deaths and attempts vary by each year and are therefore not included in this figure.

These proportions are not adjusted for differences in sex or age that may exist in populations across geographic categories, due to limitations of the military service location-based population data. In addition, suicide attempts may be underreported or reported inconsistently. These limitations could affect any comparison of the extent of suicide deaths and attempts across geographic categories. In addition, according to DOD officials, a disproportion between the population of military servicemembers and the subpopulation of those who died by suicide does not equate to higher or lower suicide risk within that population.

Due to data limitations, GAO was unable to identify a geographic category for 215 of 7,178 (2.9 percent) of reported suicide attempts, 33 of 1,806 (1.8 percent) of reported suicide deaths, and 4,492 of 6,827,400 (less than 1 percent) of active-duty personnel.

In the absence of a Department of Defense (DOD) definition, GAO defined remote installations outside the contiguous United States as those located in Alaska, Hawaii, or outside the United States that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of

morale, welfare, and recreation funding; 2) qualifies as a hardship-duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

DOD defines suicide as death caused by self-directed injurious behavior with an intent to die as a result of the behavior. DOD defines a suicide attempt as a non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior.

DOD's *Calendar Year 2020 Annual Suicide Report* states that calculating rates is necessary for making comparisons across time or groups (e.g., by geographic category), and adjustments for demographics and other factors may be required for valid comparisons. We were unable to adjust for sex or age in our analyses, due to limitations of the location-based population data we obtained from each military service, and we therefore do not present a comparison of rates in this report. We are reporting the unadjusted proportions above because we determined it was the most feasible method to compare the distribution of reported suicide deaths and attempts across geographic categories using the available data. Further, the Centers for Disease Control and Prevention used this method during the COVID-19 pandemic to examine the distribution of COVID-19 cases and deaths in relation to the distribution of the population across demographic groups.

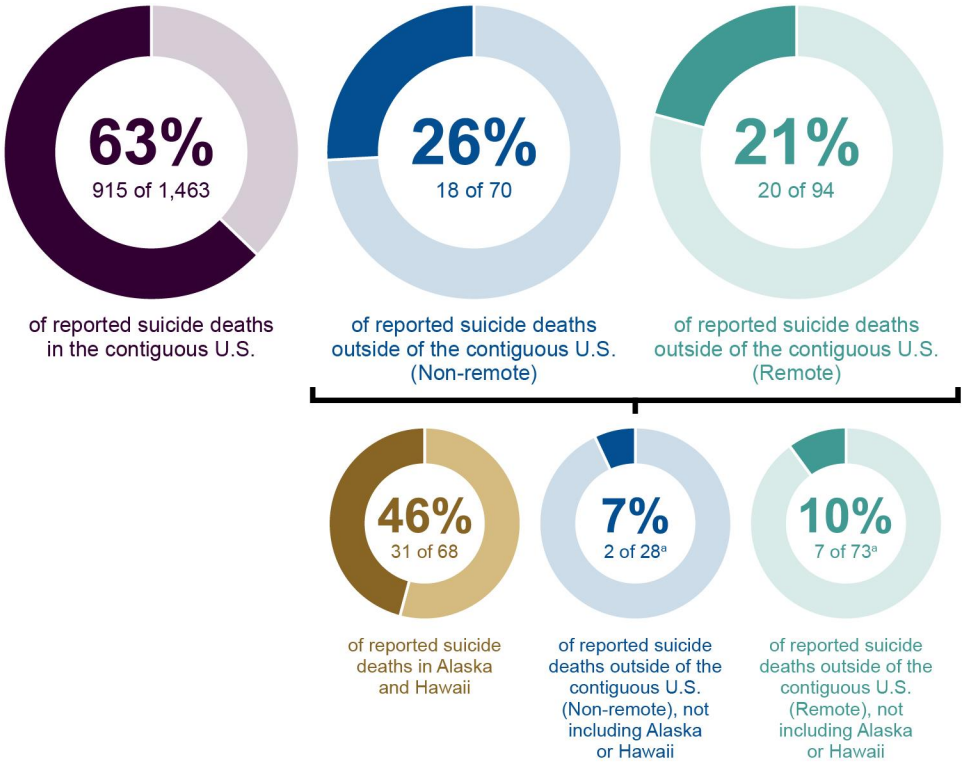
DOD and military service officials also stated that the extent of suicide at OCONUS installations—including remote OCONUS installations—is likely lower than CONUS installations because servicemembers assigned to installations outside the U.S. have limited access to non-military issued firearms. According to our analysis, non-military issued firearms were involved in over half of reported suicide deaths among servicemembers assigned to CONUS installations. In contrast, non-military issued firearms were involved in 21 percent and 26 percent of the reported suicide deaths among active-duty servicemembers assigned to remote or non-remote OCONUS installations, respectively.[30] The leading cause of reported suicide deaths among servicemembers assigned to remote or non-remote OCONUS installations during 2016 through 2020 was hanging or asphyxiation. See appendix III for additional cause of death and risk factor data.

We found that non-military issued firearms were involved in about 46 percent of the reported suicide deaths among servicemembers assigned to OCONUS installations in Alaska and Hawaii. In comparison, non-

[30]This analysis does not include 135 active-duty servicemember suicide deaths that were reported to the Armed Forces Medical Examiner, but not recorded in the DODSER system during 2016 through 2020. The Armed Forces Medical Examiner Tracking System does not record whether a firearm involved in a suicide death was military issued.

military issued firearms were involved in 10 percent or less of the reported suicide deaths involving servicemembers at remote and non-remote OCONUS installations other than in Alaska or Hawaii.[31] Figure 5 shows the percentages of non-military firearm suicides by geographic category, from 2016 through 2020.

Figure 5: Percent of Reported Active-Duty Servicemember Suicide Deaths Involving Non-military Issued Firearms by Geographic Category, 2016 through 2020



Source: GAO analysis of Department of Defense Suicide Event Report data, Armed Forces Medical Examiner Tracking System data, and service population data systems. | GAO-22-105108

[31]Army officials stated they have observed that firearm involvement in suicide deaths of servicemembers in Hawaii is unusually low for a U.S. state, while firearm involvement in suicide deaths of servicemembers in Alaska is consistent with CONUS states. According to the officials, while firearm ownership is legal in Hawaii, other factors may discourage ownership, including smaller residences, absence of available locations to use firearms, and Hawaii's wait period.

Accessible Data Table for Figure 5

		Suicide Deaths
63%	915 of 1,463	of reported suicide deaths in the contiguous U.S.
26%	18 of 70	of reported suicide deaths outside of the contiguous U.S. (Non-remote)
21%	20 of 94	of reported suicide deaths outside of the contiguous U.S. (Remote)
46%	31 of 68	of reported suicide deaths in Alaska and Hawaii
7%	2 of 28	of reported suicide deaths outside of the contiguous U.S. (Non-remote), not including Alaska or Hawaii
10%	7 of 73	of reported suicide deaths outside of the contiguous U.S. (Remote), not including Alaska or Hawaii

Notes: GAO was unable to identify a geographic category for 33 of 1,806 or (1.8 percent) of reported suicide deaths.

This analysis does not include 135 active-duty servicemember suicide deaths that were reported to the Armed Forces Medical Examiner but not recorded in the DODSER system during 2016 through 2020. The Armed Forces Medical Examiner Tracking System does not record whether a firearm involved in a suicide death was military issued.

In the absence of a Department of Defense (DOD) definition, GAO defined remote installations outside the contiguous United States as those located in Alaska, Hawaii, or outside the United States that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship-duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

DOD defines suicide as death caused by self-directed injurious behavior with an intent to die as a result of the behavior.

[a]Small numbers, such as these, may result in percentages that are unstable. As a result, these percentages should be interpreted with caution.

These findings appear consistent with DOD and military service officials' hypotheses that limited access to non-military firearms resulted in fewer suicide deaths among servicemembers assigned to remote OCONUS locations, excluding Alaska and Hawaii, relative to servicemembers assigned to CONUS installations or OCONUS installations that allow possession of non-military issued firearms. However, it is not possible to make a causal connection based on these findings. While servicemembers' individual risk factors—such as history of mental illness or substance abuse— can also influence the extent of suicide risk, DOD has recognized the effect of firearms access on suicide and undertaken

efforts to promote safe storage of lethal means among all servicemembers.[32]

DOD Has Not Fully Assessed Suicide Risk at Remote OCONUS Installations

DOD has taken steps to assess suicide risk broadly, but has not fully done so for remote OCONUS installations. According to DOD officials, the department, in line with a public health approach, has undertaken initiatives to address suicide risk across the department and at individual commands and installations, when warranted. For example, DOD has established a governance structure, monitored risk factors associated with suicide deaths, and conducted a climate survey and analyzed its results.

- DSPO officials stated that the governance structure for suicide prevention—the Suicide Prevention General Officer Steering Committee and Suicide Prevention and Risk Reduction Committee—provides a helpful mechanism for discussing installations' concerns and lessons learned. In 2020, the Suicide Prevention General Officer Steering Committee established an ongoing cross-functional working group to address stigma and barriers to care. The working group began a DOD-wide analysis, identifying gaps and recommendations for policy and program enhancements. According to DSPO officials, the committees have not undertaken any initiatives to assess risks specific to remote OCONUS installations.
- DOD tracks data on risk factors associated with individual suicide deaths and reported suicide attempts in its DODSER system and assesses these data at the department level and by military service. Risk factors include whether individuals had mental health diagnoses, were victims or perpetrators of abuse, or engaged in substance abuse. DSPO officials stated that due to the low number of suicide deaths or attempts at any given installation, paired with complexities of available location data, it may not be possible to draw meaningful conclusions about risk factors for individual locations.
- In 2020, DOD's Office of People Analytics redesigned the Defense Organizational Climate Survey to assess 19 risk and protective factors

[32]DOD's efforts to promote lethal means safety, among other suicide prevention activities, are described in appendix IV.

that can be linked to various outcomes, including suicide.[33] According to an official from the Office of Force Resiliency, that office led an initiative to rank installations based on the survey results and identify poorly scoring installations.[34] The official stated in November 2021 that the office was in the process of conducting onsite evaluations of those specific installations, many of which were OCONUS. According to the official, while remote OCONUS installations were not specifically targeted, the methodology used to identify sites for onsite evaluation captured the potential for higher risk associated with remote OCONUS locations and informed site selection.

While DOD assesses suicide risk broadly, it has not comprehensively assessed suicide risk factors and related challenges at remote OCONUS installations. DOD, service, and installation-level officials we interviewed identified risk factors for suicide and related challenges that may be more pronounced at remote OCONUS installations. For example:

- DOD officials from multiple offices stated that OCONUS installations in remote areas can present additional risk factors including less access to mental health services, increased social isolation, and more stigma associated with seeking help.[35]
- Navy and Marine Corps suicide prevention officials stated that risk factors including lack of access to behavioral health care, barriers to

[33]DOD's Office of People Analytics was established in 2016 to develop cutting-edge analytical methods and solutions for more effective personnel management in DOD. The redesigned Defense Organizational Climate Survey is a commander's tool that assesses protective and risk factors that can affect a unit or organization's climate and ability to achieve their mission.

[34]The Office of Force Resiliency is an organization within the Office of the Under Secretary of Defense for Personnel and Readiness. Its mission is to strengthen and promote the resiliency and readiness of the total force through the development of integrated policies, oversight, and synchronization of activities in the areas of diversity management and equal opportunity, personnel risk reduction, suicide prevention, sexual assault prevention and response, and collaborative efforts with the Department of Veterans' Affairs.

[35]In 2016, we found that additional actions were needed to enhance DOD's efforts to address mental health care stigma, and made seven recommendations, including that DOD clarify and update policies contributing to stigma and designate an entity to coordinate stigma reduction efforts. DOD concurred with the recommendations and has taken actions including by conducting a review of policies and recommending changes to potentially stigmatizing language and by designating its Psychological Health and Readiness Council as the coordinating entity to collect and use information related to mental health care stigma. DOD implemented all seven of our recommendations. GAO, *Human Capital: Additional Actions Needed to Enhance DOD's Efforts to Address Mental Health Care Stigma*, GAO-16-404 (Washington, D.C.: Apr.18, 2016).

health care, cultural and religious beliefs, and social isolation caused by separation from friends and family may be more prevalent at remote OCONUS installations.

- Officials from U.S. Army Garrison Alaska, Fort Wainwright and Eielson Air Force Base in Alaska stated that the long winter, with temperatures often well below zero, can contribute to a feeling of isolation. Further, according to these officials, seasonal periods of darkness and light in Alaska may affect servicemembers' sleep patterns and thereby affect mental health. The Army conducted an epidemiological consultation at U.S. Army Garrison Alaska, Fort Wainwright that made recommendations to address these and other potential risk factors.
- Officials from Commander Fleet Activities Yokosuka and Camp Butler in Japan stated that restrictions and challenges related to traveling off the installation may limit the ability for some servicemembers—especially those who are young or have limited transportation—to relax, socialize, or engage with Japanese culture. According to the officials, these challenges have been exacerbated by the COVID-19 pandemic.
- Officials from all four installations where we conducted interviews cited a challenge of limitations in the installations' abilities to provide mental health care services. For example, officials at one installation described difficulty staffing behavioral health providers at the installation. Officials at three other installations stated that in-patient psychiatric care was not available at the installation. In cases such as these, servicemembers who experience a suicide attempt or suicidal ideation need to be transported to another location—often to another country—or be released to the command for constant supervision. Officials at one installation described instances where multiple command personnel were taken away from core responsibilities to supervise those at risk for suicide as a result of the limitations in available medical care.

In part due to stressors unique to these locations, officials at the four remote OCONUS installations where we conducted interviews stated they believed servicemembers should undergo more rigorous screening for suicide risk factors either as part of the accession process or prior to being assigned to a remote OCONUS installation. In August 2020, the Defense Health Board reported that its analysis of research on suicide risk factors found that current tools for predicting suicide risk are

marginally more accurate than chance.[36] As a result of this study, the Defense Health Board recommended improvements to the mental health accession screening process, such as developing a research strategy that includes measureable outcomes and identifying new approaches for assessment and screening of potential recruits.

The White House's 2021 strategy for Reducing Military and Veteran Suicide identifies a need for improving suicide surveillance data to identify suicide hot spots and tailor interventions to subpopulations where evidence suggests that a one-size-fits-all approach may not be effective.[37] DOD guidance also requires DSPO to analyze and assess data and research to identify risk factors and inform suicide prevention policies and programs.[38] Additionally, *Standards for Internal Control in the Federal Government* states that management should identify, analyze, and respond to risks related to achieving defined objectives.[39]

However, DOD has not established a process to assess risk factors for suicide or related challenges specific to remote OCONUS installations, such as those described in this report, and taken appropriate actions. By establishing such a process to assess risk factors for suicide and related challenges associated with assignment to remote OCONUS installations, DOD can improve its understanding of risks and challenges and better address them as needed.

Policies, Programs, and Activities Are in Place, but Gaps Exist in Implementation

DOD and the military services have established policies, programs, and activities to address suicide prevention for servicemembers and their dependents, including those at remote OCONUS installations. However, gaps exist in implementation of command- and installation-level activities.

[36]Defense Health Board Report, *Examination of Mental Health Accession Screening: Predictive Value of Current Measures and Processes* (Aug. 7, 2020).

[37]White House Publication, *Reducing Military and Veteran Suicide: Advancing a Comprehensive, Cross-Sector, Evidence-Informed Public Health Strategy,* (Washington, DC: Nov. 2, 2021).

[38]DOD Instruction 6490.16, *Defense Suicide Prevention Program,* (Nov. 6, 2017) (Incorporating change 2, Sept. 11, 2020).

[39]GAO-14-704G.

For example, the Army and the Air Force have designated a director of psychological health at each remote OCONUS installation, as required by DOD policy, but the Department of the Navy has not fully done so for Navy and Marine Corps installations.[40] In addition, the Air Force has taken steps to ensure the implementation of required suicide prevention activities at its installations, but the Army, the Navy, and the Marine Corps have not done so sufficiently.

DOD and the Military Services Have Established Suicide Prevention Policies, Programs, and Activities, Including for Remote OCONUS Installations

DOD and the military services have established suicide prevention policies, programs, and activities, including for servicemembers and dependents assigned to remote OCONUS installations.

Policies. DOD maintains a suicide prevention instruction and strategy that generally addresses statutorily required elements such as awareness of mental health conditions and stigma, means to identify servicemembers at risk for suicide, and servicemembers' access to suicide prevention services.[41] According to DSPO officials, these policies cover all servicemembers and dependents regardless of their duty location, and there is no specific suicide prevention policy or program for remote OCONUS installations. In addition, each military service has established policies outlining suicide prevention program requirements intended to reduce suicides among servicemembers and their dependents.[42] DSPO regularly reviews implementation of DOD's suicide

[40]DOD requires the Secretaries of the military departments to ensure the designation of a director of psychological health at each military installation, not limited to those at remote OCONUS locations. DOD Instruction 6490.09, *DOD Directors of Psychological Health* (Feb. 27, 2012) (Incorporating change 2, Apr. 25, 2017). The Marine Corps falls within the Department of the Navy.

[41]Pub. L. No. 112-239, § 582 (2013). DOD Instruction 6490.16, *Defense Suicide Prevention Program* (Nov. 6, 2017) (incorporating change 2, Sept. 11, 2020); Department of Defense, *Department of Defense Strategy for Suicide Prevention* (December 2015). DSPO modeled the Defense Strategy for Suicide Prevention after the National Strategy for Suicide Prevention.

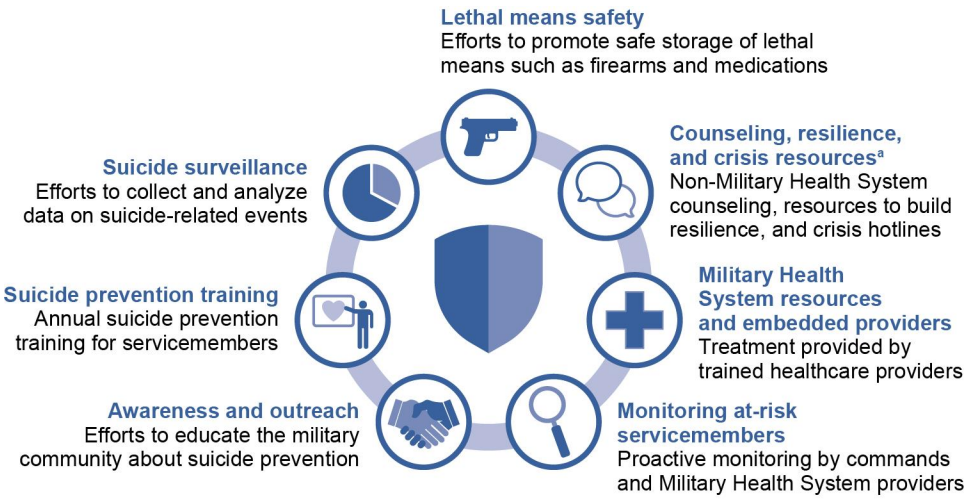
[42]Army Regulation 600-63, *Army Health Promotion* (Apr. 14, 2015). OPNAV Instruction 1720.4B, *Suicide Prevention Program* (Sept. 18, 2018). Air Force Instruction 90-5001, *Integrated Resilience* (Jan. 25, 2019) (incorporating Change 1, Oct. 21, 2021). Marine Corps Order 1720.2A, *Marine Corps Suicide Prevention System (MCSPS)* (Aug. 2, 2021). The Army has developed a draft suicide prevention policy to supersede Army Regulation 600-63.

prevention instruction by the military services, and determined that the military services' policies were in alignment with DOD's policy as a part of its calendar year 2020 review.

Programs. DSPO coordinates with the military services, other governmental agencies, non-governmental agencies, non-profit organizations, and communities to reduce the risk for suicide of servicemembers and dependents across DOD. DSPO has also taken steps to reduce suicide at remote OCONUS installations. For example, DSPO tailored training designed to reduce stigma and barriers to seeking help when servicemembers are stationed at geographically isolated and OCONUS installations, which—according to DSPO officials—took place over the course of calendar year 2021. According to DSPO officials, this training is part of a feasibility study for piloting and dissemination. In addition, each military service has established a suicide prevention program that provides direction and guidance on prevention and response activities and designates required personnel at the command or installation level.

Activities. DSPO and the military services' suicide prevention programs have implemented various activities intended to prevent suicide among servicemembers and their dependents, including at remote OCONUS installations. These include suicide prevention training and access to counseling and other mental health resources. In addition, certain suicide prevention activities implemented at the command or installation level can address specific needs or risk factors identified for those locations. Figure 6 provides examples of DOD and military service suicide prevention activities that are described in more detail in appendix IV.

Figure 6: Examples of Department of Defense and Military Service Suicide Prevention Activities



Source: GAO analysis of Department of Defense information. | GAO-22-105108

[a]The Military and Family Life Counseling Program provides non-medical counseling, which addresses issues such as improving relationships at home and work, stress management, and grief or loss. It does not address active suicidal thoughts or serious mental health conditions.

We previously found that, while DOD estimates that most of its non-clinical suicide prevention efforts are evidence based, not all have been assessed for effectiveness in the military population.[43] We recommended that DSPO collaborate with the military services to develop a process to ensure that individual non-clinical suicide prevention efforts are assessed for effectiveness in the military population. In December 2021, DOD officials stated that DSPO and the military services were collaborating to develop policy guidance to ensure that non-clinical suicide prevention efforts are assessed for effectiveness in the military population and expected this policy to be published in 2022.

The Army and the Air Force Designated Directors of Psychological Health at All Remote OCONUS Locations, but the Department of the Navy Has Not

The Army and the Air Force have designated a director of psychological health—responsible for coordinating installation psychological health resources—at all remote OCONUS installations, but the Department of the Navy has not done so for all Navy and Marine Corps installations.

[43]GAO-21-300.

These individuals serve a key role in managing the department's suicide prevention and response efforts at the installation level by ensuring the coordination of clinical, counseling, and other resources—such as chaplains, family centers, and family advocacy organizations—that promote the psychological health of servicemembers and their families. They also provide information to installation commanders regarding the status of psychological health of the beneficiary population.[44]

Among the 57 remote OCONUS installations included in our document review, we found that the Army and the Air Force designated a director of psychological health at all five Army installations and 28 Air Force installations, respectively.[45] However, Department of the Navy officials identified these personnel for seven of 19 Navy remote OCONUS installations and for none of five Marine Corps remote OCONUS installations.

Similarly, among our sample of eight remote OCONUS installations (two per service), we found that the Army and Air Force provided documentation that installation directors of psychological health generally completed required activities, but the Navy could not. Specifically, both Air Force installations and one of two Army installations provided evidence that directors of psychological health conducted meetings among installation psychological health resources, including with suicide prevention stakeholders, during calendar year 2020, as required.[46] However, of the two Navy and two Marine Corps installations, only one had a designated director of psychological health, and the Navy did not provide evidence that this director engaged in these activities.

Department of the Navy officials acknowledged the inconsistent designation of installation directors of psychological health across the

[44]DOD requirements related to installation directors of psychological health are found in DOD Instruction 6490.09, *DOD Directors of Psychological Health* (Feb. 27, 2012) (incorporating change 2, Apr. 25, 2017).

[45]The 57 remote OCONUS installations included in our document review are listed in appendix II.

[46]According to an Army official, the installation director of psychological health at the remaining Army installation had been recently designated. We requested documentation of the implementation of selected required suicide prevention activities from each military service's remote OCONUS installation that had the most reported suicide deaths and the installation that had the most reported suicide attempts during 2016 through 2020. This included documentation that installation directors of psychological health had conducted meetings with installation psychological health resources.

Navy and Marine Corps. In addition, a Department of the Navy official stated that the lack of directors of psychological health across Navy and Marine Corps installations is a known problem, and that they believed that where directors have been assigned, the designations were nominal and not carried out in a manner consistent with DOD policy. Health officials at one remote OCONUS Navy installation without a director stated that they considered the position to be an Air Force best practice, and that suicide prevention efforts within the Navy were more siloed. For example, the officials stated the suicide prevention program and health care providers work separately, although they have made efforts to network with one another.

DOD Instruction 6490.09 *DOD Directors of Psychological Health*—issued in 2012—directs the Secretaries of the military departments to ensure that each military installation has a designated installation director of psychological health who serves as the installation's principal consultant and advocate for psychological health.[47] Additionally, *Standards for Internal Control in the Federal Government* states that management should establish an organizational structure, assign responsibility, and delegate authority to achieve the entity's objectives.[48] However, despite the longstanding DOD requirement, the Department of the Navy has not issued a policy requiring the designation of installation directors of psychological health and acknowledged that doing so would bring it into compliance with DOD's requirement.

In July 2021, the Navy initiated a project to ensure compliance with DOD Instruction 6490.09. This project is expected to establish the responsibilities of installation directors of psychological health and culminate in the development of an associated implementation policy by October 2023. By issuing a policy that requires Navy and Marine Corps installations to appoint a director of psychological health and provides implementing guidance, the Department of the Navy will be better positioned to ensure this requirement is implemented consistently across Navy and Marine Corps installations. Further, by providing guidance to directors of psychological health regarding their roles and responsibilities, the Department of the Navy can enhance these personnel's ability to

[47]DOD Instruction 6490.09, *DOD Directors of Psychological Health* (Feb. 27, 2012) (incorporating Change 2, Apr. 25, 2017).

[48]GAO-14-704G.

coordinate installation resources to support the psychological health of servicemembers and their families.

Three Services Have Not Ensured Implementation of Required Suicide Prevention Activities at Installations, Including Remote OCONUS

The Air Force has taken steps to ensure the implementation of required installation-level suicide prevention activities, but the Army, the Navy, and the Marine Corps have not done so sufficiently. DOD and the military services require certain activities supporting suicide prevention for servicemembers and their dependents to be implemented at the command or installation level.[49] Specifically, DOD Instruction 6490.16 directs the military services' suicide prevention programs to include a designated person at the command or installation level to oversee its suicide prevention program.[50] In addition, each military service requires a command- or installation-level prevention team whose responsibilities include carrying out suicide prevention or resilience activities, as well as installation-level suicide prevention policies, procedures or plans.[51] We reviewed documentation related to these requirements for each service's

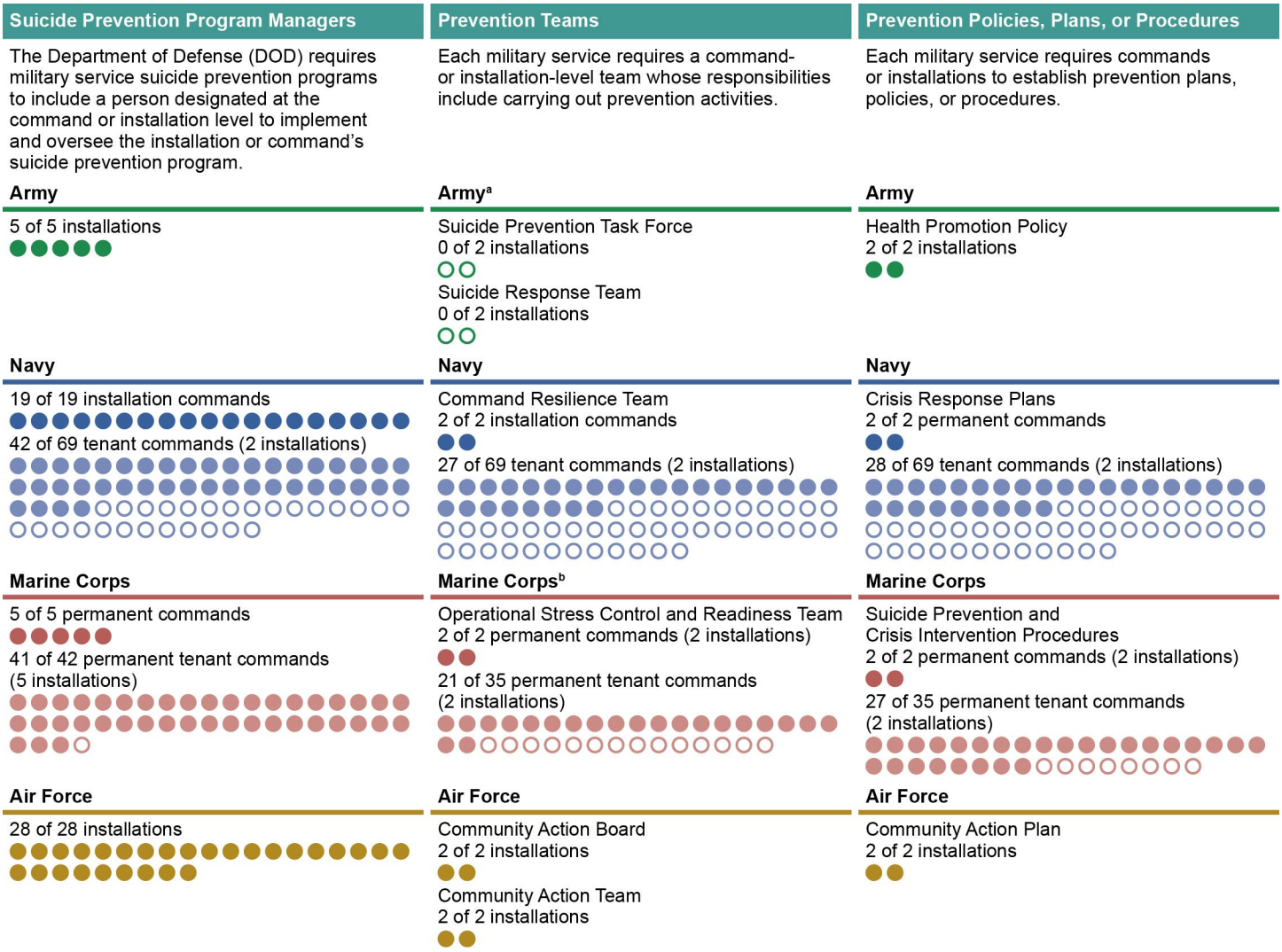
[49]Army and Air Force officials stated that their services' installations implement suicide prevention requirements—such as a designated individual to oversee suicide prevention activities—for the entire installation. Conversely, Navy and Marine Corps officials explained that Navy and Marine Corps installations implement the suicide prevention program at the command level, including for each installation's command and permanent tenant commands at the installation.

[50]DOD Instruction 6490.16.

[51]Army Regulation 600-63 directs each installation to maintain a Suicide Prevention Task Force, a Suicide Response Team, and a health promotion policy that includes suicide prevention efforts. Navy guidance directs commands to maintain a Command Resilience Team that implement positive measures that promote well-being and resilience; Navy, *Cultural Champion Network Quick Reference Guide* (December 2020). Additionally, OPNAV Instruction 1720.4B directs each command to maintain a Crisis Response Plan that outlines protocols and resources for responding to servicemembers who may be at high risk for suicide. Air Force Instruction 90-5001 directs installations to maintain a Community Action Board, Community Action Team, and Community Action Plan that addresses suicide prevention activities. Marine Corps Order 5351.1 directs each battalion or squadron-level command to maintain an Operational Stress Control and Readiness Team consisting of at least 5 percent of the unit's personnel or a minimum of 20 members, whichever is greater; Marine Corps Order 5351.1, *Combat and Operational Stress Control Program* (Feb. 22, 2013). Finally, Marine Corps Order 1720.2A directs commands to maintain Command Suicide Prevention and Crisis Intervention Plans. We selected these requirements for our documentation review for consistency across the services and based on discussion with service officials. However, the selected requirements are not inclusive of all installation-level suicide prevention activities required by each service.

remote OCONUS installations and identified gaps in the implementation of requirements for some Army, Navy, and Marine Corps remote OCONUS installations, as shown in figure 7.

Figure 7: Implementation of Selected Required Suicide Prevention Activities for Servicemembers and Dependents at Remote Installations Outside the Contiguous United States



Source: GAO analysis of military service documentation. | GAO-22-105108

Accessible Data Table for Figure 7(Part 1 of 4)

	Suicide Prevention Program Managers	Prevention Teams	Prevention Policies, Plans, or Procedures
Army	5 of 5 installations	Suicide Prevention Task Force: 0 of 2 installations Suicide Response Team: 0 of 2 installations	Health Promotion Policy: 2 of 2 installations

Accessible Data Table for Figure 7(Part 2 of 4)

	Suicide Prevention Program Managers	Prevention Teams	Prevention Policies, Plans, or Procedures
Navy	19 of 19 installation commands 42 of 69 tenant commands (2 installations)	Command Resilience Team: 2 of 2 installation commands 27 of 69 tenant commands (2 installations)	Crisis Response Plans: 2 of 2 permanent commands 28 of 69 tenant commands (2 installations)

Accessible Data Table for Figure 7(Part 3 of 4)

	Suicide Prevention Program Managers	Prevention Teams	Prevention Policies, Plans, or Procedures
Marine Corps	5 of 5 permanent commands 41 of 42 permanent tenant commands (5 installations)	Operational Stress Control and Readiness Team: 2 of 2 permanent commands (2 installations) 21 of 35 permanent tenant commands (2 installations)	Suicide Prevention and Crisis Intervention Procedures: 2 of 2 permanent commands (2 installations) 27 of 35 permanent tenant commands (2 installations)

Accessible Data Table for Figure 7(Part 4 of 4)

	Suicide Prevention Program Managers	Prevention Teams	Prevention Policies, Plans, or Procedures
Air Force	28 of 28 installations	Community Action Board: 2 of 2 installations Community Action Team: 2 of 2 installations	Community Action Plan: 2 of 2 installations

Notes: GAO requested documentation of designated suicide prevention program managers for 57 remote OCONUS installations. This included five Army installations, 19 Navy installations, five Marine Corps installations, and 28 Air Force installations. We requested documentation of establishment of prevention teams and prevention policies, plans and procedures for two remote OCONUS installations for each military service.

The Navy and the Marine Corps implement suicide prevention activities at the command level rather than the installation level. However, the Navy was unable to compile documentation for tenant commands across all 19 of its remote OCONUS installations, due to the volume of tenant commands. As a result, we requested documentation of designated suicide prevention program managers for 19 installation commands and 69 tenant commands across two installations for the Navy and for five permanent commands and 42 permanent tenant commands across five installations for the Marine Corps. The two installations for which we requested documentation of additional requirements described above included two installation commands and 69 tenant commands for the Navy and two permanent commands and 35 permanent tenant commands for the Marine Corps.

[a]Officials from one Army installation stated the installation had established a Suicide Prevention Task Force but were unable to provide documentation such as a roster or meeting minutes.

[b]Each of the 35 Marine Corps commands provided team rosters, but the rosters for 14 of these commands included less than the required number of team members.

Each service has taken steps to help ensure the implementation of required suicide prevention program activities. Specifically:

- The Air Force ensures implementation of installation suicide prevention activities through annual wing-level inspections and service-level reviews of installation self-assessments.
- The Army's Resilience Directorate conducts staff assistance visits that examine suicide prevention activities. In addition, an Army Resilience Directorate official stated that their office reviews quarterly program status reports from installation-level Commander's Ready and Resilient Councils, which coordinate a range of prevention activities at the installation.
- The Navy and the Marine Corps conduct periodic inspections of command-level suicide prevention programs and direct higher-level commands to appoint personnel who are required to monitor subordinate commands' suicide prevention activities. In addition, the Navy requires command-level personnel to examine whether a command's prevention teams are in place every 2 years.[52]

Standards for Internal Control in the Federal Government states that management should design control activities to achieve objectives and respond to risks, and remediate identified deficiencies in the internal control system.[53] However, while the Air Force's oversight mechanisms have helped it ensure that installation-level suicide prevention activities are implemented, existing Army, Navy, and Marine Corps mechanisms have not provided these services adequate oversight to ensure the implementation of all required suicide prevention activities. Specifically:

[52]OPNAV Instruction 5354.1H, *Navy Harassment Prevention and Military Equal Opportunity Program Manual* (Nov. 3, 2021)

[53]GAO-14-704G.

Army. The Army's current program status report does not cover all required activities, and an Army official stated that modifications to the program status report are needed to fully address these requirements. The Army has developed a new suicide prevention policy and supplementary guidance which, according to an Army official, is scheduled for release in April 2022. However, an Army official stated that the draft policy does not explicitly require the program status report, and that this requirement will instead be addressed through a future memorandum. The official further stated that the Army is in the process of developing a program status report focused on suicide prevention requirements, scheduled for implementation in fiscal year 2023.

Navy. Navy policy requires suicide prevention program managers at higher-level commands to maintain a roster of subordinate commands' suicide prevention program managers and assist them in meeting suicide prevention program requirements. However, the Navy has not been able to ensure that higher-level commands complete these tasks because it has not established needed oversight mechanisms in policy. In addition, Navy policy does not require command-level personnel to share the results of the aforementioned biennial assessments, which include findings on the status of commands' prevention teams.

Marine Corps. The Marine Corps' revised suicide prevention policy, issued in August 2021, requires the designation of suicide prevention program coordinators at higher commands, who Marine Corps officials stated will help ensure that commands implement required suicide prevention activities, such as maintaining command procedures for suicide prevention. However, the Marine Corps is limited in its ability to ensure that these personnel are appointed in a timely manner and are overseeing the activities of subordinate commands as intended, because the Marine Corps' policy does not establish a mechanism for service-level oversight of these personnel. As of January 2022, officials stated that some of these personnel had been appointed, but not all, and that they were unsure how many positions remained open.

Separately, the Marine Corps has established oversight mechanisms to ensure implementation of Operational Stress Control and Readiness teams, such as staff assistance visits and periodic inspections.[54]

[54]Operational Stress Control and Readiness Teams work to prevent, identify, and reduce stress issues as soon as possible and to assist leaders in promoting psychological resiliency. These teams are a part of the Marine Corps Combat and Operational Stress Control Program.

However, according to a Marine Corps official, the staff assistance visits—intended to help commands prepare for or respond to inspections—occur at the discretion of commands, and inspections are conducted every 2 to 4 years, creating potential gaps in compliance. In addition, Headquarters Marine Corps annually reports to DHA the total number of Marines trained to become Operational Stress Control and Readiness team members, but Marine Corps officials acknowledged that they do not have visibility over the number of teams and thus the extent to which each team has maintained the requisite number of members. Marine Corps officials stated that, in 2020, the Marine Corps initiated an effort to determine the number of teams across the service, and as of January 2022, this effort was still underway.[55]

Without oversight mechanisms to help ensure that all command- and installation-level suicide prevention program activities are implemented as required, the Army, Navy, and Marine Corps cannot have reasonable assurance that such activities are carried out across all installations and commands, including remote OCONUS installations. As a result, these services cannot ensure that servicemembers and dependents have access to suicide prevention resources or that suicide prevention procedures are followed in accordance with DOD and service policies.

Privacy Protections Exist; Staffing Shortages Hinder Prevention in Primary Care

DOD and the military services have established policies, procedures, resources, and training regarding the protection of information belonging to servicemembers and dependents seeking suicide prevention resources. In addition, DOD has taken steps to integrate suicide prevention into primary care by establishing screening requirements and embedding behavioral health personnel in some primary care clinics. However, we found that DHA has experienced challenges in fully staffing these positions.

[55]Marine Corps Order 5351.1 directs each battalion or squadron-level command to maintain an Operational Stress Control and Readiness Team consisting of at least 5 percent of the unit's personnel or a minimum of 20 members, whichever is greater.

DOD and the Military Departments Have Established Privacy Protections for Suicide Prevention Care

DOD and the military departments have established policies, procedures, resources, and training regarding privacy protection for servicemembers and dependents, including those seeking suicide prevention care. These include policies to ensure the protection of personal information—including protected health information—and the privacy of servicemembers and dependents seeking mental health treatment; procedures and resources for disclosing servicemembers' protected health information, when appropriate; and training for servicemembers on safeguarding personal information.

Policies. DOD and the military departments have established privacy protections for all servicemembers and dependents through policies that implement provisions of the Privacy Act of 1974 (Privacy Act) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[56] Specifically:

- DOD policy directs all DOD components to establish privacy programs that comply with the Privacy Act, among other requirements.[57] In addition, DOD policy prescribes uniform procedures for implementation of the DOD Privacy Program, including procedures for the disclosure of personal information to other agencies and third parties.[58] For example, this policy identifies conditions for appropriate non-consensual disclosure of protected health information when compelling circumstances affect the health or safety of any individual.[59]

[56]Privacy Act of 1974, Pub. L. No. 93-579 (Dec. 31, 1974), *codified as amended* at 5 U.S.C. § 552a; Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (Aug. 21, 1996), *codified as amended* in scattered sections of the United States Code.

[57]DOD Instruction 5400.11, *DOD Privacy and Civil Liberties Program* (Jan. 29, 2019) (incorporating change 1, Dec. 8, 2020). DOD 5400.11-R, *Department of Defense Privacy Program* (May 14, 2007).

[58]DOD 5400.11-R.

[59]DOD 5400.11-R provides additional conditions of non-consensual disclosures. Furthermore, it addresses disclosures to the public from medical records, which are also governed by DOD Manual 6025.18, *Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DOD Health Care Programs*.

- DOD has established policy to implement and ensure DOD's compliance with HIPAA provisions for servicemembers and dependents, including rules related to the use and disclosure of servicemembers' protected health information.[60] This policy allows DOD covered entities to use and disclose the protected health information of servicemembers for activities deemed necessary by the servicemember's command to assure the proper execution of the military mission. This includes—but is not limited to—disclosures to determine a member's fitness for duty and their fitness to perform any particular mission, assignment, or order.[61]
- Each military department has established privacy-related policies. For example, the Army has established policies that provide general guidance on collecting, safeguarding, and disclosing personal information, as well as procedures for the preparation, disposition, and use of Army electronic and paper medical records.[62] Similarly, both the Departments of the Navy and the Air Force have issued policies regarding the collection, use, and protection of personal information, as well as policies that implement practices to ensure that

[60]DOD Instruction 6025.18, *Health Insurance Portability and Accountability Act* (*HIPAA) Privacy Rule Compliance in DOD Health Care Programs* (Mar. 13, 2019). DOD Manual 6025.18, *Implementation of the Health Insurance Portability and Accountability Act* (*HIPAA) Privacy Rule in DOD Health Care Programs* (Mar. 13, 2019). HIPAA is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. We did not evaluate DOD's and the military services' efforts to implement the HIPAA Security Rule, which establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by DOD-covered entities.

[61]A covered entity is defined as a health plan or a health provider who transmits any health information in electronic form in connection with a standard transaction covered by DOD Manual 6025.18. In the case of a health plan administered by DOD, the DOD-covered entity is the DOD component or subcomponent that functions as the administrator of the health plan. Not all health care providers affiliated with the military services are DOD-covered entities. This rule does not apply to non-servicemembers.

[62]Army Regulation 25-22, *The Army Privacy Program* (Dec. 22, 2016). Army Regulation 40-66, *Medical Record Administration and Healthcare Documentation* (June 17, 2008) (Rapid Action Revision, Jan. 4, 2010).

protected health information is safeguarded in accordance with HIPAA.[63]

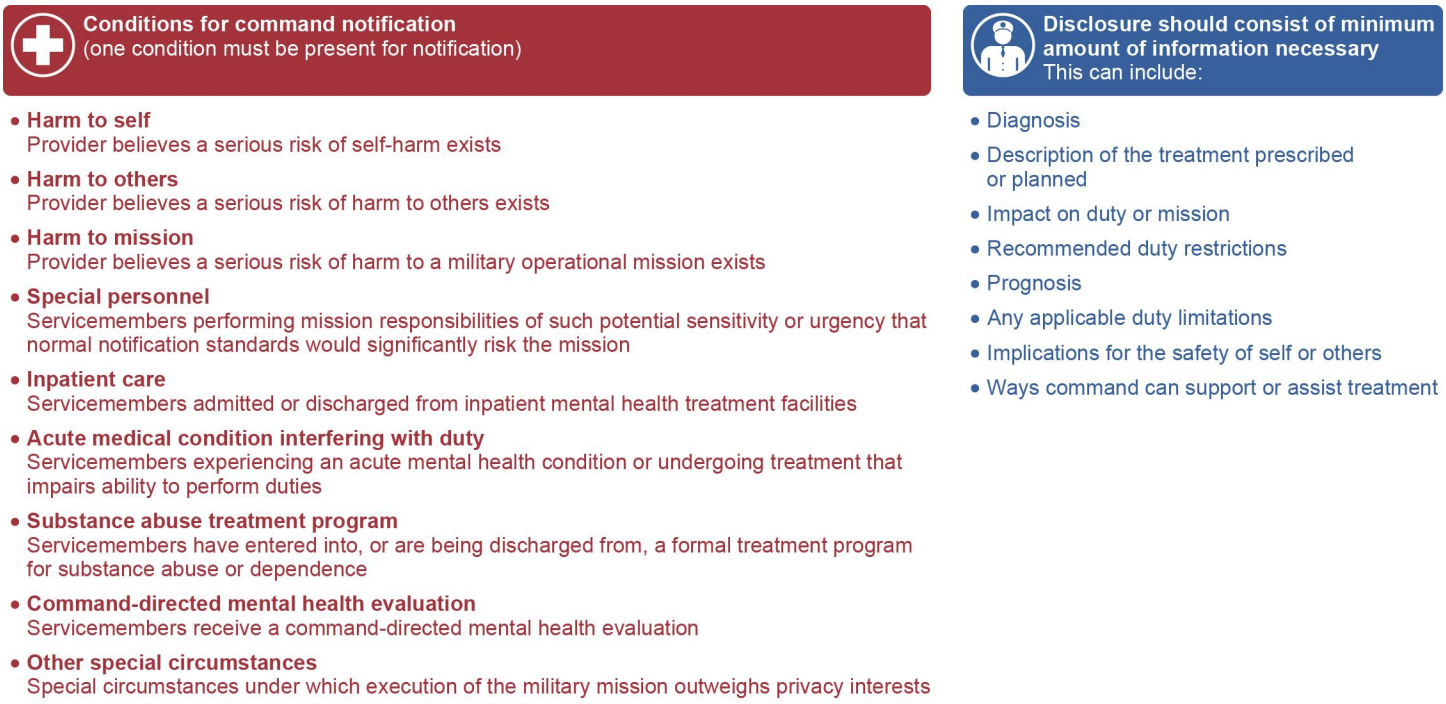
DOD has established additional privacy protections for information related to disclosure of servicemembers' mental health care information. Specifically, DOD policy states that mental health providers may not notify a command authority when a servicemember obtains mental health or substance abuse related treatment, unless one of nine notification standards are met.[64] These standards include—but are not limited to—situations in which a provider believes there is a serious risk of self-harm by the servicemember either as a result of a medical condition or medical treatment of the condition, and instances where mental health services are obtained as a result of a command-directed mental health evaluation.[65] See figure 8 for the conditions under which mental health providers may notify a command authority that a servicemember has obtained mental health services.

[63]Secretary of the Navy Instruction 5211.5F, *Department of the Navy Privacy Program* (May 20, 2019). Navy Bureau of Medicine and Surgery Instruction 5211.4, *Bureau of Medicine and Surgery Headquarters Privacy Program* (July 24, 2015). Air Force Instruction 33-332, *Air Force Privacy and Civil Liberties Program* (Mar. 10, 2020). Air Force Instruction 41-200, *Health Insurance Portability and Accountability Act (HIPAA)* (July 25, 2017).

[64]DOD Instruction 6490.08, *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members* (Aug. 17, 2011). In addition to the presumption created by DOD Instruction 6490.08, DOD Manual 6025.18 establishes strict guidelines under which psychotherapy notes can be disclosed without prior authorization.

[65]The National Defense Authorization Act for Fiscal Year 2022 required DOD to prescribe a process by which servicemembers can, on their own initiative, obtain a referral from a commander or supervisor for a mental health evaluation on any basis. The statute directed that referrals made via this process be treated in a manner similar to other medical services, to the maximum extent practicable, in order to reduce stigma around mental health treatment. Furthermore, the process should protect the confidentiality of the member to the maximum extent practicable, in accordance with law. Pub. L. No. 117-81, § 704 (2021).

Figure 8: Conditions for Command Notification of Active-Duty Servicemembers' Mental Health Treatment



Source: Department of Defense Instruction 6490.08. | GAO-22-105108

When making a disclosure pursuant to these standards, DOD requires providers to provide the minimum amount of information needed to satisfy the purpose of the disclosure.[66] Additionally, disclosures must be made to the servicemember's commander or another person specifically designated in writing for this purpose, and a record of each disclosure must be maintained.

Procedures and Resources. We also identified procedures and resources maintained by the military departments, DOD, and the DHA that are intended to support the privacy of servicemembers and dependents and help ensure that disclosures of protected health information—including those for servicemembers receiving mental health

[66]According to DOD, information disclosed shall generally consist of the diagnosis, a description of the treatment prescribed or planned, effect on duty or mission, recommended duty restrictions, the prognosis, any applicable duty limitations, implications for the safety of self or others, and ways the command can support or assist the servicemember's treatment. DOD Instruction 6490.08.

treatment—are conducted in a manner that is both secure and limited, in accordance with policy. Specifically:

- Army guidance states that unit command officials must be designated in writing by their commander to receive protected health information from health care providers.[67] These designations must also include the type of protected health information the command officials are eligible to receive. This guidance also provides information to mental health providers regarding DOD's policy for mental health disclosures. Specifically, it addresses the conditions of disclosure as well as the requirement to provide commanders the minimum amount of information necessary to satisfy the purpose of the disclosure. The Army has also created a commander's quick reference guide on HIPAA that outlines the types of protected health information that they may access.
- The Navy's *Suicide Prevention Handbook* provides guidance for commanders and mental health care providers to help ensure that disclosures of protected health information regarding servicemembers seeking mental health treatment observe the requirements of DOD's policy.[68] Additionally, the Navy has developed an information paper for health care providers that is intended to help them interpret DOD's policy regarding these disclosures. The information paper includes guidance regarding who is eligible to receive protected health information (i.e., commanders and their written designees), provides additional context regarding the circumstances under which a disclosure can be made, and recommends the use of embedded providers who may have more insight regarding the minimum information needed by commanders.
- Air Force policy specifies that military treatment facilities should maintain a roster of commanders and their designees who are eligible to receive protected health information.[69] In addition, the Air Force has also issued guidance to its mental health providers that addresses the conditions of disclosure for servicemembers seeking mental health treatment.[70] This guidance also directs mental health providers to

[67]Army Directive 2020-13, *Disclosure of Protected Health Information to Unit Command Officials* (Oct. 26, 2020).

[68]Navy Suicide Prevention Program, *Project 1 Small ACT Suicide Prevention Handbook.*

[69]Air Force Instruction 41-200, *Health Insurance Portability and Accountability Act (HIPAA)* (July 25, 2017).

[70]Air Force Instruction 44-172, *Mental Health* (Nov. 13, 2015).

provide commanders with the minimum amount of information necessary to satisfy the purpose of the disclosure.

- DOD has established non-clinical resources—such as military family life counselors and chaplains—that provide confidential counseling for servicemembers and dependents.
- DHA maintains resources for providers regarding the disclosure of protected health information, including information papers on disclosing protected health information to commanders and disclosing psychotherapy notes.

Training. DOD and the military services provide training on protecting sensitive information, including protected health information. Specifically, the military departments have developed required annual training for all servicemembers on the Privacy Act.[71] In addition, DOD requires that military, civilian, and contractor personnel—as required by contract—working within the military health system receive training on HIPAA and Privacy Act protections for servicemembers and dependents when hired and through annual refresher training.[72] Each of the military services has implemented supplemental efforts to educate commanders regarding their responsibilities in safeguarding protected health information.

- Officials from U.S. Army Garrison Humphreys provide commanders and first sergeants with information covering the installation's behavioral health resources, as well as their responsibilities in safeguarding protected health information. Officials from U.S. Army Garrison Alaska, Fort Wainwright provided similar materials that describe limits on commanders' access to protected health information.
- Officials from multiple Navy commands at remote OCONUS installations stated that commanders receive training on handling protected health information pursuant to disclosures made under DOD Instruction 6490.08, and Navy officials provided us with an example of a local training that addressed this topic.

[71]Army Regulation 25-22. SECNAV Instruction 5211.5F. Air Force Instruction 33-332. The military departments also require their civilian employees to complete annual Privacy Act training. In addition, the Departments of the Army and Air Force require all contractor personnel to complete Privacy Act training, and the Department of the Navy requires contract personnel to receive this training based on applicable contract requirements.

[72]DHA Administrative Instruction 74, *Workforce Training Pursuant to the Requirements of the Privacy Act and the Health Insurance Portability and Accountability Act* (Dec. 2, 2014).

- Air Force policy requires that installation medical treatment facility HIPAA Privacy Officers or medical group leadership provide commanders and first sergeants with general training on HIPAA within 90 days of their assignment.[73] To facilitate this training, the Air Force has developed standardized briefings to be used by facilitators.
- A Marine Corps official at Marine Corps Base Camp Butler stated that commanders participate in leadership activities where specific privacy protections are discussed, including disclosures of protected health information of servicemembers seeking mental health treatment.

DOD Has Taken Steps to Integrate Suicide Prevention into Primary Care but Faces Staffing Shortages

DOD has taken steps to integrate suicide prevention into primary care for servicemembers and dependents by establishing screening requirements for suicide risk and embedding behavioral health personnel into primary care clinics. Specifically, DOD requires that primary care managers annually screen adult patients for major depressive disorders and post-traumatic stress disorder using DHA-approved instruments.[74] Additionally, DOD has implemented a uniform periodic health assessment program across the military services that requires servicemembers to undergo annual health screenings to determine medical readiness. The annual screening includes a self-assessment to evaluate suicide risk, among

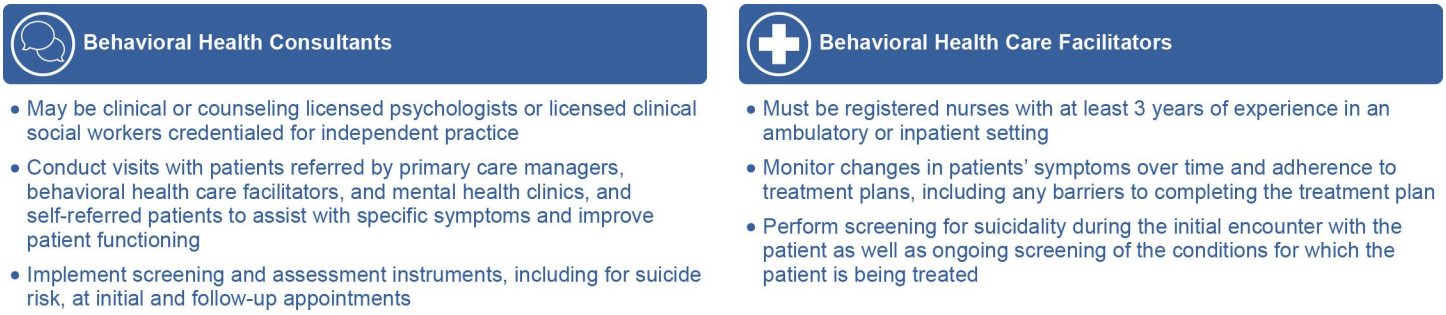
[73]Air Force Instruction 41-200.

[74]Primary care managers are responsible for providing routine, non-emergency, and urgent health care and can provide patients referrals to specialty care. DOD screening requirements are identified in DOD Instruction 6490.15, *Integration of Behavioral Health Personnel (BHP) Services Into Patient-Centered Medical Home (PCMH) Primary Care and Other Primary Care Service Settings* (Aug. 8, 2013) (incorporating change 2, Nov. 20, 2014) and DHA Procedural Instruction 6025.27, *Integration of Primary Care Behavioral Health (PCBH) Services into Patient-Centered Medical Home (PCMH) and Other Primary Care Service Settings within the Military Health System (MHS)* (Oct. 18, 2019). On January 25, 2022, the DHA augmented existing screening requirements by publishing new requirements for depression and suicide risk screening. Specifically, all beneficiaries age 11 years and older will be screened for depression at every face-to-face or virtual primary care appointment using a standardized screening instrument, and those that screen positive will undergo additional standardized screening. DHA Administrative Instruction 6025.04, *Standardization of Depression and Suicide Risk Screening in Primary Care During and Subsequent to the Coronavirus Disease 2019 Pandemic* (Jan. 25, 2022). According to a DHA official, the DHA is in the process of implementing these requirements across all clinics.

other things; a person-to-person mental health assessment with a trained health care provider; and the review of medical records.[75]

In addition to annual screening, DOD, through its primary care behavioral health program, has embedded behavioral health personnel within primary care clinics that meet patient enrollment thresholds. These personnel include behavioral health consultants and behavioral health care facilitators, whose roles are described in figure 9.

Figure 9: Roles of Department of Defense Behavioral Health Consultants and Behavioral Health Care Facilitators



Source: GAO analysis of Defense Health Agency guidance. | GAO-22-105108

DOD's enrollment thresholds determine which primary care clinics are required to staff embedded behavioral health personnel. Specifically, DOD guidance requires one full-time behavioral health consultant at each primary care clinic with 3,000 or more adult enrollees, and one full-time behavioral health care facilitator at each primary care clinic with 7,500 or more adult enrollees.[76] Clinics that demonstrate a need for an additional full-time behavioral health consultant or full-time behavioral health care facilitator can request funding from DHA for additional positions.

As a part of our review, we evaluated the extent to which DOD had filled authorized billets for behavioral health consultants and facilitators at

[75]DOD Instruction 6200.06, *Periodic Health Assessment (PHA) Program* (Sept. 8, 2016). DHA Procedural Instruction 6200.06, *Periodic Health Assessment (PHA) Program* (May 9, 2017).

[76]DOD Instruction 6490.15. DHA Procedural Instruction 6025.27. If two or more primary care clinics at an installation do not meet the enrollment thresholds individually for a behavioral health consultant or behavioral health care facilitator but their combined enrollment does, DHA can authorize those clinics to hire and share an embedded provider. Finally, DHA officials told us they consider requests for personnel from individual clinics that do not meet enrollment thresholds.

OCONUS installations.[77] We found that as of October 2021, 17 of 42 (40 percent) authorized billets for such personnel at remote OCONUS installations were unfilled.[78] Similarly, across all OCONUS installations, 37 of 84 (44 percent) authorized billets for these positions were unfilled. DHA officials stated these positions can be difficult to fill due to challenges that include high demand for behavioral health providers, difficulties in recruiting behavioral health personnel that want to work in a primary care setting, undesirable locations, and prolonged hiring and on-boarding processes.[79]

DHA Procedural Instruction 6025.27 requires DHA to provide oversight and management of primary care behavioral health program training, implementation, sustainment, and evaluation. Additionally, GAO's key practices for strategic human capital management state that effective organizations develop strategies to address human capital gaps and achieve programmatic goals and results.[80] However, while DHA is aware of the challenges it faces in sustaining primary care behavioral health program personnel, it has not been able to address staffing shortages because—according to an official—it has not developed a strategy to do so. According to a DHA official, as of October 2021, DHA was discussing

[77]The billets identified in the DHA data include both those required per the enrollment thresholds and those authorized by DHA, as described above.

[78]Specifically, 11 of 33 authorized billets for Behavioral Health Consultants and 6 of 9 authorized billets for Behavioral Health Care Facilitators at remote OCONUS installations were unfilled.

[79]Similarly, in 2020, the DOD Office of Inspector General found that DOD did not consistently meet outpatient mental health access-to-care standards for active-duty servicemembers and their families. For example, the office found that DOD did not consistently meet outpatient mental health access-to-care standards because the DHA lacked a military health system-wide model to identify appropriate levels of staffing in direct and purchased care. The DOD Office of Inspector General report stated that, as a result, thousands of active-duty servicemembers and their families may have experienced delays in obtaining mental health care. The office recommended, among other things, that DHA (1) develop a military health system-wide staffing approach for behavioral health care that estimates the number of appointments and personnel required to meet the enrolled population's demand for mental health services and (2) establish a policy that identifies which population of beneficiaries by military treatment facility will receive outpatient specialty mental health services through the direct care system. Department of Defense Office of Inspector General Report No. DODIG-2020-112, *Evaluation of Access to Mental Health Care in the Department of Defense* (Aug. 10, 2020).

[80]GAO, *A Model of Strategic Human Capital Management,* GAO-02-373SP (Washington, D.C.: March 2002).

the development of a strategy to address behavioral health personnel shortages in primary care, but had not yet taken any steps.

By developing a strategy to address shortages of primary care behavioral health personnel—including at remote OCONUS installations—DHA can help ensure the services' ability to provide more comprehensive and effective behavioral health care to servicemembers and dependents through primary care resources. As a result, DOD may be able to enhance its clinical suicide prevention efforts, including for servicemembers and dependents at remote OCONUS installations.

Gaps Exist in Suicide Response Guidance and Training for Key Personnel

DOD and the military services have established guidance that fully addresses commanders' response to suicide deaths, but DOD has not established statutorily required guidance for responding to suicide attempts or required training for responding to deaths and attempts. In addition, each service has established or planned guidance to address suicide prevention program managers' responsibilities for responding to suicide deaths and attempts, but gaps exist in the provision and oversight of required training for these personnel.

Gaps Exist in Suicide Response Guidance and Training for Commanders

Guidance for Commanders Fully Addresses Response to Suicide Deaths, but Not Suicide Attempts

DOD and the military services have established statutorily required guidance that fully addresses commanders' response to suicide deaths, but not for suicide attempts. In 2020, DOD issued guidance for commanders and other personnel for responding to suicide deaths, which addressed topics including required notifications, announcing the death to the military community, and providing support to unit members and next of kin, such as through holding a unit memorial.[81] However, the guidance states that it is not intended to address response to suicide attempts.

[81]Department of Defense, *Postvention Toolkit for a Military Suicide Loss* (2020).

Other DOD policy and guidance addresses the response to suicide attempts generally, but does not specify commanders' roles in response. For example, DOD's suicide prevention policy addresses data reporting requirements for servicemember suicide attempts, among other things, but does not include guidance for commanders' response to suicide attempts. In addition, DOD's strategy for suicide prevention addresses the response to suicide attempts broadly, such as by addressing the continuity of care by clinical providers following a suicide attempt, but similarly does not identify specific guidance for commanders.

DSPO officials stated that the office's *Leaders Suicide Prevention Safe Messaging Guide a*pplies to commanders' communication in the workplace regarding suicide attempts within the unit.[82] For example, this resource provides suggested language to use when talking about a suicide, as well as common misconceptions about suicide. However, where this guidance specifically addresses commanders' communication following a suicide attempt, it directs commanders to access the previously described guidance that addresses the response only to suicide deaths.

Each military service has established a suicide prevention policy and supplemental guidance for commanders that addresses their response to suicide deaths and attempts. For example, the guidance addresses coordinating with behavioral health resources and ensuring affected individuals have access to bereavement or other support resources. We found that this service-level guidance is generally consistent with DOD's guidance for responding to suicide deaths. Officials from each military service stated that they view the service-level guidance as complementary to DOD's guidance, and described various methods for disseminating the DOD and service guidance to commanders. For example, officials described posting the guidance on the service suicide prevention website and encouraging suicide prevention program managers to share the guidance with commanders within their installation or unit.

However, we found that the guidance regarding commanders' response to suicide attempts varies across the services. Specifically, Navy, Air Force, and Marine Corps guidance includes guidelines for commanders

[82]Department of Defense, *Leaders Suicide Prevention Safe Messaging Guide*.

related to the reintegration of servicemembers into the unit following a suicide attempt, but Army guidance does not, as described below.

- The Navy's *Suicide Prevention Handbook* identifies key reintegration considerations for leaders when a sailor is in treatment, such as helping other personnel understand the importance of seeking treatment.[83] It also identifies considerations following treatment, such as facilitating a transition between the medical provider and command leadership to ensure that the sailor continues to receive needed support.
- The Air Force has established a *Standard Operating Procedure for Reintegration Following a Crisis* (including a suicide attempt) that includes recommended steps in preparation for reintegration and following an airman's return to work.[84] Such steps include coordinating with mental health and other helping agencies and consulting with the servicemembers to discuss how they would prefer leadership answer questions or discuss their absence.
- The Marine Corps' *Commander's Checklist for Response to Suicide-Related Events* identifies recommended actions for reintegration following a suicide attempt, such as ensuring frequent check-ins with the Marine and assigning duties that do not require use of a weapon if personal safety is a concern.[85]

An Army official stated that the Army has not addressed servicemember reintegration in its suicide prevention policy because they do not have sufficient guidance from DOD. Similarly, officials from each service stated they had not received guidance from DOD on reintegrating personnel into their units following a suicide attempt. Navy and Air Force officials stated it would be helpful to have DOD guidance on the topic, but that any guidance would need to be broad enough to adapt to variations across the services and the differing types and severity of suicide attempts. For example, an Air Force official stated that some suicide attempt survivors may prefer more privacy regarding the suicide attempt, and that it would therefore be important for any guidance to allow for flexibility in this

[83]Navy Suicide Prevention Program, *Project 1 Small ACT Suicide Prevention Handbook.*

[84]Department of the Air Force Resilience, *Standard Operating Procedure for Reintegration Following a Crisis.*

[85]Headquarters Marine Corps, Behavioral Programs Branch, Suicide Prevention Capability Section, *Commander's Checklist for Response to Suicide-Related Events.*

regard, rather than requiring commanders to take certain actions during reintegration following every suicide attempt.

The National Defense Authorization Act for 2013 required DOD to develop a suicide prevention policy with standards for responding to attempted or completed suicides among members, including guidance and training for commanders.[86] According to the National Action Alliance for Suicide Prevention, organizations should employ a patient-centered approach that involves all providers, the patient, and the family and natural supports when transitioning a patient from inpatient to outpatient care.[87] Similarly, Navy policy states that reintegration is critical to the healing process, and it is important that the affected servicemember, mental health provider, and command leaders work together to develop an effective reintegration process.[88]

A DSPO official stated that the response to suicide attempt survivors who seek medical care moves from non-clinical prevention—led by DSPO—to clinical care, which would fall under the purview of the Office of the Assistant Secretary of Defense for Health Affairs. However, officials from the Office of the Assistant Secretary of Defense for Health Affairs stated that they were not aware of DOD-level policy or guidance on commanders' response to a suicide attempt, including reintegrating personnel into the unit.

DSPO has provided guidance for commanders in other areas—such as the response to suicide deaths. In addition, the *Defense Strategy for Suicide Prevention i*dentifies certain aspects of the response to suicide attempts as non-clinical. For example, the strategy identifies the inclusion of suicide attempt survivors' perspectives in suicide prevention planning and support services as a non-clinical suicide prevention activity.

According to the Centers for Disease Control and Prevention, 12 to 25 percent of suicide attempt survivors reattempt within a year, and 3 to 9 percent die by suicide within 1 to 5 years of their initial attempt. Actions

[86]Pub. L. No. 112-239, § 582.

[87]The National Action Alliance for Suicide Prevention, *Best Practices in Care Transitions for Individuals with Suicide Risk*: *Inpatient Care to Outpatient Care* (Washington, D.C.: 2019). The National Action Alliance for Suicide Prevention, in partnership with the U.S. Surgeon General, issued the National Strategy for Suicide Prevention (2012), which is the basis for the Defense Strategy for Suicide Prevention (2015).

[88]OPNAV Instruction 1720.4B, *Suicide Prevention Program* (Sept. 18, 2018).

taken by commanders following a suicide attempt, including during the reintegration of servicemembers, can be critical to ensuring the safety of suicide attempt survivors and mitigating suicide risk within the unit. By establishing guidance for commanders' response to suicide attempts—such as reintegration into the unit—DOD can better ensure that commanders across the military services are equipped to support servicemembers returning to duty following a suicide attempt.

DOD Has Not Established Statutorily Required Suicide Response Training for Commanders

Although statutorily required, DOD has not established training for commanders for responding to suicide deaths or attempts. DSPO officials stated the office has established training for servicemembers and dependents who have been affected by a suicide death, but that this training does not specifically address commanders, and it does not address response to a suicide attempt. Officials from each military service suicide prevention program also did not identify training for commanders focused on the response to suicide deaths or attempts.

As previously stated, the National Defense Authorization Act for 2013 required DOD to develop a suicide prevention policy including standards for responding to attempted or completed suicides among members, including guidance and training for commanders.[89] In addition, *Standards for Internal Control in the Federal Government* states that management should internally communicate the necessary quality information to achieve the organization's objectives, including by selecting appropriate methods of communication.[90]

DSPO officials stated that training could help support commanders' understanding of the information presented in DSPO's guidance for responding to suicide deaths, but that the office has not yet developed commander-specific training for responding to suicide deaths or attempts. A DSPO official further stated that the office generally considers this type of training to be within the purview of the military services. However, as previously stated, DOD is statutorily required to develop training for commanders regarding their response to suicide deaths and attempts. According to a DSPO official, the office plans to conduct a review in 2022 of existing service-level guidance and training related to responding to

[89]Pub. L. No. 112-239, § 582.

[90]GAO-14-704G.

suicide deaths and will then develop a new course if the review indicates it is needed.

By establishing training for commanders that addresses the response to suicide deaths and attempts, DOD can better ensure that these personnel are prepared to carry out actions, such as providing support to the bereaved and to suicide attempt survivors. In doing so, DOD and the military services can enhance their suicide prevention efforts by mitigating risk for further suicides at military installations and by providing critical resources and support to suicide attempt survivors.

Guidance Addresses Suicide Prevention Program Manager Responsibilities, but Gaps Exist in Training and Oversight

DOD guidance requires the military services to designate and train suicide prevention personnel at the command or installation level—referred to in this report as suicide prevention program managers—and each military service has established or planned guidance to address responsibilities of these personnel for responding to suicide deaths and attempts.[91] Specifically, the Navy, Air Force, and Marine Corps have established, and the Army has planned, guidance requiring suicide prevention program managers to assist commanders regarding all aspects of suicide prevention, including following a suicide death or attempt. For example, responsibilities of suicide prevention program managers include advising commanders of requirements and resources following a suicide death or attempt and completing or assisting with reporting requirements.

In addition, two services have established training for suicide prevention program managers that addresses suicide response. Specifically, the Navy and the Marine Corps have required training for suicide prevention program managers that addresses response to suicide deaths and attempts, such as information on reporting requirements and support resources. Separately, Marine Corps officials stated that they are developing revised training that aligns with the Marine Corps' recently

[91]DOD Instruction 6490.16; DOD Instruction 6400.09. In addition, DOD's *Postvention Toolkit for a Military Suicide Loss* includes guidance for suicide prevention program managers for responding to suicide deaths. These responsibilities include providing assistance to the unit commander and ensuring that reporting requirements are met.

updated suicide prevention policy, and that they expect the training to be available in 2022.

However, the Army and the Air Force do not have training in place for suicide prevention program managers that meets each service's requirement for training these personnel.

- **Army.** According to Army officials, required training for suicide prevention program managers has not been available to those personnel since at least 2020 due to technical issues. The officials stated that the U.S. Army Installation Management Command has delivered supplemental training to suicide prevention program managers during this time, but that it does not fulfill Army's training requirement for these personnel. An Army official described plans to develop new training for suicide prevention managers aligned with the service's forthcoming suicide prevention policy once that policy is issued.
- **Air Force.** According to Air Force officials, the Air Force had been in the process of updating its training for suicide prevention program managers and had planned to begin delivering the training in February 2022. However, an Air Force official stated that the service has identified the need for changes to the planned training resulting from DOD's Independent Review Commission on Sexual Assault in the Military.[92] As a result, the official stated the Air Force plans to revise its suicide prevention program manager training, but was unable to provide an estimated time frame for completion. In the interim, the official stated that Air Force suicide prevention program managers will receive DOD primary prevention training, which will partially meet the service's training requirement for these personnel.

In addition, we found gaps in the oversight of training completion across all of the military services. Specifically:

Army. An Army official stated that once updated training is developed, the Installation Management Command will assist in tracking training completion. However, a process for overseeing training completion has not yet been developed.

[92]Independent Review Commission on Sexual Assault in the Military, *Hard Truths and the Duty to Change: Recommendations from the Independent Review Commission on Sexual Assault in the Military* (July 2, 2021). The report made recommendations related to, among other things, the establishment of a primary prevention workforce.

Navy. Navy officials stated that the headquarters suicide prevention program records the names of suicide prevention program managers who have completed the training, but that they are unable to identify personnel who do not complete the required training because they do not maintain a roster of all suicide prevention program managers. The Navy has designated suicide prevention program managers at higher-level commands who are responsible for maintaining a roster of subordinate commands' suicide prevention program managers. However, Navy officials stated that higher-level command suicide prevention program managers often perform this role as a collateral duty, and the level of participation or engagement in the program varies among these personnel.

Air Force. Air Force officials stated that once the updated suicide prevention program manager training is developed, the service will track those who attend the updated training, but major command program managers are ultimately responsible to ensure that installation suicide prevention program managers attend the training. Air Force officials stated that there is no standardized policy or guidance that requires major command program managers to ensure suicide prevention program managers complete the required training. According to the officials, such guidance will be provided once the training is launched.

Marine Corps. Marine Corps officials stated that they track suicide prevention program managers who have completed the training, but that they are unable to identify those who do not complete the required training because they do not maintain a roster of these personnel. The Marine Corps' revised suicide prevention policy, issued in August 2021, requires the designation of suicide prevention program coordinators at higher-level commands, who Marine Corps officials stated will be responsible to provide oversight of suicide prevention program managers at subordinate commands. However, the Marine Corps policy does not establish a mechanism for oversight of the higher-level command suicide prevention program coordinators to ensure they carry out required duties—such as monitoring training completion. Additionally, the Marine Corps requires suicide prevention program managers to complete training within 30 days of appointment and maintain training certificates at the command level, subject to inspection by the Inspector General of the Marine Corps. However, the inspections occur only every 2 to 4 years, creating potential gaps in compliance.

DOD Instruction 6400.09 requires the military departments to direct commanders to require prevention personnel to complete initial training

and ongoing professional development, and each military service has issued policies requiring initial training for suicide prevention program managers. In addition, *Standards for Internal Control in the Federal Government* states that management should design control activities to achieve objectives and respond to risks and remediate internal control deficiencies on a timely basis.[93] However, as previously described, the Army and Air Force have not yet developed required training that meets these services' training requirements for suicide prevention program managers, and no service has developed a process for overseeing training completion.

Without providing required training to suicide prevention program managers, the Army and the Air Force cannot ensure that these personnel are familiar with key concepts and requirements of the services' suicide prevention programs, including those that relate to the response to suicide deaths and attempts. Similarly, without oversight of suicide prevention program managers' completion of required training, the military services will lack reasonable assurance that these key personnel are equipped to carry out their suicide response responsibilities in accordance with DOD and service requirements. As a result, suicide prevention program managers may not be familiar with their responsibilities for suicide response, and may not be positioned to advise commanders of their roles in responding to suicide deaths and attempts, which is especially important in the absence of related training for commanders.

Conclusions

Suicide deaths and attempts within the military community are devastating events for families. They can also harm unit morale, esprit de corps, and readiness—and increase the risk for suicide among affected servicemembers and family members. Servicemembers and dependents assigned to remote OCONUS installations can experience unique factors and challenges that may increase their suicide risk. While DOD has acknowledged the effects of suicide and taken various steps to address suicide prevention and response across all installations, significant gaps exist. For example, DOD has collected required suicide data for servicemembers and dependents across the department, but it has not comprehensively assessed risk factors for suicide and related challenges

[93]GAO-14-704G.

affecting servicemembers and dependents assigned to remote OCONUS installations. By identifying an approach to assess such risk factors and challenges, DOD will enhance its ability to understand and address them—and thereby improve its prevention efforts at remote OCONUS installations.

In addition, while DOD and the military services have established suicide prevention policies, programs, and activities for servicemembers and dependents—including those at remote OCONUS installations—gaps exist in the implementation of directors of psychological health at Department of the Navy installations and command- and installation-level suicide prevention activities within the Army, the Navy, and the Marine Corps. Without addressing these gaps, the Army, Navy, and Marine Corps cannot ensure that key suicide prevention personnel are assigned, and activities are implemented, at commands and installations as required by DOD and service policies, creating the potential for negative consequences for servicemembers and families at these locations.

Similarly, although DOD and the military services have established important privacy protections for servicemembers and dependents seeking suicide prevention care, challenges in staffing behavioral health consultants and facilitators have limited the integration of suicide prevention into primary care at some remote OCONUS installations. By developing a strategy to address these challenges, DHA can enhance the provision of suicide prevention-related care across remote OCONUS installations.

Finally, despite recent efforts and planned improvements, significant gaps exist in guidance and training provided to key personnel for responding to suicide deaths and attempts. By establishing comprehensive suicide response guidance and training for commanders, the department can better ensure that commanders across the department are equipped to respond to suicide deaths and attempts, such as by providing support to the bereaved and to suicide attempt survivors. Similarly, by developing required training for suicide prevention program managers, the Army and the Air Force can better ensure that these personnel are prepared to support installation suicide prevention programs. Moreover, by developing processes to ensure suicide prevention program managers' training completion, each military service can help ensure that these critical personnel are well positioned to provide needed support to servicemembers and dependents most directly affected by suicide.

Recommendations for Executive Action

We are making a total of 14 recommendations, including four to the Secretary of Defense, three to the Secretary of the Army, five to the Secretary of the Navy, and two to the Secretary of the Air Force.

The Secretary of Defense should ensure the Under Secretary of Defense for Personnel and Readiness, in collaboration with the Defense Suicide Prevention Office, establishes a process to assess risk factors for suicide and related challenges associated with OCONUS installations that could be considered remote and take any appropriate actions. (Recommendation 1)

The Secretary of the Navy should establish a policy that requires the designation of Directors of Psychological Health at Navy and Marine Corps installations and provides implementing guidance for these personnel, in accordance with DOD policy. (Recommendation 2)

The Secretary of the Army should establish oversight mechanisms, such as by updating the content of the program status report and clarifying the requirement for its submission, to ensure that installation-level suicide prevention program requirements are implemented in accordance with DOD and service policies. (Recommendation 3)

The Secretary of the Navy should establish oversight mechanisms, such as by specifying oversight requirements in policy, to ensure that command-level suicide prevention program requirements are implemented in accordance with DOD and service policies. (Recommendation 4)

The Secretary of the Navy should ensure that the Commandant of the Marine Corps establishes oversight mechanisms, such as by specifying oversight requirements in policy, to ensure that command-level suicide prevention program requirements are implemented in accordance with DOD and service policies. (Recommendation 5)

The Secretary of Defense should ensure that the Director, DHA, develops a strategy to address shortages in primary care behavioral health providers, including at OCONUS installations that could be considered remote. (Recommendation 6)

The Secretary of Defense should ensure that the Under Secretary of Defense for Personnel and Readiness, in collaboration with DSPO, establishes guidance, such as by updating the department's suicide prevention policy, to address commanders' response to suicide attempts, including the extent of any responsibilities related to reintegration of servicemembers into the workplace following a suicide attempt. (Recommendation 7)

The Secretary of Defense should ensure that the Under Secretary of Defense for Personnel and Readiness, in collaboration with DSPO, establishes training resources for commanders that address their response to suicide deaths and attempts. (Recommendation 8)

The Secretary of the Army should develop, and ensure the availability of, training for suicide prevention program managers that covers the scope of their responsibilities, including those related to responding to suicide deaths and attempts. (Recommendation 9)

The Secretary of the Air Force should develop, and ensure the availability of, training for suicide prevention program managers that covers the scope of their responsibilities, including those related to responding to suicide deaths and attempts. (Recommendation 10)

The Secretary of the Army should develop a process to ensure that installation suicide prevention program managers complete required training. (Recommendation 11)

The Secretary of the Navy should develop a process to ensure that command suicide prevention program managers complete required training. (Recommendation 12)

The Secretary of the Air Force should develop a process to ensure that installation suicide prevention program managers complete required training. (Recommendation 13)

The Secretary of the Navy should ensure that the Commandant of the Marine Corps develops a process to ensure that command suicide prevention program managers complete required training. (Recommendation 14)

Agency Comments and Our Evaluation

We provided a draft of this report to DOD for review and comment. In its written comments, reproduced in their entirety in appendix V, DOD concurred with 11 of our 14 recommendations and partially concurred with three recommendations. In some instances, DOD described planned or completed actions that it indicated would fully address the recommendation, as discussed below. DOD also provided technical comments, which we have incorporated as appropriate.

DOD partially concurred with our first, seventh, and eighth recommendations, which relate to establishing a process to assess risk factors for suicide and related challenges at remote OCONUS installations, guidance for commanders related to the response to suicide attempts, and training for commanders on their response to suicide deaths and attempts. The department requested that these three recommendations be directed solely to the Under Secretary of Defense for Personnel and Readiness, noting that specifying collaboration with DSPO was unnecessary and that there are several other entities with which it would be helpful for the Under Secretary of Defense for Personnel and Readiness to collaborate. As noted in our report, DSPO is responsible for leading, guiding, and overseeing the department's suicide prevention program. This includes assisting in the development of non-clinical suicide prevention programs, implementing strategic communications to promote effective messaging, and overseeing the military services' compliance with non-clinical prevention activities. Therefore, we continue to believe it is important for the Under Secretary of Defense for Personnel and Readiness to collaborate with DSPO to implement these recommendations.

In concurring with recommendation 5, that the Marine Corps should establish oversight mechanisms to ensure that command-level suicide prevention program requirements are implemented in accordance with DOD and service policies, the Marine Corps stated, among other things, that August 2021 updates to its prevention policy and related guidance established procedures to ensure the consistency of suicide prevention efforts throughout the Marine Corps. The Marine Corps further stated that additional oversight mechanisms are supported by the Commanding Generals Inspection Program, which was established to assess, assist, and enhance the ability of the unit to prepare for and perform its assigned mission through a centralized inspection program. Based on these policy

updates and oversight mechanisms, the Marine Corps requested that we close this recommendation as implemented.

However, as described in this report, we evaluated the provisions of the Marine Corps' August 2021 policy, in addition to other existing mechanisms, and found that they have not provided adequate oversight to ensure the implementation of all required suicide prevention activities. For example, we found that the Marine Corps' revised suicide prevention policy requires the designation of suicide prevention program coordinators at higher commands who may help ensure that commands implement required suicide prevention activities, but the policy does not establish a mechanism for service-level oversight of these personnel. In addition, we found that the frequency of Marine Corps inspections—which occur every 2 to 4 years—can create potential gaps in compliance. As a result, we continue to believe that by establishing oversight mechanisms to ensure the implementation of command-level suicide prevention program requirements, the Marine Corps can better ensure that suicide prevention procedures are followed in accordance with DOD and service policies.

In concurring with recommendation 10, that the Air Force should develop—and ensure the availability of—training for suicide prevention program managers, the Air Force stated the development of this training was completed in December 2021 and that the first training was conducted in February 2022. However, as we noted in our report, in February 2022, an Air Force official stated that the service had identified the need for changes to the planned training resulting from DOD's Independent Review Commission on Sexual Assault in the Military and therefore planned to revise the training. This official was unable to provide an estimated time frame for completion. As a result, we continue to believe that by establishing and ensuring the availability of required training for suicide prevention program managers, the Air Force can better ensure that these personnel are familiar with the key concepts and requirements of their roles within the suicide prevention program. We will review documentation of the Air Force's suicide prevention program manager training content and delivery as part of our standard recommendation follow-up process.

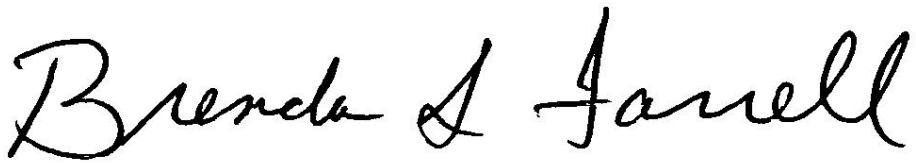
In concurring with recommendation 14, that the Marine Corps should develop a process to ensure that command suicide prevention program managers complete required training, the Marine Corps stated, among other things, that the service maintains a listing of suicide prevention program managers and takes various steps to verify their completion of

the required training. These include quarterly meetings and monthly emails with headquarters Marine Corps and suicide prevention program managers, automated queries of additional duty codes for suicide prevention program manager responsibilities, and Inspector General Marine Corps inspections. Additionally, the Marine Corps stated that technical assistance visits further support compliance with the required training. Based on these actions, the Marine Corps requested that we close this recommendation as implemented.

As described in this report, during our review, Marine Corps suicide prevention program officials told us that they track suicide prevention program managers who have completed the training, but are unable to identify those who do not complete the required training because they do not maintain a roster of these personnel. Additionally, as described in our report, we found that while the suicide prevention program managers are required to complete the training within 30 days of appointment, inspections of the training certificates occur only every 2 to 4 years, creating potential gaps in compliance. We will review any additional documentation of the Marine Corps' processes to ensure completion of suicide prevention program managers' required training as part of our standard recommendation follow-up process.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Defense, the Secretary of the Army, the Secretary of the Navy, the Secretary of the Air Force, and the Commandant of the Marine Corps. In addition, this report is available at no charge on the GAO website at http://www.gao.gov.

If you or members of your staff have any questions regarding this report, please contact me at (202) 512-3604 or farrellb@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix VI.



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Appendix I: Review of Related Academic Research

This appendix provides information on academic research related to suicide prevention for (1) servicemembers and dependents assigned to remote installations outside the contiguous United States (OCONUS) and (2) populations indigenous to such locations. For information on the steps we took to identify and evaluate relevant academic research on these topics, please see appendix II.

We identified three articles related to suicide prevention for servicemembers and dependents assigned to remote OCONUS installations and seven articles related to suicide prevention among populations indigenous to such locations that we selected for further review. For each article, we identified the following information.

1. The geographic area covered
2. Risk & protective factors discussed
3. Prevention or intervention methods studied
4. Conclusions and any associated caveats or limitations
5. Recommendations and any associated caveats or limitations

Table 1 summarizes the results of our review of articles related to suicide prevention for servicemembers and dependents assigned to remote OCONUS installations.

Table 1: Summary of Academic Research on Suicide Prevention at Remote Installations Outside the Contiguous United States

Citation	Article Details
Corr, William P. "Suicides and Suicide Attempts Among Active Component Members of the U.S. Armed Forces, 2010-2012: Methods of Self-Harm Vary by Major Geographic Region of Assignment." *Medical Surveillance Monthly Report (MSMR)*, vol. 21, no.10 (2014): 1-5.	**Geographic Area:** U.S., Europe/Asia, combat zones **Risk Factors Discussed:** Access to firearms **Protective Factors Discussed:** None **Prevention or Intervention Methods Studied:** None **Conclusions:** The author found differences in rates and methods of suicide between servicemembers assigned in the U.S., Europe/Asia, and in combat zones. Servicemembers in the U.S. were more likely to die by suicide using a non-military issued firearm, those in Europe or Asia were more likely to die by hanging or asphyxiation, and those in combat zones were more likely to die using a military-issued firearm. The author theorized that these differences may be due to variations in access to firearms. **Recommendations:** None
Carr, Russell B. "When a Soldier Commits Suicide in Iraq: Impact on Unit and Caregivers." *Psychiatry*, vol. 74, no. 2 (2011): 95-106.	**Geographic Area:** U.S. military base in Iraq **Risk Factors Discussed:** Major depressive disorder **Protective Factors Discussed:** None **Prevention or Intervention Methods Studied:** Anti-depressant medication, counseling following exposure to a suicide, and reduced access to lethal means **Conclusions:** The article presents a case study based on a psychiatrist's personal experiences before and after one soldier's suicide in Iraq. The soldier had been diagnosed with major depressive disorder up to 3 weeks prior to the death. After the suicide, fellow soldiers expressed grief, guilt, and other negative emotions. Some contemplated harm to self or others. Restricting access to the soldier's memorial service on base "created a sense of shame about the death" among fellow soldiers (a form of stigma). "The mental health providers who treated the soldier before he committed suicide were the same ones who responded to the needs of his survivors, […which…] can complicate the bereavement process for the providers." This, combined with undergoing scrutiny during a case review process, "place unusual stress on deployed mental health care providers, […which…] raises the need for a strategy to support them following a suicide." The experiences cannot be generalized beyond this case. **Recommendations:** Given the unique circumstances of suicide, especially in a deployed military environment, those close to the deceased may be affected by both grief and trauma. This must be taken into account when designing any postvention strategy. Additionally: "Even while strategies are developed for intervention with military units in a combat zone, there must remain a focus on helping the individual soldier and mental health care provider deal with the suicide of a fellow soldier." Finally, as the author states: "Future research is needed in several areas, including the effects of a suicide on the survivors in a military setting and best practices for postvention strategies to help them deal with the loss. Such research will need to take into account the unique circumstances of a military environment in a combat zone and also the longitudinal needs of military personnel after they return home."

Citation	Article Details
Warner, Christopher H., et al. “Suicide Prevention in a Deployed Military Unit.” *Psychiatry*, vol. 74, no. 2 (2011): 127-141.	**Geographic Area:** Iraq deployment **Risk Factors Discussed:** Multiple risk factors are mentioned, but this study looked at overall outcomes, not the effects of particular factors. **Protective Factors Discussed:** None **Prevention or Intervention Methods Studied:** The prevention program “included education, early detection, intervention, communication, command/leader emphasis, and treatment within the various phases of the deployment cycle for all unit members and their significant others.” **Conclusions:** The authors found that the Army division going through the suicide prevention program had an overall rate of suicides lower than that of the U.S. Army rate or the in-theater rate. However, there were no controlled comparisons, so it is unclear whether the difference can be attributed to the suicide prevention program or whether there were particular aspects that were successful. **Recommendations:** The authors urge consideration of a standardized deployed suicide prevention program and further study of interventions to reduce rates of suicide among soldiers deployed to war.

Source: GAO analysis of selected literature review sources. | GAO-22-105108

Table 2 summarizes the results of our review of articles related to suicide prevention for populations indigenous to areas surrounding remote OCONUS installations.

Table 2: Summary of Academic Research on Suicide Prevention for Indigenous Populations at Remote Installations Outside the Contiguous United States

Citation	Article Details
Lehti, Venla, et al. “Mental Health, Substance Use and Suicidal Behaviour Among Young Indigenous People in the Arctic: A Systematic Review.” *Social Science & Medicine*, vol. 69 (2009): 1194–1203.	**Geographic Area:** The Arctic—defined as “Alaska, Northern Canada (Yukon, Northwest Territories, Nunavut, the northernmost parts of Quebec and Labrador), Greenland, and the parts of Norway, Sweden, Finland and Russia that are located within the Arctic Circle.” **Risk Factors Discussed:** Individual studies examined substance use, parental substance use, physical abuse, a psychiatric problem, recent life events, suicides or attempts among friends, alcohol intoxication, single-parent home, and paternal overprotection. **Protective Factors Discussed:** None **Prevention or Intervention Methods Studied:** None **Conclusions:** Despite some data showing that suicide rates among youth are relatively high and substance use is common in parts of the Arctic, there is limited data available to determine why. **Recommendations:** Considering any limitations around issues such as validity, it may be useful for future research to take interdisciplinary and multi-method approaches when studying indigenous youth mental health, suicide rates, and substance use within the Arctic.

Citation	Article Details
Redvers, Jennifer, et al. "A Scoping Review of Indigenous Suicide Prevention in Circumpolar Regions." *International Journal of Circumpolar Health. Special Issue: Suicide and Resilience in Circumpolar Populations*, vol. 74, no. 1 (2015).	**Geographic Area:** Circumpolar regions (the Arctic). Of the seven evaluation studies identified, five were in Alaska and two were in Nunavut. **Risk Factors Discussed:** None **Protective Factors Discussed:** None **Prevention or Intervention Methods Studied:** "Specific interventions were classified as either: policies, strategies and services; community prevention programs; or education and training initiatives. Most of the circumpolar suicide interventions we found mentioned in the peer-reviewed literature were not described in any detail, but merely mentioned in passing, or listed as brief examples." **Conclusions:** Authors acknowledge the small number of evaluative studies related to suicide intervention in the Arctic and suggest further research and expansion of search criteria to include related interventions. **Recommendations:** Authors recommend that more culturally appropriate evaluation and community capacity building around evaluation be supported.
Harlow, Alyssa F., India Bohanna, and Alan Clough. "A Systematic Review of Evaluated Suicide Prevention Programs Targeting Indigenous Youth." *Crisis*, vol. 35, no.5 (2014): 310–321.	**Geographic Area:** Australia, Canada, New Zealand, or the United States **Risk Factors Discussed:** None **Protective Factors Discussed:** None **Prevention or Intervention Methods Studied:** Varied by study: some were culturally adapted versions of existing validated prevention methods for non-indigenous populations. Others were "grassroots" prevention strategies, developed in response to community concerns. Several programs used elements of participatory action research approaches in their development and implementation. **Conclusions:** The results of this review indicate that improvements are needed in study design and evaluation around programs to prevent suicide among indigenous youth to increase confidence in the evidence and reported outcomes. Some of the stronger studies reviewed suggest that use of community-integrated development and strong youth involvement may be promising approaches, but more research is needed. **Recommendations:** Authors indicated a need for better study design, comprehensive evaluations, and reporting development and implementation clearly.
Clifford, Anton C., Christopher M. Doran, and Komla Tsey. "A Systematic Review of Suicide Prevention Interventions Targeting Indigenous Peoples in Australia, United States, Canada and New Zealand." *BioMed Central Public Health*, vol. 13, no. 463 (2013).	**Geographic Area:** Australia, United States, Canada and New Zealand **Risk Factors Discussed:** None **Protective Factors Discussed:** None **Prevention or Intervention Methods Studied:** Intervention strategies included community prevention initiatives (four studies), gatekeeper training (three to four studies), and education programs (two studies). **Conclusions:** To reduce the disproportionately high rates of suicide in Indigenous peoples of Australia, New Zealand, Canada and the United States, increasing "the number of evaluations of preventive interventions targeting reductions in Indigenous suicide using methodologically rigorous study designs across geographically and culturally diverse Indigenous population groups is required." **Recommendations:** When designing and/or evaluating interventions, developing collaborations amongst the relevant players—including Indigenous peoples, government, researchers, health-care providers, etc.—and ensuring an Indigenous, culture-specific perspective are both critically important pieces.

Citation	Article Details
Allen, James, Marya Levintova, and Gerald Mohatt. "Suicide and Alcohol-Related Disorders in the U.S. Arctic: Boosting Research to Address a Primary Determinant of Health Disparities." *International Journal of Circumpolar Health*, vol. 70, no. 5 (2011): 473-487.	**Geographic Area:** U.S. Arctic **Risk Factors Discussed:** Article does not emphasize interconnection between alcohol-use disorders and suicide, but covers both topics, and cites research and funding linking the two. **Protective Factors Discussed:** None **Prevention or Intervention Methods Studied:** None **Conclusions:** As of 2011, neither alcohol-use disorder and suicide comorbidity, nor protective factors for suicide prevention, among communities in the U.S. Arctic had been a focus of much research. The authors reviewed one study that showed suicide rates in Alaska from 1990 to 2005 were consistently higher than those in the U.S. general population, particularly among Alaska Native populations. **Recommendations:** The authors recommend leveraging U.S. investments in biomedical research infrastructure in Alaska, distance learning, and telemedicine tools to better study behavioral and mental health in the U.S. Arctic.
Allen, James, Sarah Beehler, and John Gonzalez. "Suicide and Substance Use Disorder Prevention for Rural American Indian and Alaska Native Youth." In *Rural Ethnic Minority Youth and Families in the United States, Advancing Responsible Adolescent Development*, edited by L.J. Crockett and G. Carlo, 185-201. Springer International Publishing, 2016.	**Geographic Area:** Focused on American Indian and Alaska Native youth, so locations are limited to the U.S. **Risk Factors Discussed:** Substance abuse disorder **Protective Factors Discussed:** Social skills, problem-solving skills, communication skills, self-esteem, ability to identify emotions and stress, personal and social skills **Prevention or Intervention Methods Studied:** School-based skill building. Counseling for family and friends of decedents. Community-based efforts, including gatherings to discuss recent suicides; law enforcement changes, including increased presence in high-risk areas and bringing people who threatened suicide to a hospital rather than jail; a ceremony to aid community healing and increase community cohesion; and "community education, use of the media, and broad-based universal programming within the schools and in the broader community." Community-based intervention with no details on factors provided. **Conclusions:** The authors concluded that the studies they reviewed indicated "more culture-informed, strengths-focused interventions" and "ongoing community involvement in all aspects of program development and implementation" are needed. However, as the authors state, there is little evidence about the effectiveness of most interventions, due to the designs and reporting of previous studies. **Recommendations:** Interventions with rural American Indian/Alaska Native youth should focus on prevention of suicide and substance abuse together, and local communities should be involved in the development and implementation of interventions.

Citation	Article Details
Alonzo, D., and R.E. Gearing. "Suicide Across Buddhism, American Indian–Alaskan Native, and African Traditional Religions, Atheism and Agnosticism: An Updated Systematic Review." *Journal of Religion and Health*, vol. 60, no. 4 (2021): 2527–2546.	**Geographic Area:** Not specified **Risk Factors Discussed:** Age, specifically unspecified age "young adults," and the combination/interaction of age and sex, specifically adolescent males (15-24 years old). **Protective Factors Discussed:** Awareness of "traditional tribal suicide beliefs"; maintaining, preserving, or reclaiming "cultural heritage"; spirituality; the culture-specific concept of "being in balance with one's body, mind, and environment." **Prevention or Intervention Methods Studied:** The authors recommend that professionals assess their clients' belief systems. **Conclusions:** Young adults and especially adolescent males (15-24 years old) are at highest risk of suicide among the American Indian and Alaska Native population. Maintaining, preserving, reclaiming cultural heritage; spirituality; and "being in balance with one's body, mind, and environment" are protective factors against suicide. **Recommendations:** The authors recommend that professionals assess the following of their clients: • The significance of religion to the individual client • The significance of religion to the client's social network (e.g., family/significant others) • The significance of religion to the client's identity • Attitudes toward and conceptualization of suicide in the client's religion • The historical role of religiosity as a risk or protective factor during previous times of stress and difficulties in the client's life • The potential benefit of strengthening the client's religiosity and participation in their religion • Belief in an afterlife • Meaning in life • The strength of conviction/belief in either direction, existence of God or belief that there is no higher power • Traditional folk leaders/figures and spiritual healers/guides as a source of support These recommendations are based on a review of multiple religious, spiritual, and atheistic belief systems, and not exclusively for religious/spiritual beliefs of American Indian and Alaska Native populations.

Source: GAO analysis of selected literature review sources. | GAO-22-105108

Appendix II: Objectives, Scope, and Methodology

This report examines the extent to which the Department of Defense (DOD) and the military services have (1) collected required data regarding suicide incidents among servicemembers and dependents, and what is known about the incidence of suicide deaths and attempts and related risk factors among servicemembers stationed at remote installations outside of the contiguous United States (OCONUS) during 2016 through 2020; (2) established and ensured the implementation of policies, programs, and activities that address suicide prevention among servicemembers and dependents stationed at remote OCONUS installations; (3) established privacy protections for servicemembers and dependents seeking suicide prevention care and integrated suicide prevention into the delivery of primary care at remote OCONUS installations; and (4) established guidance and training for key personnel for responding to incidents of attempted or completed suicide at remote OCONUS installations.[1] It also examines what is known about suicide prevention among servicemembers and dependents stationed at remote OCONUS installations, as well as populations indigenous to such locations, based on academic research.

DOD does not have a general definition for what constitutes a remote installation. For the purposes of this review, we used DOD guidance to develop our scope of remote OCONUS installations. Consistent with this guidance, we defined OCONUS installations as those located in Alaska, Hawaii, U.S. territories, or outside the U.S. We defined remote installations using the following DOD criteria:

- **Morale, Welfare, and Recreation Funding.** DOD has designated certain installations as remote and isolated for the purpose of funding morale, welfare, and recreation programs at the installation. Installations with this designation receive additional financial support to sustain morale, welfare, and recreation programs that are typically revenue-generating, such as hospitality and lodging and activities

[1]On December 20, 2019, the National Defense Authorization Act for Fiscal Year 2020, Pub. L. No. 116-92, established the United States Space Force as a military service within DOD. We did not gather data from the Space Force given its status as a new organization. Throughout this report, we refer to only four military services within DOD.

including bowling and horseback riding. We obtained from DOD a list of installations designated as remote and isolated for morale, welfare, and recreation purposes as of September 2021.

- **Hardship Duty Pay Location.** Hardship duty pay can be based on hardships that arise from the specific location, mission, operational tempo, or restriction of movement. DOD designates locations eligible for hardship pay as locations where living conditions are substantially below those normally found within the continental United States.[2] According to DOD, hardship duty pay locations are intended to recognize the extraordinarily arduous living conditions, excessive physical hardship, and/or unhealthful conditions that exist in a location or assignment.
- **Tour Length.** DOD has identified standards for tour length at OCONUS installations.[3] These standards include tour length when a servicemember is accompanied by dependents (i.e., accompanied tour) and when a servicemember either chooses or is not permitted to be accompanied by dependents based on the standards for a given location (i.e., unaccompanied tour). The standard overseas tour is 36 months when accompanied or 24 months when unaccompanied. Less than standard tour lengths are determined based on various factors including quality of life factors, the presence of arduous conditions, or potential threats to safety. DOD considers factors influencing quality of life at duty locations to include geography, climate, housing options, availability of medical and educational support, as well as access to other support services including religious and recreational activities, social customs, and security considerations.

Methods Used to Assess DOD and the Military Services' Data Collection and to Analyze Suicide Death and Attempt Data

To determine the extent to which DOD and the military services have collected required data regarding suicide among servicemembers and dependents stationed at remote OCONUS installations, we compared

[2]Department of Defense Financial Management Regulation 7000.14-R, Volume 7A, Chapter 17, *Special Pay – Hardship Duty* (December 2020).

[3]Department of Defense, *Tour Lengths and Tours of Duty Outside the Continental United States (OCONUS),* (Oct. 15, 2020).

DOD's collection of suicide incident data and assessment of related risks against statutory and DOD policy requirements.[4] We determined the risk assessment component of *Standards for Internal Control in the Federal Government* was significant to this objective, along with the underlying principle that management should identify, analyze, and respond to risks related to achieving the defined objectives.[5] We assessed the extent to which DOD has identified, analyzed, and responded to potential suicide risks associated with remote OCONUS installations by reviewing DOD documentation related to suicide risk assessment and interviewing DOD, service, and installation-level officials.

To determine the number and proportion of reported suicide deaths and attempts at remote OCONUS installations relative to installations in other geographic categories, we obtained and analyzed suicide death and attempt data from the Armed Forces Medical Examiner Tracking System and the DOD Suicide Event Reporting (DODSER) system and location-based population data from each military service, both for active-duty servicemembers during 2016 through 2020.

One analyst coded each suicide event and population data record by geographic categories of (1) inside the contiguous United States (CONUS), (2) non-remote OCONUS, and (3) remote OCONUS based on the servicemember's assigned duty location. When a geographic category could not be determined based on the available data, the analyst coded the record as "unknown." A second analyst checked these determinations. Any disagreements were resolved through discussion. Based on this process, we identified active-duty servicemember populations of about 5.8 million assigned to CONUS locations; 502,145 assigned to non-remote OCONUS locations; 546,891 assigned to remote OCONUS locations; and 4,492 assigned to locations for which we could not identify a geographic category.

We determined proportions of reported suicide deaths, reported suicide attempts, and active-duty personnel by dividing the number of reported suicide deaths, reported suicide attempts, and active-duty servicemembers for each geographic category, respectively, by the total number of reported suicide deaths, reported suicide attempts, and active-

[4]Pub. L. No. 116-92 § 741. Department of Defense (DOD) Instruction 6490.16, *Defense Suicide Prevention Program* (Nov. 6, 2017) (incorporating change 2, Sept. 11, 2020).

[5] GAO, *Standards for Internal Control in the Federal Government,* GAO-14-704G (Washington, D.C.: September 2014).

duty servicemembers across the geographic categories for each year. We then averaged the yearly proportions to obtain an average proportion across the 5-year period.

As stated where we present the results of this analysis in our report, reported suicide attempts may be underreported or be reported inconsistently. In addition, according to DOD, a potential source of error is the misclassification of a death as either a suicide or not a suicide due to variation or uncertainty that exists in the manner of death determination process.[6] For example, at times a death that may have been a suicide cannot be classified as a suicide due to a lack of evidence of intent. These limitations of the data could affect comparisons of the distribution by geographic category of suicide attempts, suicide, and the active-duty population.

However, we determined the most feasible approach was to show the distribution of suicide deaths and attempts at remote OCONUS installations and other locations, based on the available data. Calculating adjusted suicide death rates would have allowed us to make geographic comparisons while accounting for the potentially different age and sex distributions of the active due populations in each of the geographic areas. However, the age and sex distributions of the suicides and active-duty populations in each geographic area were not available for us to calculate adjusted suicide death rates.

We assessed the reliability of DOD suicide incident and military service population data by reviewing the data for errors, omissions, and inconsistencies; reviewing documentation on data collection procedures and systems; interviewing cognizant officials; and administering questionnaires on data collection and synthesis. We determined that these data were sufficiently reliable to provide counts of suicide deaths and attempts by service and by geographic category for calendar years 2016 through 2020. In addition, we determined the data were sufficiently reliable to describe the proportion of suicide deaths and attempts relative to the proportion of population across during 2016 through 2020 among CONUS, remote OCONUS, and non-remote OCONUS installations, while noting the previously described limitations. We also found that the DOD suicide incident data were sufficiently reliable to describe the number of

[6]Department of Defense (DOD), *Annual Suicide Report Calendar Year 2020* (Sept. 3, 2021).

suicide deaths and attempts, as well as associated risk factors and characteristics, by geographic category during 2016 through 2020.

Methods Used to Assess Suicide Prevention Policies, Programs, and Activities

To determine the extent to which DOD and the military services have established and ensured the implementation of policies, programs, and activities that address suicide prevention among servicemembers and dependents stationed at remote OCONUS installations, we evaluated DOD Instruction 6490.16 and the DOD Strategy for Suicide Prevention against statutorily required elements outlined by the National Defense Authorization Act for Fiscal Year 2013.[7] We also reviewed the military services' suicide prevention policies to identify required suicide prevention activities, as well as information regarding other DOD and military service suicide prevention activities and resources.[8]

Additionally, we evaluated the extent to which remote OCONUS installations have implemented select required suicide prevention activities. Specifically, we reviewed DOD and military service policies to identify required suicide prevention activities at the command or installation level. Next, we narrowed the list of originally identified requirements to those for which documentation could reasonably be expected to exist. We interviewed military service officials to confirm that the identified activities were required. We obtained input from service officials on the extent to which such documentation was maintained at the service level or could be feasibly obtained from individual commands and installations within our scope. Based on this input, the team selected requirements to be included in our request for documentation. To provide consistency in our review across the services, we requested documentation related to DOD-level requirements and additional service-level requirements that were similar across the services.

[7]Department of Defense Instruction 6490.16, *Defense Suicide Prevention Program* (Nov. 6, 2017) (incorporating change 2, Sept. 11, 2020). Department of Defense, *Department of Defense Strategy for Suicide Prevention* (December 2015). Pub. L. No. 112-239, § 582 (2013).

[8]Army Regulation 600-63, *Army Health Promotion* (Apr. 14, 2015). OPNAV Instruction 1720.4B, *Suicide Prevention Program* (Sept. 18, 2018). Air Force Instruction 90-5001, *Integrated Resilience* (Jan. 25, 2019) (incorporating Change 1, Oct. 21, 2021). Marine Corps Order 1720.2A, *Marine Corps Suicide Prevention System (MCSPS)* (Aug. 2, 2021).

To select remote OCONUS installations for our document review, we obtained a list of installations for each military service. For the Army, the Marine Corps, and the Air Force, we used the list of installations from the data dictionary for the DODSER system. At the time of our review, the DODSER data dictionary did not include a list of Navy installations. Therefore, we obtained a list of Navy installations from the Commander, Naval Installations Command website, accessed during June 2021 through October 2021.

For each installation, one analyst coded whether the installation was OCONUS and whether it was designated as remote for morale, welfare, and recreation funding; identified as a hardship duty pay location; or had a designated tour length of less than a standard tour. Any installations identified based on these criteria that were not included in the initial listing of installations were added to the listing. A second analyst checked these determinations. Any disagreements were resolved through discussion. This process identified 67 remote OCONUS installations for inclusion in our document review.

We provided the initial list of the 67 remote OCONUS installations to service officials, and in some cases, the officials identified installations that had closed, realigned, or were not subject to suicide prevention program requirements examined in the scope of this review. As a result, we identified a total of 57 remote OCONUS installations for inclusion in our document review, which are listed at the conclusion of this appendix.

For all 57 of the identified remote OCONUS installations, we requested the names of key suicide prevention personnel to determine the extent to which those personnel had been designated as required. Specifically, for

each installation, we requested the names of the designated suicide prevention program manager and director of psychological health.[9]

We selected a non-generalizable sample of two installations from each military service, and we requested documentation from each installation to assess the extent to which required activities had been implemented. For each military service, we selected the remote OCONUS installation that had the highest number of suicide deaths and the remote OCONUS installation that had the highest number of suicide attempts during 2016 through 2020 based on DODSER system data.[10] For this sample, we requested documentation of their implementation of requirements to establish prevention teams responsible for planning and executing suicide prevention activities and develop required installation policies and procedures related to suicide prevention, as described in the body of this report.

We also evaluated the military services' oversight of installation-level requirements against *Standards for Internal Control in the Federal Government.*[11] We determined:

[9]Each military service uses a different title for the command- or installation-level position that meets the DOD requirement for a suicide prevention program manager. Specifically, these personnel are referred to as suicide prevention program managers in the Army, suicide prevention coordinators in the Navy, violence prevention integrators in the Air Force, and suicide prevention program officers in the Marine Corps. The Army and the Air Force require these personnel to be designated at the installation level, while the Navy and the Marine Corps require the personnel to be designated at the command level, including for installation commands. Given the number of commands located at remote OCONUS Navy installations, Navy officials asked that we narrow the scope of our request. As a result, for the Navy, we requested the names of these personnel for each installation command and for each permanent tenant command at two installations. For the Marine Corps, we requested the names of the personnel for each installation command and permanent tenant command at the remote OCONUS Marine Corps installations.

[10]If the same installation had both the highest number of reported suicide deaths and reported suicide attempts, we selected the installation with the second highest number of suicide attempts. In addition, if the installation with the highest number of suicide attempts was within 50 miles of the installation with the most suicide deaths for a given service, we selected the installation with the next highest number of suicide attempts. The selected installations were the Army's U.S. Army Garrison Alaska, Fort Wainwright, and U.S. Army Garrison Humphreys, Korea; the Navy's Commander Fleet Activities Yokosuka, Japan, and Naval Base Guam; the Air Force's Eielson Air Force Base, Alaska, and Kadena Air Base, Japan; and the Marine Corps' Marine Corps Base Camp Butler, Japan, and Marine Corps Air Station Iwakuni, Japan.

[11]GAO-14-704G.

- The control environment component of internal control was significant to the objective, along with the underlying principle that management should establish an organizational structure, assign responsibility, and delegate authority to achieve the entity's objectives. We interviewed service officials and obtained installation-level documentation to determine the extent to which each service had established an organization structure, assigned responsibility, and designated authority as needed to implement a DOD requirement for installation directors of psychological health.
- The control activities and monitoring components of internal control were significant to this objective, along with the underlying principles that management should design control activities to achieve objectives and respond to risks and remediate identified internal control deficiencies on a timely basis. We assessed military service policies, reviewed service and installation level documentation, and interviewed service officials to determine the extent to which each service had established sufficient oversight mechanisms to achieve suicide prevention program objectives, respond to associated risks, and address any deficiencies on a timely basis.

Methods Used to Assess Privacy Protections and Integration of Suicide Prevention into Primary Care

To determine the extent to which DOD and the military departments have implemented privacy protections for servicemembers and dependents seeking suicide prevention care, we examined DOD and military service policies and procedures regarding the protection of personally identifiable information and protected health information.[12] We also reviewed DOD's policy outlining protections for servicemembers seeking and receiving mental health treatment and military department guidance on implementing these protections.[13] From the eight selected remote

[12]DOD Instruction 5400.11, *DOD Privacy and Civil Liberties Programs* (Jan. 29, 2019) (incorporating Change 1, Dec. 8, 2020). DOD 5400.11-R, *Department of Defense Privacy Program* (May 14, 2007). DOD Instruction 6025.18, *Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule Compliance in DOD Health Care Programs* (Mar. 13, 2019). DOD Manual 6025.18, *Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DOD Health Care Programs* (Mar. 13, 2019). Army Regulation 25-22, *The Army Privacy Program* (Dec. 22, 2016). Secretary of the Navy Instruction 5211.5F, *Department of the Navy Privacy Program* (May 20, 2019). Air Force Instruction 33-332, *Air Force Privacy and Civil Liberties Program* (Mar. 10, 2020).

[13]Department of Defense Instruction 6490.08, *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members* (Aug. 17, 2011).

OCONUS installations that had the highest number of reported suicide deaths and attempts during 2016 through 2020, we also requested information and documentation related to procedures and training for privacy protection for the purpose of providing illustrative examples of installation-level efforts. In addition, we interviewed DOD, service, and installation officials about their efforts to maintain the privacy of servicemembers and dependents seeking suicide prevention care.

We evaluated DOD's efforts to integrate suicide prevention into primary care at remote OCONUS installations by reviewing screening requirements for suicide risk factors to be carried out by primary care managers within the military health system and as a part of DOD's periodic health assessment program.[14] In addition, we evaluated DOD's efforts to integrate behavioral health providers into its primary care clinics. Specifically, we examined data on authorized billets and staffing levels for behavioral health personnel in OCONUS primary care clinics, including those we identified as remote. We assessed the reliability of these data by administering a questionnaire on data collection and synthesis. We determined that these data were sufficiently reliable to assess the extent to which authorized billets for behavioral health personnel in OCONUS primary care clinics had been filled.

We also interviewed DHA officials about efforts to address staffing shortages for behavioral health personnel in remote OCONUS primary care clinics. We evaluated DOD's efforts to hire and retain personnel for unfilled positions against requirements for program oversight as well as our prior work on human capital management that describes the importance of developing strategies to address human capital gaps.[15]

Methods Used to Assess Guidance and Training for Key Personnel for Responding to Suicide Deaths and Attempts

To determine the extent to which DOD and the military services have established guidance and training for key personnel for responding to

[14]DOD Instruction 6200.06, *Periodic Health Assessment (PHA) Program* (Sept. 8, 2016).

[15]DHA Procedural Instruction 6025.27, *Integration of Primary Care Behavioral Health (PCBH) Services into Patient-Centered Medical Home (PCMH) and Other Primary Care Service Settings within the Military Health System (MHS)* (Oct. 18, 2019). GAO, *A Model of Strategic Human Capital Management,* GAO-02-373SP (Washington, D.C.: March 2002).

suicide deaths and attempts, we identified our scope of key personnel as commanders and command- or installation-level suicide prevention program managers. We interviewed DOD and service officials to identify sources of guidance or training related to suicide response for commanders or suicide prevention program managers. We reviewed DOD and military service policies and guidance to assess the extent to which they address commanders' response to suicide deaths and attempts and compared the DOD materials against relevant statutory requirements.[16] We further compared the service-level guidance against DOD guidance to identify any areas of difference.

With regard to training for commanders, we determined that the information and communication component of *Standards for Internal Control in the Federal Government* was significant, along with the underlying principle that management should internally communicate the necessary quality information to achieve the entity's objectives. We interviewed DOD and service officials to assess the extent to which DOD has internally communicated quality information regarding commanders' response to suicide deaths and attempts by providing training resources.

We also reviewed DOD and military service policies and guidance and military service training materials to assess the extent to which they address suicide prevention program managers' response to suicide deaths and attempts. With regard to oversight of training completion, we determined the control activities and monitoring components of *Standards for Internal Control in the Federal Government* were significant, along with the underlying principles that management should design control activities to achieve objectives and respond to risk and remediate identified internal control deficiencies on a timely basis.[17] We reviewed service policies and interviewed service officials regarding methods for overseeing suicide prevention program managers' completion of required training to assess the extent to which the services have established control activities sufficient to ensure training completion and remediate any deficiencies in oversight on a timely basis.

[16]Pub. L. No. 112-239, § 582.

[17]GAO-14-704G.

Methods Used to Review Academic Research Regarding Suicide Prevention among Servicemembers and Indigenous Populations

We conducted two separate literature reviews in completing our review of academic studies pertaining to suicide prevention among servicemembers and dependents stationed at remote OCONUS installations and indigenous populations at such locations. One literature review examined academic research regarding suicide related information at remote military OCONUS installations. The second literature review examined suicide related information regarding indigenous populations located near remote OCONUS military installations.

To identify relevant sources for the literature reviews, a librarian conducted keyword searches of various databases, including ProQuest, EBSCO, DIALOG, and Scopus.[18] The searches were scoped using parameters that limited our results to, among other things, those published in English from 2006 through October 2021. They included articles from scholarly journals, government reports, books, conference papers, dissertations, and association, nonprofit and think tank publications. We also obtained recommendations from DSPO, resulting in eight recommended articles included in our search parameters.

The search focused on military populations yielded 66 titles and abstracts after a librarian and an analyst reviewed the initial search results to eliminate irrelevant results and duplicates. The search focused on indigenous populations generated 81 titles and abstracts after a librarian and an analyst reviewed the initial search results to eliminate irrelevant results and duplicates.

We reviewed the bibliographies of these identified sources for previously unidentified sources and identified four additional sources for the military review and 17 for the indigenous review. As a result, we identified a total of 70 sources for screening for the military population review and 98 sources for the indigenous population review. To screen these sources,

[18]For both literature searches, we used keywords such as suicid* OR self harm and remote OR isolated OR overseas OR secluded OR OCONUS, among others. For the literature search focused on the military population, we additionally used keywords such as military OR servicemember OR DOD OR defense OR Army OR Navy OR Air Force OR Marine*, among others. For the literature search focused on indigenous populations, we additionally used keywords such as indigenous OR native OR local OR “American Indian” OR original OR aboriginal, among others.

one analyst conducted key word searches and reviewed the titles and abstracts of these sources for relevance. A second analyst conducted a sequential review, and the analysts discussed and resolved differences as necessary.

For efficiency, we examined whether it was possible to limit the scope of each literature review to review articles (e.g., published literature reviews or meta-analyses) on both populations rather than review primary studies. We determined there was not a sufficient number of relevant review articles in our search results focused on the military population to take this approach. We determined there was a sufficient number of relevant review articles in our search results focused on indigenous populations and thus limited our review to such articles.

A social science specialist conducted screening of the relevant articles to identify methodological or other limitations. In addition, to be included in our reviews, all sources had to include empirical evidence (not only theory/models) and had to directly reference suicide ideation, attempts, conclusions, or interventions (i.e., not exclusively other mental health issues that might be related to suicide). For both reviews, “academic” was defined as published in an academic or professional journal or if in a book by an author with an academic affiliation. Further, to be included in our review about the military population, sources had to include active-duty military personnel (including reserve forces in an active-duty status) serving in geographic regions where U.S. military installations are located. Similarly, to be included in our review about indigenous populations, sources had to include geographic regions where U.S. military installations were also located.

Based on these screening processes, we identified six sources focused on the military population and nine sources focused on indigenous populations for further review. For these articles, a social science specialist conducted a detailed, full text review of each source that evaluated the methodology of each study—for example, identifying any assumptions made or limitations of the study—and identified any potential risk or protective factors for suicide and prevention or intervention methods discussed by the study. A second specialist conducted a sequential full text review of the same articles. The specialists discussed and resolved any differences, as necessary. At the conclusion of this screening, three sources for the military review and seven sources for the indigenous review met our criteria for inclusion in the report.

Organizations Contacted to Support Audit Work on All Objectives

For all objectives, we interviewed or requested information from DOD and military service officials regarding suicide prevention policies, activities, and oversight mechanisms, including for remote OCONUS installations. We also interviewed officials from the remote OCONUS installation for each service that had the highest number of reported suicide deaths during 2016 through 2020. The selected installations were U.S. Army Garrison Alaska, Fort Wainwright; Commander Fleet Activities Yokosuka, Japan (Navy); Eielson Air Force Base, Alaska; and Marine Corps Base Camp Butler, Japan. In addition, as recommended by an official at Camp Butler, we interviewed officials from Marine Corps Air Station Iwakuni. At each location, we interviewed suicide prevention program managers, medical personnel, unit commanders and senior non-commissioned officers, and servicemembers serving on suicide prevention-related teams.

Table 3 presents the DOD programs and locations we contacted during our review to address our four objectives.

Table 3: Department of Defense Programs and Locations Contacted by GAO

Organization	Program or location contacted
Department of Defense	Defense Health Agency
	Armed Forces Medical Examiner System
	Primary Care Behavioral Health Program
	Psychological Health Center of Excellence
	Defense Manpower Data Center
	Defense Suicide Prevention Office Office of the Assistant Secretary of Defense for Health Affairs Office of the Executive Director for Force Resiliency
Department of the Army	U.S. Army Installation Management Command U.S. Army Medical Command Army Resilience Directorate Office of the Deputy Chief of Staff, G-9 Installations
	Remote OCONUS Installations: U.S. Army Garrison Alaska, Fort Greely U.S. Army Garrison Alaska, Fort Wainwright U.S. Army Garrison Daegu (Korea) U.S. Army Garrison Humphreys (Korea) U.S. Army Garrison Yongsan-Casey (Korea)

Organization	Program or location contacted
Department of the Navy	Office of the Deputy Chief of Naval Operations for Manpower, Personnel, Training, and Education Navy Sexual Assault, Sexual Harassment, and Suicide Prevention and Response Office Navy Bureau of Medicine and Surgery Navy Twenty-First Century Sailor Office **Remote OCONUS Installations:** Camp Lemonnier (Djibouti) Commander Fleet Activities Chinhae (Korea) Commander Fleet Activities Okinawa (Japan) Commander Fleet Activities Sasebo (Japan) Commander Fleet Activities Yokosuka (Japan) Naval Air Facility Atsugi (Japan) Naval Air Facility Misawa (Japan) Naval Air Station Sigonella (Italy) Naval Base Guam Naval Station Guantanamo Bay (Cuba) Naval Station Rota (Spain) Naval Support Activity Bahrain Naval Support Activity Naples (Italy) Naval Support Activity Souda Bay (Greece) Naval Support Facility Deveselu (Romania) Naval Support Facility Diego Garcia Naval Support Facility Redzikowo (Poland) Pacific Missile Range Facility Barking Sands (Hawaii) Singapore Area Coordinator
United States Marine Corps	Marine Corps Behavioral Programs, Marine and Family Programs Division Marine Corps Health Services **Remote OCONUS Installations:** Marine Corps Air Station Futenma (Japan) Marine Corps Air Station Iwakuni (Japan) Marine Corps Base Camp Butler (Japan) Combined Arms Training Center Camp Fuji (Japan) Marine Corps Installation Camp Mujuk (Korea)

Organization	Program or location contacted
Department of the Air Force	Air Force Medical Readiness Agency Air Force's Personnel Center Air Force Integrated Resilience Air National Guard Readiness Center
	Remote OCONUS Installations: Andersen Air Force Base (Guam) Ankara (Turkey) Aviano Air Base (Italy) Buechel Air Base (Germany) Clear Air Force Station (Alaska) Eareckson Air Station (Alaska) Eielson Air Force Base (Alaska) Eskisehir (Turkey) Ghedi Air Base (Italy) Incirlik Air Base (Turkey) Istanbul (Turkey) Izmir Air Station (Turkey) Kadena Air Base (Japan) Kalkar U.S. Air Force Element (Germany) Kleine Brogel Air Base (Belgium) Kunsan Air Base (Korea) Royal Air Force Menwith Hill (United Kingdom) Misawa Air Base (Japan) Moron Air Base (Spain) Naples (Italy) Osan Air Base (Korea) Oslo (Norway) Spangdahlem Air Base (Germany) Stavenger (Norway) Thule Air Base (Greenland) Volkel Air Base (Netherlands) Yokota Air Base (Japan) Yurmutalik (Turkey)

Source: GAO. | GAO-22-105108

Note: OCONUS refers to installations outside of the contiguous United States.

We conducted this performance audit from March 2021 to April 2022 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix III: Detailed Suicide Incident Data by Geographic Category

This appendix presents the results of our analyses of methods of reported suicide deaths and attempts and selected risk and contextual factors associated with suicide deaths and attempts that occurred during calendar years 2016 through 2020, by geographic category. We determined the geographic category for each suicide death and attempt record based on the recorded assigned duty location for the record. For the purposes of this review, we defined remote installations outside of the contiguous U.S. (OCONUS) as those located in Alaska, Hawaii, or outside the U.S. that met one or more of the following criteria: 1) designated by the Department of Defense (DOD) as remote or isolated for the purpose of morale, welfare, and recreation funding; 2) qualifies for hardship duty play; or 3) has a less than standard accompanied or unaccompanied tour length. For more information on these criteria and our selection of remote OCONUS installations, please see appendix II.

Table 4: Methods of Reported Suicide Deaths of Active-Duty Servicemembers, by Geographic Category, Calendar Years 2016 through 2020

	Reported Suicide Deaths, 2016-2020				
Event Method	**Inside the Contiguous U.S.**	**Outside the Contiguous U.S. (OCONUS), non-remote**	**OCONUS, remote**	**Unknown**	**Total**
Drugs	25	1	2	0	**28**
Alcohol	4	0	0	0	**4**
Gas, vapor poisoning by vehicle exhaust	12	1	0	0	**13**
Gas, vapor poisoning by utility or other gas	21	2	2	1	**26**
Solvents, pesticides and other agricultural chemicals	0	0	0	0	**0**
Hanging/Asphyxiation	360	38	47	6	**451**
Drowning	3	0	2	0	**5**
Firearm/gun, military issue or duty weapon	62	4	10	5	**81**

Firearm/gun, other than military issue	915	18	20	14	**967**
Fire, steam, etc.	3	0	0	0	**3**
Sharp or blunt object	13	1	2	0	**16**
Jumping from high place	19	4	7	3	**33**
Struck by moving object	5	0	1	0	**6**
Crashing a motor vehicle	5	0	0	0	**5**
Other	16	1	1	1	**19**

Source: GAO Analysis of Department of Defense (DOD) Suicide Event Report System data. | GAO-22-105108

Note: For this review, we defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

Table 5: Methods of Reported Suicide Attempts of Active-Duty Servicemembers, by Geographic Category, Calendar Years 2016 through 2020

Reported Suicide Attempts, 2016-2020					
Event Method	**Inside the Contiguous U.S.**	**Outside the Contiguous U.S. (OCONUS), non-remote**	**OCONUS, remote**	**Unknown**	**Total**
Drugs	2,655	312	269	92	**3,328**
Alcohol	160	20	21	7	**208**
Gas, vapor poisoning by vehicle exhaust	93	9	4	2	**108**
Gas, vapor poisoning by utility or other gas	16	3	4	2	**25**
Solvents, pesticides and other agricultural chemicals	65	3	2	3	**73**
Hanging/Asphyxiation	730	118	84	24	**956**
Drowning	45	4	8	2	**59**
Firearm/gun, military issue or duty weapon	35	4	2	4	**45**
Firearm/gun, other than military issue	264	12	2	4	**282**
Fire, steam, etc.	4	1	1	0	**6**
Sharp or blunt object	723	128	93	32	**976**
Jumping from high place	73	20	21	10	**124**
Struck by moving object	21	4	0	2	**27**
Crashing a motor vehicle	128	13	5	2	**148**
Other	578	62	87	24	**751**

Source: GAO Analysis of Department of Defense (DOD) Suicide Event Report System data. | GAO-22-105108

Note: For this review, we defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

Appendix III: Detailed Suicide Incident Data by Geographic Category

Table 6: Reported Suicide Deaths and Attempts Where Active-Duty Servicemembers Communicated Intent for Self Harm, by Geographic Category, Calendar Years 2016 through 2020

Location	Communicated Intent for Self Harm	Reported Suicide Deaths						Reported Suicide Attempts					
		2016	2017	2018	2019	2020	Total	2016	2017	2018	2019	2020	Total
Inside the contiguous U.S.	Yes	62	89	85	98	115	**449**	212	267	231	298	263	**1,271**
	No	171	159	157	164	226	**877**	742	765	866	907	890	**4,170**
	No known history	0	21	33	33	37	**124**	0	26	37	26	35	**124**
Outside the contiguous U.S. (OCONUS), non-remote	Yes	1	7	1	6	6	**21**	21	26	28	35	50	**160**
	No	7	4	9	8	12	**40**	86	138	126	99	103	**552**
	No known history	0	2	1	2	1	**6**	0	1	2	5	4	**12**
OCONUS, remote	Yes	6	3	3	10	6	**28**	43	29	27	33	36	**168**
	No	14	8	14	16	4	**56**	60	91	91	86	89	**417**
	No known history	0	2	1	3	1	**7**	0	6	6	2	3	**17**
Unknown	Yes	1	1	2	0	2	**6**	7	8	9	8	13	**45**
	No	2	4	0	5	6	**17**	21	25	31	48	33	**158**
	No known history	0	3	2	1	0	**6**	0	0	1	3	2	**6**
All Locations	Yes	70	100	91	114	129	**504**	283	330	295	374	362	**1,644**
	No	194	175	180	193	248	**990**	909	1,019	1,114	1,140	1,115	**5,297**
	No known history	0	28	37	39	39	**143**	0	33	46	36	44	**159**

Source: GAO Analysis of Department of Defense (DOD) Suicide Event Report System data. | GAO-22-105108

Note: For this review, we defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

Table 7: Reported Suicide Deaths and Attempts Where Active-Duty Servicemembers Were Seen at a Military Treatment Facility, by Geographic Category, Calendar Years 2016 through 2020

Location	Seen at Military Treatment Facility	Reported Suicide Deaths						Reported Suicide Attempts					
		2016	2017	2018	2019	2020	Total	2016	2017	2018	2019	2020	Total
Inside the contiguous U.S.	Yes	175	161	165	176	208	**885**	682	668	694	785	664	**3,493**
	No	76	97	97	106	151	**527**	305	386	433	436	518	**2,078**
	No known history	0	11	13	13	19	**56**	0	5	10	13	8	**36**
Outside the contiguous U.S. (OCONUS), non-remote	Yes	11	7	4	8	15	**45**	59	69	81	70	102	**381**
	No	3	4	7	8	4	**26**	43	96	75	69	52	**335**
	No known history	0	2	0	0	0	**2**	0	0	0	0	3	**3**
OCONUS, remote	Yes	15	7	13	16	7	**58**	59	71	70	69	66	**335**
	No	7	6	5	13	4	**35**	49	54	53	51	62	**269**
	No known history	0	0	0	0	0	**0**	0	2	1	1	0	**4**
Unknown	Yes	1	5	2	2	6	**16**	20	13	20	26	29	**108**
	No	3	2	1	4	2	**12**	9	20	21	32	19	**101**
	No known history	0	1	1	0	0	**2**	0	0	0	1	0	**1**
All Locations	Yes	202	180	184	202	236	**1,004**	820	821	865	950	861	**4,317**
	No	89	109	110	131	161	**600**	406	556	582	588	651	**2,783**
	No known history	0	14	14	13	19	**60**	0	7	11	15	11	**44**

Source: GAO Analysis of Department of Defense (DOD) Suicide Event Report System data. | GAO-22-105108

Note: In the absence of a DOD definition, GAO defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

Table 8: Reported Suicide Deaths and Attempts Where Active-Duty Servicemembers Were Seen by Substance Abuse Services, by Geographic Category, Calendar Years 2016 through 2020

Location	Seen by Substance Abuse Services	Reported Suicide Deaths						Reported Suicide Attempts					
		2016	2017	2018	2019	2020	Total	2016	2017	2018	2019	2020	Total
Inside the contiguous U.S.	Yes	40	57	57	58	75	**287**	166	178	193	171	187	**895**
	No	207	190	189	200	268	**1,054**	824	861	913	1,028	967	**4,593**
	No known history	0	22	29	37	35	**123**	0	20	29	35	36	**120**
Outside the contiguous U.S. (OCONUS), non-remote	Yes	6	1	3	2	4	**16**	11	26	29	24	34	**124**
	No	8	11	8	12	13	**52**	91	138	125	109	116	**579**
	No known history	0	1	0	2	2	**5**	0	1	2	6	7	**16**
OCONUS, remote	Yes	5	2	0	2	2	**11**	15	25	20	20	20	**100**
	No	18	10	16	22	9	**75**	93	90	98	100	103	**484**
	No known history	0	1	2	5	0	**8**	0	12	5	1	5	**23**
Unknown	Yes	1	3	1	1	1	**7**	5	3	7	10	5	**30**
	No	3	4	2	5	6	**20**	24	28	34	44	38	**168**
	No known history	0	1	1	0	1	**3**	0	2	0	5	5	**12**
All Locations	Yes	52	63	61	63	82	**321**	197	232	249	225	246	**1,149**
	No	236	215	215	239	296	**1,201**	1,032	1,117	1,170	1,281	1,224	**5,824**
	No known history	0	25	32	44	38	**139**	0	35	36	47	53	**171**

Source: GAO Analysis of Department of Defense (DOD) Suicide Event Report System data. | GAO-22-105108

Note: In the absence of a DOD definition, GAO defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

Table 9: Reported Suicide Deaths and Attempts Where Active-Duty Servicemembers Were Seen by the Family Advocacy Program, by Geographic Category, Calendar Years 2016 through 2020

Location	Seen by the Family Advocacy Program	Reported Suicide Deaths						Reported Suicide Attempts					
		2016	2017	2018	2019	2020	Total	2016	2017	2018	2019	2020	Total
Inside the contiguous U.S.	Yes	24	29	23	26	45	**147**	75	91	88	95	68	**417**
	No	218	208	211	219	287	**1,143**	903	934	997	1,088	1,071	**4,993**
	No known history	0	32	41	50	46	**169**	0	33	51	51	51	**186**
Outside the contiguous U.S. (OCONUS), non-remote	Yes	0	1	3	0	2	**6**	12	8	12	10	17	**59**
	No	13	11	8	13	14	**59**	89	155	143	123	128	**638**
	No known history	0	1	0	3	3	**7**	0	2	1	6	12	**21**
OCONUS, remote	Yes	2	0	2	1	3	**8**	8	10	2	6	8	**34**
	No	20	13	12	21	8	**74**	100	103	114	113	113	**543**
	No known history	0	0	4	7	0	**11**	0	14	8	2	7	**31**
Unknown	Yes	1	1	1	0	3	**6**	0	1	2	1	2	**6**
	No	3	6	2	6	5	**22**	29	30	34	54	41	**188**
	No known history	0	1	1	0	0	**2**	0	2	5	4	5	**16**
All Locations	Yes	27	31	29	27	53	**167**	95	110	104	112	95	**516**
	No	254	238	233	259	314	**1,298**	1,121	1,222	1,288	1,378	1,353	**6,362**
	No known history	0	34	46	60	49	**189**	0	51	65	63	75	**254**

Source: GAO Analysis of Department of Defense (DOD) Suicide Event Report System data. | GAO-22-105108

Note: In the absence of a DOD definition, GAO defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

Table 10: Reported Suicide Deaths and Attempts Where Active-Duty Servicemembers Had Mental Health Treatment Recorded, by Geographic Category, Calendar Years 2016 through 2020

Location	Mental Health Treatment Recorded	Reported Suicide Deaths						Reported Suicide Attempts					
		2016	2017	2018	2019	2020	Total	2016	2017	2018	2019	2020	Total
Inside the contiguous U.S.	Yes	128	138	137	146	171	**720**	638	650	696	742	670	**3,396**
	No	125	131	138	149	207	**750**	360	410	441	492	520	**2,223**
Outside the contiguous U.S. (OCONUS), non-remote	Yes	9	7	4	8	14	**42**	56	79	104	78	99	**416**
	No	5	6	7	8	5	**31**	49	86	52	61	58	**306**
OCONUS, remote	Yes	11	3	7	11	6	**38**	56	75	61	73	75	**340**
	No	12	10	11	18	5	**56**	53	52	63	48	53	**269**
Unknown	Yes	2	4	1	2	5	**14**	18	18	23	34	32	**125**
	No	2	4	3	4	3	**16**	11	15	18	25	16	**85**
All Locations	Yes	150	152	149	167	196	**814**	768	822	884	927	876	**4,277**
	No	144	151	159	179	220	**853**	473	563	574	626	647	**2,883**

Source: GAO Analysis of Department of Defense (DOD) Suicide Event Report System data. | GAO-22-105108

Note: In the absence of a DOD definition, GAO defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

Table 11: Reported Suicide Deaths and Attempts Where Active-Duty Servicemembers Were Involved in Legal or Administrative Proceedings, by Geographic Category, Calendar Years 2016 through 2020

Location	Legal or Administrative Proceedings	Reported Suicide Deaths						Reported Suicide Attempts					
		2016	2017	2018	2019	2020	Total	2016	2017	2018	2019	2020	Total
Inside the contiguous U.S.	Yes	69	76	78	74	93	**390**	359	349	359	370	315	**1,752**
	No	185	193	197	221	285	**1,081**	637	711	778	864	875	**3,865**
Outside the contiguous U.S. (OCONUS), non-remote	Yes	4	4	2	5	7	**22**	33	45	49	45	50	**222**
	No	8	9	9	11	12	**49**	79	120	107	94	107	**507**
OCONUS, remote	Yes	4	3	3	7	5	**22**	29	34	27	30	21	**141**
	No	18	10	15	22	6	**71**	80	93	97	91	107	**468**
Unknown	Yes	1	2	1	0	3	**7**	10	9	11	14	10	**54**
	No	3	6	3	6	5	**23**	19	24	30	45	38	**156**
All Locations	Yes	78	85	84	86	108	**441**	431	437	446	459	396	**2,169**
	No	214	218	224	260	308	**1,224**	815	948	1,012	1,094	1,127	**4,996**

Source: GAO Analysis of Department of Defense (DOD) Suicide Event Report System data. | GAO-22-105108

Note: In the absence of a DOD definition, GAO defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

Table 12: Reported Suicide Deaths and Attempts Where Active-Duty Servicemembers Had a History of Direct Combat, by Geographic Category, Calendar Years 2016 through 2020

Location	History of Direct Combat	Reported Suicide Deaths						Reported Suicide Attempts					
		2016	2017	2018	2019	2020	Total	2016	2017	2018	2019	2020	Total
Inside the contiguous U.S.	Yes	23	23	23	26	24	**119**	86	83	72	68	52	**361**
	No	196	202	200	221	297	**1,116**	852	905	999	1,112	1,059	**4,927**
	No known history	0	44	52	48	55	**199**	0	68	60	46	69	**243**
Outside the contiguous U.S. (OCONUS), non-remote	Yes	2	1	0	0	2	**5**	3	11	3	6	5	**28**
	No	7	9	8	14	15	**53**	96	140	148	123	133	**640**
	No known history	0	3	3	2	2	**10**	0	12	4	9	18	**43**
OCONUS, remote	Yes	0	0	0	0	1	**1**	10	3	7	5	6	**31**
	No	19	11	12	17	9	**68**	92	113	109	104	118	**536**
	No known history	0	2	6	12	1	**21**	0	11	5	6	4	**26**
Unknown	Yes	0	1	0	0	0	**1**	3	5	2	5	3	**18**
	No	3	5	4	6	5	**23**	22	25	34	49	37	**167**
	No known history	0	1	0	0	2	**3**	0	3	5	5	7	**20**
All Locations	Yes	25	25	23	26	27	**126**	102	102	84	84	66	**438**
	No	225	227	224	258	326	**1,260**	1,062	1,183	1,290	1,388	1,347	**6,270**
	No known history	0	50	61	62	60	**233**	0	94	74	66	98	**332**

Source: GAO Analysis of Department of Defense (DOD) Suicide Event Report System data. | GAO-22-105108

Note: In the absence of a DOD definition, GAO defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

Table 13: Reported Suicide Deaths and Attempts Where Active-Duty Servicemembers Were Under Investigation, by Geographic Category, Calendar Years 2016 through 2020

Location	Under Investigation	Reported Suicide Deaths						Reported Suicide Attempts					
		2016	2017	2018	2019	2020	Total	2016	2017	2018	2019	2020	Total
Inside the contiguous U.S.	Yes	29	34	51	43	45	**202**	102	114	115	120	121	**572**
	No	213	230	219	242	324	**1,228**	872	932	1,012	1,099	1,051	**4,966**
Outside the contiguous U.S. (OCONUS), non-remote	Yes	3	2	3	3	7	**18**	13	17	13	25	14	**82**
	No	7	11	8	13	12	**51**	98	147	143	112	139	**639**
OCONUS, remote	Yes	5	2	4	5	2	**18**	15	9	10	19	12	**65**
	No	18	11	14	22	9	**74**	93	113	112	102	115	**535**
Unknown	Yes	2	1	1	1	1	**6**	4	5	2	1	4	**16**
	No	2	7	3	5	6	**23**	25	28	38	57	41	**189**
All Locations	Yes	39	39	59	52	55	**244**	134	145	140	165	151	**735**
	No	240	259	244	282	351	**1,376**	1,088	1,220	1,305	1,370	1,346	**6,329**

Source: GAO Analysis of Department of Defense (DOD) Suicide Event Report System data. | GAO-22-105108

Note: In the absence of a DOD definition, GAO defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

Table 14: Reported Suicide Deaths and Attempts Where Active-Duty Servicemember Was a Victim of Abuse, by Geographic Category, Calendar Years 2016 through 2020

Location	Victim of Abuse	Reported Suicide Deaths						Reported Suicide Attempts					
		2016	2017	2018	2019	2020	Total	2016	2017	2018	2019	2020	Total
Inside the contiguous U.S.	Yes	29	37	38	45	50	**199**	362	384	448	546	503	**2,243**
	No	198	232	237	250	328	**1,245**	624	676	689	688	687	**3,364**
Outside the contiguous U.S. (OCONUS), non-remote	Yes	2	0	1	1	1	**5**	33	37	40	49	72	**231**
	No	8	13	10	15	18	**64**	77	128	116	90	85	**496**
OCONUS, remote	Yes	2	0	2	3	2	**9**	32	40	37	48	60	**217**
	No	21	13	16	26	9	**85**	77	87	87	73	68	**392**
Unknown	Yes	1	1	1	1	2	**6**	8	9	7	13	16	**53**
	No	2	7	3	5	6	**23**	21	24	34	46	32	**157**
All Locations	Yes	34	38	42	50	55	**219**	435	470	532	656	651	**2,744**
	No	229	265	266	296	361	**1,417**	799	915	926	897	872	**4,409**

Source: GAO Analysis of Department of Defense (DOD) Suicide Event Report System data. | GAO-22-105108

Note: In the absence of a DOD definition, GAO defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

Table 15: Reported Suicide Deaths and Attempts Where Active-Duty Servicemember Was a Perpetrator of Abuse, by Geographic Category, Calendar Years 2016 through 2020

Location	Perpetrator of Abuse	Reported Suicide Deaths						Reported Suicide Attempts					
		2016	2017	2018	2019	2020	Total	2016	2017	2018	2019	2020	Total
Inside the contiguous U.S.	Yes	26	37	36	32	53	**184**	74	73	74	95	69	**385**
	No	208	232	239	263	325	**1,267**	906	987	1,063	1,139	1,121	**5,216**
Outside the contiguous U.S. (OCONUS), non-remote	Yes	0	1	1	0	3	**5**	11	6	10	10	14	**51**
	No	9	12	10	16	16	**63**	100	159	146	129	143	**677**
OCONUS, remote	Yes	3	1	3	3	2	**12**	6	10	6	10	4	**36**
	No	20	12	15	26	9	**82**	100	117	118	111	124	**570**
Unknown	Yes	1	2	1	0	2	**6**	1	1	0	1	3	**6**
	No	2	6	3	6	6	**23**	28	32	41	58	45	**204**
All Locations	Yes	30	41	41	35	60	**207**	92	90	90	116	90	**478**
	No	239	262	267	311	356	**1,435**	1,134	1,295	1,368	1,437	1,433	**6,667**

Source: GAO Analysis of Department of Defense (DOD) Suicide Event Report System data. | GAO-22-105108

Note: In the absence of a DOD definition, GAO defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

Table 16: Reported Suicide Deaths and Attempts Where Active-Duty Servicemember Had a Failed Intimate Relationship, by Geographic Category, Calendar Years 2016 through 2020

Location	Failed Intimate Relationship	Reported Suicide Deaths						Reported Suicide Attempts					
		2016	2017	2018	2019	2020	Total	2016	2017	2018	2019	2020	Total
Inside the contiguous U.S.	Yes	159	146	147	162	209	**823**	537	556	558	612	540	**2,803**
	No	80	123	128	133	169	**633**	455	504	579	622	650	**2,810**
Outside the contiguous U.S. (OCONUS), non-remote	Yes	6	6	6	8	11	**37**	54	68	78	70	90	**360**
	No	7	7	5	8	8	**35**	56	97	78	69	67	**367**
OCONUS, remote	Yes	11	8	5	11	7	**42**	59	55	52	61	49	**276**
	No	9	5	13	18	4	**49**	49	72	72	60	79	**332**
Unknown	Yes	2	4	3	1	6	**16**	12	14	19	30	13	**88**
	No	1	4	1	5	2	**13**	17	19	22	29	35	**122**
All Locations	Yes	178	164	161	182	233	**918**	662	693	707	773	692	**3,527**
	No	97	139	147	164	183	**730**	577	692	751	780	831	**3,631**

Source: GAO Analysis of Department of Defense (DOD) Suicide Event Report System data. | GAO-22-105108

Note: In the absence of a DOD definition, GAO defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

Table 17: Reported Suicide Deaths and Attempts Where Active-Duty Servicemember Had Experienced a Family, Friend, or Spousal Suicide, by Geographic Category, Calendar Years 2016 through 2020

Location	Family, Friend, or Spousal Suicide	Reported Suicide Deaths						Reported Suicide Attempts					
		2016	2017	2018	2019	2020	Total	2016	2017	2018	2019	2020	Total
Inside the contiguous U.S.	Yes	24	28	25	40	37	**154**	151	167	209	285	258	**1,070**
	No	223	241	250	255	341	**1,310**	842	893	928	949	932	**4,544**
Outside the contiguous U.S. (OCONUS), non-remote	Yes	0	1	1	1	1	**4**	8	12	13	21	26	**80**
	No	14	12	10	15	18	**69**	101	153	143	118	131	**646**
OCONUS, remote	Yes	1	1	0	3	1	**6**	11	14	19	22	24	**90**
	No	22	12	18	26	10	**88**	97	113	105	99	104	**518**
Unknown	Yes	0	1	2	0	1	**4**	3	4	3	11	7	**28**
	No	4	7	2	6	7	**26**	25	29	38	48	41	**181**
All Locations	Yes	25	31	28	44	40	**168**	173	197	244	339	315	**1,268**
	No	263	272	280	302	376	**1,493**	1,065	1,188	1,214	1,214	1,208	**5,889**

Source: GAO Analysis of Department of Defense (DOD) Suicide Event Report System data. | GAO-22-105108

Note: In the absence of a DOD definition, GAO defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

Table 18: Reported Suicide Deaths and Attempts Where Active-Duty Servicemember Had Experienced a Family, Friend, or Spousal Death, by Geographic Category, Calendar Years 2016 through 2020

Location	Family, Friend, or Spousal Death	Reported Suicide Deaths						Reported Suicide Attempts					
		2016	2017	2018	2019	2020	Total	2016	2017	2018	2019	2020	Total
Inside the contiguous U.S.	Yes	37	19	34	29	47	**166**	203	175	254	338	306	**1,276**
	No	186	250	241	266	331	**1,274**	780	885	883	896	884	**4,328**
Outside the contiguous U.S. (OCONUS), non-remote	Yes	1	2	0	0	0	**3**	15	18	20	35	40	**128**
	No	8	11	11	16	19	**65**	95	147	136	104	117	**599**
OCONUS, remote	Yes	1	2	2	3	2	**10**	20	23	21	30	30	**124**
	No	18	11	16	26	9	**80**	88	104	103	91	98	**484**
Unknown	Yes	0	0	0	0	0	**0**	4	5	8	10	9	**36**
	No	4	8	4	6	8	**30**	23	28	33	49	39	**172**
All Locations	Yes	39	23	36	32	49	**179**	242	221	303	413	385	**1,564**
	No	216	280	272	314	367	**1,449**	986	1,164	1,155	1,140	1,138	**5,583**

Source: GAO Analysis of Department of Defense (DOD) Suicide Event Report System data. | GAO-22-105108

Note: In the absence of a DOD definition, GAO defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

Table 19: Reported Suicide Deaths and Attempts Where Active-Duty Servicemember Had Physical Health Problems, by Geographic Category, Calendar Years 2016 through 2020

Location	Physical Health Problems	Reported Suicide Deaths						Reported Suicide Attempts					
		2016	2017	2018	2019	2020	Total	2016	2017	2018	2019	2020	Total
Inside the contiguous U.S.	Yes	43	55	59	57	64	**278**	224	193	202	258	186	**1,063**
	No	201	172	154	186	249	**962**	763	829	881	928	945	**4,346**
	No known history	0	41	61	52	65	**219**	0	36	53	47	59	**195**
Outside the contiguous U.S. (OCONUS), non-remote	Yes	2	2	2	4	3	**13**	15	19	16	17	27	**94**
	No	10	8	9	10	13	**50**	95	146	140	116	123	**620**
	No known history	0	3	0	2	3	**8**	0	0	0	6	7	**13**
OCONUS, remote	Yes	3	2	6	4	2	**17**	11	19	20	13	21	**84**
	No	20	11	9	16	9	**65**	97	98	98	104	97	**494**
	No known history	0	0	3	9	0	**12**	0	10	6	4	10	**30**
Unknown	Yes	0	0	1	0	1	**2**	9	4	2	7	7	**29**
	No	4	7	3	4	6	**24**	19	29	35	49	37	**169**
	No known history	0	1	0	2	1	**4**	0	0	4	3	4	**11**
All Locations	Yes	48	59	68	65	70	**310**	259	235	240	295	241	**1,270**
	No	235	198	175	216	277	**1,101**	974	1,102	1,154	1,197	1,202	**5,629**
	No known history	0	45	64	65	69	**243**	0	46	63	60	80	**249**

Source: GAO Analysis of Department of Defense (DOD) Suicide Event Report System data. | GAO-22-105108

Note: In the absence of a DOD definition, GAO defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

Table 20: Reported Suicide Deaths and Attempts Where Active-Duty Servicemember Had Excessive Debt or Bankruptcy, by Geographic Category, Calendar Years 2016 through 2020

Location	Excessive Debt or Bankruptcy	Reported Suicide Deaths						Reported Suicide Attempts					
		2016	2017	2018	2019	2020	Total	2016	2017	2018	2019	2020	Total
Inside the contiguous U.S.	Yes	18	35	23	19	26	**121**	90	85	95	101	81	**452**
	No	200	163	151	178	255	**947**	875	918	956	1,048	1,028	**4,825**
	No known history	0	71	101	98	97	**367**	0	55	85	84	81	**305**
Outside the contiguous U.S. (OCONUS), non-remote	Yes	0	0	1	2	0	**3**	10	5	6	9	15	**45**
	No	10	7	9	10	14	**50**	97	160	148	125	135	**665**
	No known history	0	6	1	4	5	**16**	0	0	2	5	7	**14**
OCONUS, remote	Yes	2	0	0	1	2	**5**	6	11	8	8	8	**41**
	No	20	10	12	19	4	**65**	102	103	106	106	110	**527**
	No known history	0	3	6	9	5	**23**	0	13	10	7	10	**40**
Unknown	Yes	0	0	1	0	0	**1**	2	3	1	4	1	**11**
	No	4	5	2	4	6	**21**	25	29	34	52	43	**183**
	No known history	0	2	1	2	2	**7**	0	1	6	3	4	**14**
All Locations	Yes	20	35	25	22	28	**130**	108	104	110	122	105	**549**
	No	234	185	174	211	279	**1,083**	1,099	1,210	1,244	1,331	1,316	**6,200**
	No known history	0	82	109	113	109	**413**	0	69	103	99	102	**373**

Source: GAO Analysis of Department of Defense (DOD) Suicide Event Report System data. | GAO-22-105108

Note: In the absence of a DOD definition, GAO defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

Table 21: Reported Suicide Deaths and Attempts Where Active-Duty Servicemember Had Experienced Job Related Problems, by Geographic Category, Calendar Years 2016 through 2020

Location	Job Related Problems	Reported Suicide Deaths						Reported Suicide Attempts					
		2016	2017	2018	2019	2020	Total	2016	2017	2018	2019	2020	Total
Inside the contiguous U.S.	Yes	56	59	62	54	72	**303**	362	373	400	455	383	**1,973**
	No	185	210	213	241	306	**1,155**	623	687	737	779	807	**3,633**
Outside the contiguous U.S. (OCONUS), non-remote	Yes	6	4	2	2	5	**19**	29	46	42	56	64	**237**
	No	5	9	9	14	14	**51**	80	119	114	83	93	**489**
OCONUS, remote	Yes	2	2	2	2	2	**10**	36	46	45	52	45	**224**
	No	20	11	16	27	9	**83**	72	81	79	69	83	**384**
Unknown	Yes	1	5	1	1	1	**9**	12	14	8	17	14	**65**
	No	3	3	3	5	7	**21**	17	19	33	42	34	**145**
All Locations	Yes	65	70	67	59	80	**341**	439	479	495	580	506	**2,499**
	No	213	233	241	287	336	**1,310**	792	906	963	973	1,017	**4,651**

Source: GAO Analysis of Department of Defense (DOD) Suicide Event Report System data. | GAO-22-105108

Note: In the absence of a DOD definition, GAO defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

Table 22: Reported Suicide Deaths and Attempts Where Active-Duty Servicemember Was a Victim of Workplace Hazing, by Geographic Category, Calendar Years 2016 through 2020

Location	Victim of Workplace Hazing	Reported Suicide Deaths						Reported Suicide Attempts					
		2016	2017	2018	2019	2020	Total	2016	2017	2018	2019	2020	Total
Inside the contiguous U.S.	Yes	0	0	2	3	4	**9**	40	37	54	75	55	**261**
	No	237	231	212	235	304	**1,219**	908	960	1,004	1,069	1,041	**4,982**
	No known history	0	38	61	57	70	**226**	0	62	79	90	94	**325**
Outside the contiguous U.S. (OCONUS), non-remote	Yes	0	0	0	0	0	**0**	1	3	2	10	11	**27**
	No	9	11	10	12	17	**59**	109	159	153	122	138	**681**
	No known history	0	2	1	4	2	**9**	0	2	1	7	8	**18**
OCONUS, remote	Yes	0	0	0	0	0	**0**	4	2	1	3	6	**16**
	No	20	12	17	21	10	**80**	100	109	113	111	113	**546**
	No known history	0	1	1	8	1	**11**	0	16	10	7	9	**42**
Unknown	Yes	0	0	0	0	0	**0**	1	3	0	3	1	**8**
	No	3	6	2	4	6	**21**	25	29	36	52	42	**184**
	No known history	0	2	2	2	2	**8**	0	1	5	4	5	**15**
All Locations	Yes	0	0	2	3	4	**9**	46	45	57	91	73	**312**
	No	269	260	241	272	337	**1,379**	1,142	1,257	1,306	1,354	1,334	**6,393**
	No known history	0	43	65	71	75	**254**	0	81	95	108	116	**400**

Source: GAO Analysis of Department of Defense (DOD) Suicide Event Report System data. | GAO-22-105108

Note: In the absence of a DOD definition, GAO defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

Table 23: Reported Suicide Deaths and Attempts Where Active-Duty Servicemember Had a Firearm in Their Immediate Environment, by Geographic Category, Calendar Years 2016 through 2020

Location	Firearm in Immediate Environment	Reported Suicide Deaths						Reported Suicide Attempts					
		2016	2017	2018	2019	2020	Total	2016	2017	2018	2019	2020	Total
Inside the contiguous U.S.	Yes	168	180	173	181	252	**954**	126	104	126	163	163	**682**
	No	58	65	79	92	114	**408**	806	923	980	1,042	986	**4,737**
Outside the contiguous U.S. (OCONUS), non-remote	Yes	5	2	1	7	6	**21**	7	6	9	8	9	**39**
	No	6	9	9	9	12	**45**	99	150	147	130	145	**671**
OCONUS, remote	Yes	1	2	4	12	5	**24**	1	3	0	5	1	**10**
	No	21	11	13	15	6	**66**	105	114	119	114	127	**579**
Unknown	Yes	1	5	4	4	4	**18**	5	6	2	4	3	**20**
	No	1	3	0	1	4	**9**	19	24	36	52	42	**173**
All Locations	Yes	175	189	182	204	267	**1,017**	139	119	137	180	176	**751**
	No	86	88	101	117	136	**528**	1,029	1,211	1,282	1,338	1,300	**6,160**

Source: GAO Analysis of Department of Defense (DOD) Suicide Event Report System data. | GAO-22-105108

Note: In the absence of a DOD definition, GAO defined remote OCONUS installations as those located in Alaska, Hawaii, or outside the U.S. that met at least one of the following criteria: 1) designated by DOD as remote for the purpose of morale, welfare, and recreation funding; 2) qualifies as a hardship duty pay location; or 3) has a less-than-standard accompanied or unaccompanied tour length.

Appendix IV: Department of Defense and Military Service Suicide Prevention Activities

The Department of Defense's (DOD) and the military services' suicide prevention programs include various activities intended to address suicide among servicemembers and their dependents. These include prevention efforts such as outreach campaigns and mandatory suicide prevention training as well as targeted interventions for at-risk servicemembers through the military health system. DOD and the military services also offer resources intended to promote resiliency among servicemembers and their dependents. Table 24 provides examples of suicide prevention and resilience activities performed by DOD and the military services.

Table 24: Overview of Suicide Prevention Activities within the Department of Defense (DOD)

Activity	Activity Description
Outreach and Awareness	Outreach and awareness activities educate the military community about suicide prevention. For example, each year DOD observes Suicide Prevention Month; for 2021, this campaign focused on promoting connectedness and relationships with family, friends, and the broader community. In addition, the Defense Suicide Prevention Office maintains various resources to help the DOD community navigate the issue of suicide, such as its Leaders Suicide Prevention Safe Messaging Guide, Postvention Toolkit for a Military Suicide Loss, and Lethal Means Safety Guide for Military Servicemembers and Their Families.
Suicide Prevention Training	DOD Instruction 6490.16 requires all servicemembers to complete suicide prevention training.[a] In addition to this training, the military services offer additional suicide prevention training. These include leader training, such as the Army's one-time training to prepare leaders and first-line supervisors to intervene for at-risk personnel, Navy "gatekeeper" training for personnel likely to encounter at-risk personnel in the performance of their duties, and Marine Corps training for command personnel to recognize operational stress. In addition, the Army and the Air Force offer optional suicide prevention training for military families.
Counseling, Resilience, and Crisis Resources	Counseling, resilience, and crisis resources are available to servicemembers and their dependents. DOD's Military and Family Life Counselors provide confidential non-medical counseling, and DOD chaplains are trained counselors that offer confidential assistance and referral services. The military services also maintain resilience resources, such as Army Ready and Resilient Performance Centers, Navy Fleet and Family Support Centers, the Air Force Airman and Family Readiness Center, and the Marine Corps Community Counseling Program. Finally, DOD promotes crisis resources that are available to servicemembers and their dependents, such as the Military Crisis Line and the National Suicide Prevention Lifeline.

Activity	Activity Description
Lethal Means Safety	DOD has taken steps to promote lethal means safety, including requiring DOD installations to provide servicemembers and their dependents not living on the installation the opportunity to voluntarily store their privately owned firearms on the installation. Additionally, DOD has established procedures for reducing the access to lethal means in cases where a servicemember is a danger to themselves or others. The Defense Suicide Prevention Office also maintains a suite of lethal means resources, including a Lethal Means Safety Guide for Military Servicemembers and Their Families, a communication guide for military leaders, and a toolkit of resources that firearms retailers can share to promote safe storage.
Military Health System Resources and Embedded Providers	DOD's military health system provides behavioral health services through multiple forums, including embedded behavioral health personnel in primary care clinics, outpatient behavioral health clinics, and inpatient behavioral health units. Military treatment facilities may also offer emergency care to help stabilize servicemembers or dependents experiencing behavioral health emergencies. In addition to these military health system resources, each military service maintains an embedded behavioral health program to support operational units.
Monitoring At-Risk Servicemembers	The military services have developed processes to monitor at-risk servicemembers. Both the Army and the Air Force have developed processes by which at-risk servicemembers are monitored by military health system personnel. Within the Department of the Navy, Navy and Marine Corps command teams conduct monthly meetings to review the risk levels of servicemembers under their commands and identify those who require additional resources. In addition, the Navy and Marine Corps maintain programs to provide ongoing suicide risk assessment and care coordination for servicemembers that experience a suicide-related behavior.
Suicide Surveillance	In addition to completing DOD Suicide Event Reports, the military services have developed additional suicide surveillance requirements. Specifically, Army commanders are responsible for submitting a completed report to the Army Resilience Directorate following every suicide to help facilitate its analysis of suicide events. Navy commands are responsible for conducting a Suicide Event Review Board following each confirmed suicide death. Similarly, Air Force Major Commands each perform an annual Suicide Analysis Board, during which Air Force leaders and subject matter experts review suicide deaths and submit a report to the Department of Air Force's Integrated Resilience. Finally, Marine Corps policy requires the Marine and Family Programs Division to perform a service-wide Death by Suicide Review Board each year based on the prior year's DOD Suicide Event Reports.

Source: GAO analysis of Department of Defense information. | GAO-22-105108

[a]Department of Defense Instruction 6490.16, Defense Suicide Prevention Program (Nov. 6, 2017) (incorporating change 2, Sept. 11, 2020).

Appendix V: Comments from the Department of Defense

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

FORCE RESILIENCY

April 7, 2022

Brenda S. Farrell
Director, Defense Capabilities and Management
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Farrell:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) Draft Report, GAO-22-105108, "SUICIDE PREVENTION: DOD Should Enhance Oversight, Staffing, Guidance, and Training Affecting Certain Remote Installations," dated March 1, 2022.

The Department concurs with eleven of the recommendations in this report and is currently taking steps to address them. The Department partially concurs with three recommendations and proposes modifications to the GAO recommendations.

Dr. Liz Clark, Deputy Director, Defense Suicide Prevention Office, is the point of contact for this action. She may be reached at sandra.e.clark28.civ@mail.mil, or (703) 614-1824.

Sincerely,

Elizabeth B. Foster
Executive Director, Force Resiliency

Enclosures:
As stated

Enclosure 1

GAO DRAFT REPORT DATED APRIL 1, 2021
GAO-22-105108 (GAO CODE 105108)

"SUICIDE PREVENTION: DOD SHOULD ENHANCE OVERSIGHT, STAFFING, GUIDANCE, AND TRAINING AFFECTING CERTAIN REMOTE INSTALLATIONS."

DEPARTMENT OF DEFENSE COMMENTS TO THE GAO RECOMMENDATIONS

RECOMMENDATION 1: The Secretary of Defense should ensure the Under Secretary of Defense for Personnel and Readiness, in collaboration with the Defense Suicide Prevention Office, establishes a process to assess risk factors for suicide and related challenges associated with OCONUS installations that could be considered remote and take any appropriate actions.

DoD RESPONSE:

Partially concur.

The Department requests the recommendation be directed solely to USD (P&R) and the words "in collaboration with the Defense Suicide Prevention Office" be deleted as unnecessary. There are several other entities under the purview of the USD (P&R) with which it would be beneficial for USD (P&R) to collaborate to address this recommendation.

RECOMMENDATION 2: The Secretary of the Navy should establish a policy that requires the designation of and provides implementing guidance for Directors of Psychological Health at Navy and Marine Corps installations, in accordance with DOD policy.

DoD RESPONSE: Concur.

RECOMMENDATION 3: The Secretary of the Army should establish oversight mechanisms, such as by updating the content of the program status report and clarifying the requirement for its submission, to ensure that installation-level suicide prevention program requirements are implemented in accordance with DOD and service policies.

DoD RESPONSE: Concur.

RECOMMENDATION 4: The Secretary of the Navy should establish oversight mechanisms, such as by specifying oversight requirements in policy, to ensure that command-level suicide prevention program requirements are implemented in accordance with DOD and service policies.

DoD RESPONSE: Concur.

RECOMMENDATION 5: The Secretary of the Navy should ensure that the Commandant of the Marine Corps establishes oversight mechanisms, such as by specifying oversight

requirements in policy, to ensure that command-level suicide prevention program requirements are implemented in accordance with DOD and service policies.

DoD RESPONSE: Concur and completed.

The August 2021 update to the Suicide Prevention Marine Corps Order (MCO), 1720.2A, page 3, paragraph (2) (d), requires that all Major Operational and Installation Level Commands shall: "Establish and implement, in writing, a command suicide prevention program integrating awareness education, early identification, referral of at-risk personnel to treatment, reporting requirements, reintegration, and postvention support."

NAVMC 1720.1, published August 2021, establishes procedures to support suicide prevention, intervention, and postvention efforts and to ensure consistency throughout the Marine Corps. The NAVMC details the activities of all stakeholders involved in the Marine Corps Suicide Prevention System (MCSPS), which incorporates critical elements and resources to support suicide prevention, intervention, and postvention efforts. Page 1-1, provides detailed guidance to support the requirements of the command-level suicide prevention program requirements.

Additional oversight mechanisms are supported via the Commanding General's Inspection Program (CGIP). The CGIP is established to assess, assist and enhance the ability of the unit to prepare for and to perform its assigned mission through a centralized inspection program

Based on actions completed via the update to MCO 1720.2A and the publication of procedural guidance included in NAVMC 1720.1, and additional oversight mechanisms IAW MCO 5430.1, the Department requests GAO close Recommendation 5.

RECOMMENDATION 6: The Secretary of Defense should ensure the Director, DHA, develops a strategy to address shortages in primary care behavioral health providers, including at OCONUS installations that could be considered remote.

DoD RESPONSE: Concur.

RECOMMENDATION 7: The Secretary of Defense should ensure the Under Secretary of Defense for Personnel and Readiness, in collaboration with DSPO, establishes guidance, such as by updating the Department's suicide prevention policy, to address commanders' response to suicide attempts, including the extent of any responsibilities related to reintegration of servicemembers into the workplace following a suicide attempt.

DoD RESPONSE: Partially concur. Please see DoD response to Recommendation 1.

RECOMMENDATION 8: The Secretary of Defense should ensure the Under Secretary of Defense for Personnel and Readiness, in collaboration with DSPO, establishes training resources for commanders' that address their response to suicide deaths and attempts.

DoD RESPONSE: Partially concur. Please see DoD response to Recommendation 1.

RECOMMENDATION 9: The Secretary of the Army should develop, and ensure the availability of, training for suicide prevention program managers that covers the scope of their responsibilities, including those related to responding to suicide deaths and attempts.

DoD RESPONSE: Concur.

RECOMMENDATION 10: The Secretary of the Air Force should develop, and ensure the availability of, training for suicide prevention program managers that covers the scope of their responsibilities, including those related to responding to suicide deaths and attempts.

DoD RESPONSE: Concur.

The Air Force has already developed and finalized this training since the drafting of this report. The training development was completed in December 2021, and the first iteration of the training was conducted in February 2022.

RECOMMENDATION 11: The Secretary of the Army should develop a process to ensure that installation suicide prevention program managers complete required training.

DoD RESPONSE: Concur.

RECOMMENDATION 12: The Secretary of the Navy should develop a process to ensure that command suicide prevention program managers complete required training.

DoD RESPONSE: Concur.

RECOMMENDATION 13: The Secretary of the Air Force should develop a process to ensure that installation suicide prevention program managers complete required training.

DoD RESPONSE: Concur.

RECOMMENDATION 14: The Secretary of the Navy should ensure that the Commandant of the Marine Corps develops a process to ensure that command suicide prevention program managers complete required training.

DoD RESPONSE: Concur and completed.

The August 2021 update to the Suicide Prevention Marine Corps Order (MCO), 1720.2A, page 3, paragraph (2) (d), requires that all Major Operational and Installation Level Commands: "Appoint, in writing, suicide prevention program personnel. Suicide prevention program personnel must complete the required M&RA, MF online training within 30 days of appointment and must remain current with annual suicide prevention training in accordance with reference (a). Designation, selection criteria, training requirements, and responsibilities for suicide prevention program personnel are further outlined in reference (r)."

NAVMC 1720.1, published Aug 2021, establishes procedures to support suicide prevention, intervention, and postvention efforts, and to ensure consistency throughout the Marine Corps. Page 1-1 details the activities of all stakeholders involved in the Marine Corps Suicide Prevention System (MCSPS), which incorporates critical elements and resources to support suicide prevention, intervention, and postvention efforts. Page 1-3, requires that Commanders appoint in writing a Marine or Sailor, E-6 or above, as a Suicide Prevention Program Officer (SPPO), paragraph d.(1). Paragraph c.(9) requires that the appointed SPPO, "Contact M&RA, MF, SPC within 30 days of appointment in writing, and when replaced, to establish and maintain a line of communication to facilitate reception of information, resources and policy clarification from HQMC. An additional duty code (SPPO/SPPC) is entered into the Marine Corps Total Force System (MCTFS) for identification purposes."

In order to ensure that the SPPOs complete required training, a point of contact list is maintained for all SPPOs across the fleet and the status of the appointment and required training is verified via: 1) quarterly meetings with HQMC; 2) monthly emails from HQMC; 3) automated queries of additional duty codes from MCTFS; and 4) the Inspector General Marine Corps inspections. Suicide prevention is a Critical or Required Evaluation (CoRE) functional area and, "shall be inspected to the maximum extent possible within all commands regardless of size, mission, or location," IAW MCO 5430.1.

Technical assist visits, both in person and via teleconference, further support compliance for the required SPPO training.

Based on actions completed via the update to MCO 1720.2A and the publication of procedural guidance included in NAVMC 1720.1, and additional oversight mechanisms IAW MCO 5430.1, the department requests GAO close recommendation 14.

Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact

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In addition to the contact named above, Ryan D'Amore (Assistant Director), Serena Epstein (Analyst-in-Charge), Vincent Buquicchio, Christopher Gezon, Jesse Jordan, Grant Mallie, Richard Powelson, Paul Seely, and Mike Silver made key contributions to this report. Other contributors include Denise Cook, Michele Fejfar, Serena Lo, Sam Portnow, Rebecca Sero, Pam Snedden, Rachel Stoiko, and Sirin Yaemsiri.

Appendix VII: Related GAO Products

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