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DEFENSE HEALTH CARE

DOD Needs to Fully Assess Its Non-clinical Suicide Prevention Efforts and Address Any Impediments to Effectiveness

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Why GAO Did This Study

Suicide is a public health problem facing all populations, including the military. From 2014 to 2019, the rate of suicide increased from 20.4 to 25.9 per 100,000 active component servicemembers. Over the past decade, DOD has taken steps to address the growing rate of suicide in the military through efforts aimed at prevention.

The National Defense Authorization Act for Fiscal Year 2020 included a provision for GAO to review DOD's suicide prevention programs. This report examines DOD's suicide prevention efforts, including, among other objectives, (1) the extent to which non-clinical efforts are assessed for being evidence based and effective and (2) any impediments that hamper the effectiveness of these efforts.

GAO examined suicide prevention policies, reports, and assessments and interviewed officials from DOD, the military services, and the Reserve components. GAO also interviewed officials at four installations and a National Guard site selected for variety in military service, location, and size.

What GAO Recommends

GAO recommends that (1) DSPO and the military services develop a process to ensure that individual non-clinical suicide prevention efforts are assessed for effectiveness, (2) DSPO and the military services work together to develop and use consistent suicide-related definitions, and (3) DOD improve collaboration on its annual suicide reports to reduce duplication of effort. DOD concurred with all of GAO's recommendations and identified actions it will take to implement them.

View GAO-21-300. For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

What GAO Found

The Department of Defense (DOD) has a variety of suicide prevention efforts that are implemented by the military services (Army, Navy, Air Force, and Marine Corps). These include clinical prevention efforts that are generally focused on individual patient treatment and interventions, as well as non-clinical efforts that are intended to reduce the risk of suicide in the military population. This includes, for example, training servicemembers to recognize warning signs for suicide and encouraging the safe storage of items such as firearms and medications.

Officials with DOD's Defense Suicide Prevention Office (DSPO) told GAO that most ongoing non-clinical efforts are evidence based. Officials added that a suicide prevention effort is considered to be evidence based if it has been assessed for effectiveness in addressing the risk of suicide in the military population, which has unique risk factors such as a higher likelihood of experiencing or seeing trauma. These officials stated that newer efforts are generally considered to be "evidence informed," which means that they have demonstrated effectiveness in the civilian population, but are still being assessed in the military population.

DSPO officials further explained that assessments of individual prevention efforts can be challenging because suicide is a complex outcome resulting from many interacting factors. In 2020, DSPO published a framework for assessing the collective effect of the department's suicide prevention efforts by measuring outcomes linked to specific prevention strategies, such as creating protective environments. However, this framework does not provide DOD with information on the effectiveness of individual non-clinical prevention efforts. Having a process to assess individual efforts would help DOD and the military services ensure that their non-clinical prevention efforts effectively reduce the risk of suicide and suicide-related behaviors.

GAO also identified impediments that hamper the effectiveness of DOD's suicide prevention efforts, including those related to the reporting of suicide data.

- **Definitions.** The military services use different definitions for key suicide-related terms, such as suicide attempt, which may result in inconsistent classification and reporting of data. These data are used to develop the department's annual suicide event report. DOD officials stated that this could negatively affect the reliability and validity of the reported data, which may impede the department's understanding of the effectiveness of its suicide prevention efforts and limit its ability to identify and address any shortcomings.
- **Annual suicide reports.** DOD publishes two yearly suicide reports through two different offices that are based on some of the same data and provide some of the same information, resulting in the inefficient use of staff. While these reports serve different purposes, improved collaboration between the two offices could help minimize duplication of effort and improve efficiency, potentially freeing resources for other suicide prevention activities.

Contents

Letter		1
Background		6
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		11
Mental Health Care Access Issues and Inconsistent Data Definitions and Reporting May Hamper the Effectiveness of the Department's Suicide Prevention Efforts		14
Limited Access to Military Resources and Difficulties Collecting Data May Additionally Hamper Suicide Prevention Efforts for Reserve Components		22
Conclusions		24
Agency Comments		24
Appendix I	Examples of Non-clinical Suicide Prevention Efforts in the Department of Defense	26
Appendix II	Comments from the Department of Defense	29
Appendix III	GAO Contact and Staff Acknowledgments	31
Tables		
Table 1: Examples of Centers for Disease Control (CDC) Suicide Prevention Strategies and Associated Department of Defense (DOD) Prevention Efforts, Proximal Outcomes, and Baseline Metrics		13
Table 2: Department of Defense (DOD) and Military Service-Specific Definitions for Suicide Attempt		18
Table 3: Defense Suicide Prevention Office's List of Non-clinical Suicide Prevention Efforts across the Department of Defense (DOD) and Military Services		26
Figures		
Figure 1: Offices within the Department of Defense (DOD) Involved with Suicide Prevention Efforts		7
Figure 2: National Guard Organizational Structure		9

Abbreviations

CDC	Centers for Disease Control and Prevention
DHA	Defense Health Agency
DOD	Department of Defense
DODSER	Department of Defense Suicide Event Report
DSPO	Defense Suicide Prevention Office
NDAA	National Defense Authorization Act

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U.S. GOVERNMENT ACCOUNTABILITY OFFICE
A Century of Non-Partisan Fact-Based Work

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April 26, 2021

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

Suicide is a public health problem facing all populations, including the military, which comprises active component servicemembers in each of the military services (Army, Navy, Air Force, and Marine Corps), and members of the Reserve components (National Guard and Reserves).¹ Suicide has been a growing concern for the Department of Defense (DOD). In its 2019 Annual Suicide Report, the department stated that the suicide rate for active component servicemembers continued to increase over the past 5 years, reaching 25.9 per 100,000 in 2019.² The report also noted that military suicide rates for both active component

¹The National Guard includes the Army National Guard and the Air National Guard. The Reserves include the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air Force Reserve, and the Coast Guard Reserve. However, because our review is focused on the Department of Defense, we did not include the Coast Guard Reserve, which is part of the Department of Homeland Security.

²Department of Defense, Under Secretary of Defense for Personnel and Readiness, *Annual Suicide Report: Calendar Year 2019* (October 1, 2020). Between 2014 and 2019, the suicide rate for active component servicemembers increased by 27 percent, 20.4 to 25.9 per 100,000.

servicemembers and the National Guard were comparable with that of the U.S. adult population.³

DOD has taken steps to address the growing rate of suicide in the military. Specifically, in 2011, DOD established the Defense Suicide Prevention Office (DSPO) to develop and oversee standardized policies, procedures, and surveillance activities for the department's suicide prevention efforts aimed at reducing the risk of suicide in the military population.⁴ As part of its duties, DSPO has developed the *Defense Strategy for Suicide Prevention*, as well as policies that, for example, establish department-wide responsibilities for suicide prevention and outline the process for reporting suicides and suicide attempts.⁵ In addition, the military services, including their respective Reserve components, have developed and implemented their own service-specific suicide prevention efforts.⁶

The department's suicide prevention efforts are guided by the *Defense Strategy for Suicide Prevention*, which establishes a public health approach for suicide prevention.⁷ This approach encompasses both clinical and non-clinical suicide prevention efforts. Clinical efforts include activities such as screening patients for depression and suicide, medical treatment (e.g., medication and cognitive behavior therapy), and other types of interventions involving health care providers. Non-clinical efforts include programs that train servicemembers to recognize warning signs

³Specifically, after accounting for age and sex differences between the military and civilian populations, the 2019 active component and National Guard rates were comparable to the 2018—the most recent year for which U.S. population suicide data were available for DOD to analyze—suicide rate for the U.S. population, ages 17–59, which was 18.4 deaths per 100,000 individuals. The Reserve rate was determined to be lower at 18.2 deaths per 100,000 members.

⁴DSPO was established in response to a recommendation from the DOD Task Force on the Prevention of Suicide by Members of the Armed Forces to create a suicide prevention policy division.

⁵Department of Defense, *Defense Suicide Prevention Program*, DOD Instruction 6490.16 (Sept. 11, 2020).

⁶These prevention efforts must comply with DOD's policy requirements, though DSPO officials noted the military services are afforded flexibility in implementing service-specific prevention activities to meet their unique needs.

⁷Department of Defense, Under Secretary of Defense for Personnel and Readiness, *Department of Defense Strategy for Suicide Prevention* (Washington, D.C.: Dec. 29, 2015).

for suicide and assist at-risk servicemembers, as well as programs that encourage servicemembers to safely store items such as firearms and medications.

The National Defense Authorization Act (NDAA) for Fiscal Year 2020 included a provision for us to describe the suicide prevention efforts and activities of DOD and the military services, including the Reserve components.⁸ In response, we reviewed the department's suicide prevention efforts, focusing mainly on non-clinical suicide prevention efforts that are intended to reduce the risk of suicide in the military population versus clinical efforts that are generally focused on individual patient treatment and intervention.⁹

Specifically, we examined

1. the extent to which the department's non-clinical efforts are assessed for being evidence based and effective,
2. any impediments that may hamper the effectiveness of the department's efforts, and
3. any additional impediments that may hamper the effectiveness of the department's efforts for members of the Reserve components.

To examine the extent to which the department's non-clinical suicide prevention efforts are assessed for being evidence based and effective, we reviewed relevant DOD and military service-specific suicide prevention policies, as well as the department's suicide prevention strategic plan.¹⁰ To identify these efforts, their evidence base, and any associated assessments, we interviewed officials with DSPO, the Office of Force Resiliency, the Office of the Assistant Secretary of Defense for Health Affairs, the Defense Health Agency (DHA), the Military Operational Medicine Research Program, the DOD Education Activity, Military Community and Family Policy, the U.S. Army Chaplains, and suicide prevention officials with the military services and Reserve components. Our interviews also included officials who participate in two committees that oversee department-wide suicide prevention—the Suicide Prevention

⁸Pub. L. No. 116-92, Div. A, tit. VII, § 741(b), 133 Stat. 1198, 1468 (2019).

⁹For the purposes of this report, we will refer to the collective suicide prevention efforts of DOD and the military services, including the Reserve components, as the department's suicide prevention efforts.

¹⁰Department of Defense, *Department of Defense Strategy for Suicide Prevention*.

General Officer Steering Committee and the Suicide Prevention and Risk Reduction Committee. We reviewed documentation both at the department level and across the military services that included descriptions of the evidence basis for some prevention efforts. We also reviewed assessments of prevention efforts conducted by DSPO and the military services. Additionally, we reviewed DOD's enterprise-wide evaluation framework, as outlined in its 2019 Annual Suicide Report.¹¹ We relied on federal standards for internal control to determine whether DOD assessed its individual non-clinical suicide prevention efforts for effectiveness in the military population.¹²

To examine any impediments that may hamper the effectiveness of the department's suicide prevention efforts, we reviewed relevant documentation, including prior reports by GAO, DOD's Inspector General, RAND, and the Institute for Defense Analyses.¹³ We also reviewed internal reports developed by the military services and the U.S. Special Operations Command. In addition, we analyzed and compared definitions of suicide related terms across department-wide and military service-specific suicide prevention policies for consistency. Furthermore, we evaluated DOD's two yearly suicide reports—the DOD Suicide Event Report (DODSER) Annual Report and the Annual Suicide Report—and we interviewed officials with DSPO and the Psychological Health Center of Excellence who are involved with the creation of these reports.¹⁴ We

¹¹Department of Defense, *Annual Suicide Report: Calendar Year 2019*.

¹²GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: Sept. 10, 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. We determined the monitoring component was significant to this objective, including the principle that management should perform monitoring activities.

¹³GAO, *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); Department of Defense, Office of the Inspector General, *Department of Defense Suicide Event Report (DoDSER) Data Quality Assessment*, DODIG-2015-016 (Alexandria, Va.: Nov. 14, 2014); Department of Defense, Office of the Inspector General, *Assessment of DOD Suicide Prevention Policies*, DODIG-2015-182 (Alexandria, Va.: Sept. 30, 2015); Rajeev Ramchand et al., *The War Within: Preventing Suicide in the U.S. Military* (Santa Monica, Calif.: RAND Corporation, 2011); Institute for Defense Analyses, *Strengthening the Contributions of the Defense Suicide Prevention Office to DOD's Suicide Prevention Efforts*, Institute for Defense Analyses Paper P-8248 (Alexandria, Va.: November 2016).

¹⁴For example, see Department of Defense, Psychological Health Center of Excellence, *Department of Defense Suicide Events Report, Calendar Year 2018 Annual Report* (July 19, 2019); and Department of Defense, *Annual Suicide Report: Calendar Year 2019*.

examined clinical and non-clinical aspects of suicide prevention to identify any impediments, which included interviews with clinical and public health officials from each of the military services to obtain their perspective on impediments to the department's suicide prevention efforts. We also interviewed officials with the DOD Inspector General and RAND about their prior reports and the impediments they identified.

To identify impediments at the local level, we conducted interviews with suicide prevention officials from a non-generalizable sample of four military installations: U.S. Army Fort Riley (Kansas), Norfolk Navy Base (Virginia), McGuire Air Force Base (New Jersey), and Marine Corps Air Ground Combat Center Twentynine Palms (California). We selected one installation from each of the military services with a range in population size and geographic diversity. To assess the reporting of suicide data, we relied on federal internal control standards for information and communication, including the principle that management should use quality information.¹⁵ To assess DOD's two yearly suicide reports, we relied on criteria we developed for overlap and duplication.¹⁶

To examine any additional impediments that may hamper the effectiveness of the department's suicide prevention efforts for members of the Reserve components, we reviewed relevant policies and guidance specific to these components. We also reviewed documentation describing suicide prevention programs available to members of the National Guard and Reserves, as well as guidance and policy related to members' eligibility for DOD's TRICARE health benefit program.¹⁷ We examined both clinical and non-clinical aspects of suicide prevention in order to identify any additional impediments. In addition, we interviewed officials from the National Guard Bureau headquarters about specific challenges facing National Guard suicide prevention efforts. We also spoke with officials from the Army Reserve, Navy Reserve, Air Force Reserve, and Marine Corps Reserve about their suicide prevention efforts and any specific impediments to these efforts. Additionally, we

¹⁵GAO-14-704G.

¹⁶GAO, *Fragmentation, Overlap, and Duplication: An Evaluation and Management Guide*, GAO-15-49SP (Washington, D.C.: Apr. 14, 2015).

¹⁷Under DOD's TRICARE program, eligible beneficiaries can obtain health care, including mental health care services, through the department's direct care system of military hospitals and clinics, referred to as military treatment facilities, or through its private sector care system of civilian providers.

interviewed officials with the National Guard's North Las Vegas Readiness Center (Nevada).¹⁸

We conducted this performance audit from March 2020 to April 2021 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

To help servicemembers at risk for suicide, DOD and the military services provide a variety of clinical and non-clinical efforts intended to reduce the risk of suicide. Clinical efforts include, for example, depression and suicide-specific screening in primary care and during annual periodic health assessments.¹⁹ 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 help-seeking; 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. (See appendix I for a list of DOD's non-clinical suicide prevention efforts.)

Within DOD, multiple offices are involved in the department's suicide prevention efforts, including the reporting and surveillance of suicide data (see fig. 1.):

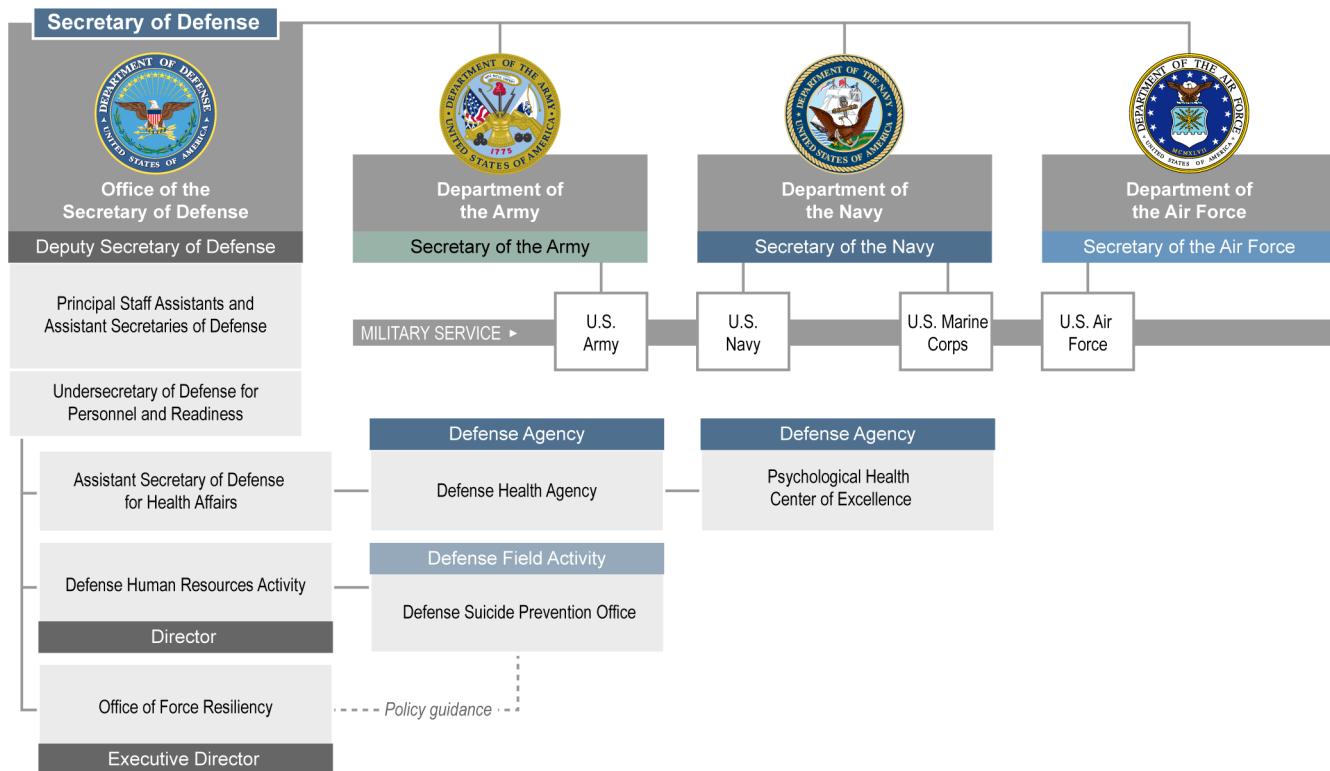
- DSPO performs a range of policy and operational functions, including leading, guiding, and overseeing the department's non-clinical suicide prevention efforts.

¹⁸We selected this facility for geographic diversity, along with the four military installations, but we could not consider population size in its selection because it is not an installation where people are stationed. Additionally, in selecting a National Guard site, we took into consideration where the National Guard has its suicide prevention staff located.

¹⁹DOD and the Department of Veterans Affairs developed joint clinical practice guidelines for the assessment and management of patients at risk for suicide. Department of Defense and Department of Veterans Affairs, *Assessment and Management of Patients at Risk for Suicide* (2019).

- Each of the military services develops and implements its own service-specific suicide prevention efforts that incorporate department-wide suicide prevention policy and requirements.
- The Psychological Health Center of Excellence provides surveillance using suicide-related data reported by the military services and the Armed Forces Medical Examiner System to track deaths by suicide, suicide attempts and, for some services, suicide ideations.²⁰

Figure 1: Offices within the Department of Defense (DOD) Involved with Suicide Prevention Efforts



Source: GAO analysis of DOD organizational charts. | GAO-21-300

Note: These offices represent the key DOD offices involved in the department's clinical and non-clinical suicide prevention efforts.

²⁰The 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.

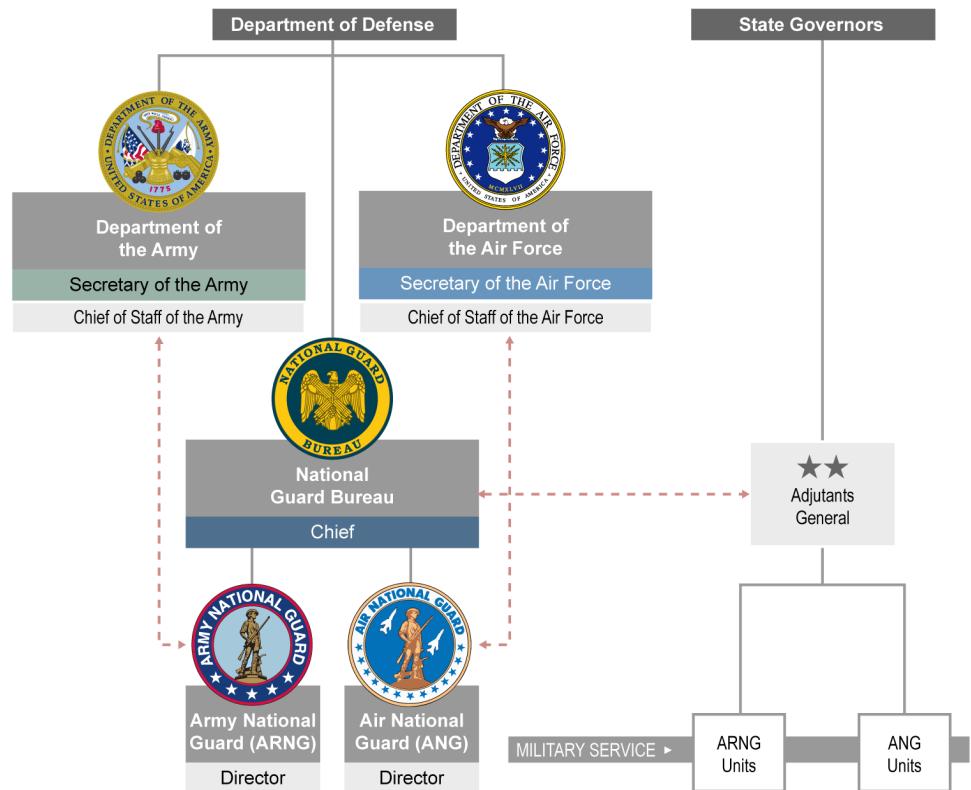
The department also has governance structures for formal collaboration for suicide prevention among clinical and non-clinical officials at the department and military service levels through the Suicide Prevention General Officer Steering Committee, which includes senior executive leaders and general officers, and the Suicide Prevention and Risk Reduction Committee, a complimentary action-officer level committee.²¹

The military services provide suicide prevention resources to members of the Reserve components, including the National Guard (Army and Air National Guard) and the Army, Navy, Air Force, and Marine Corps Reserves. While the Army, Navy, Air Force, and Marine Corps Reserves are governed by and receive resources from their respective military service's suicide prevention efforts, the National Guard units are managed in part by their respective state's Adjutant General and governor.²² As a result, governors have discretion in making policy decisions on suicide prevention, which distinguishes the National Guard from the other military services. (See fig. 2.)

²¹The Suicide Prevention General Officer Steering Committee leads the department's suicide prevention efforts. Its members include the Director of DSPO, a brigadier general in the Air Force, and a rear admiral in the Navy. 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 a research psychologist with the Psychological Health Center of Excellence, a captain in the National Guard, and a major in the Air Force.

²²An Adjutant General is appointed by the governor of each state; the duties of the Adjutant General are laid out in each state's statutes. The Adjutant General is typically the senior officer of the National Guard unit of the state. For the District of Columbia, this officer is referred to as the Commanding General.

Figure 2: National Guard Organizational Structure



Source: U.S. Army National Guard. | GAO-21-300

TRICARE

Under DOD's TRICARE program, eligible beneficiaries can obtain health care, including mental health care, through the department's direct care system of military hospitals and clinics, referred to as military treatment facilities, or through its private sector care system of civilian providers. Eligible TRICARE beneficiaries generally include active duty servicemembers and their dependents, as well as retirees and their dependents or survivors.²³ Members of the Reserve component are eligible for TRICARE Reserve Select, a premium-based benefit, as long

²³Active duty personnel include members of the Army, Navy, Air Force, and Marine Corps Reserves on active duty for more than 30 days. When these members serve on active duty for more than 30 consecutive days, they are eligible for the same health benefits as active component servicemembers. National Guard personnel health eligibility is based on their military status as defined in Title 10 of the United States Code.

as they meet certain requirements such as not being on active-duty orders.²⁴

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 the 2012 National Strategy created by the Department of Health and Human Services' Office of the Surgeon General as an interim strategy.²⁵ The 2012 National Strategy identified four strategic directions for suicide prevention: (1) healthy and empowered individuals, families, and communities, (2) clinical and community preventive services, (3) treatment and support services, and (4) surveillance, research, and evaluation.²⁶
- **Defense Strategy for Suicide Prevention.** In December 2015, DOD published the *Defense Strategy for Suicide Prevention*, which used the framework laid out in the 2012 National Strategy for Suicide Prevention.²⁷ It is the department's most current suicide prevention strategy as of December 2020.
- **Centers for Disease Control and Prevention's (CDC) seven strategies for suicide prevention.** With the publication of a new integrated violence prevention policy in September 2020, DOD required suicide prevention policies and efforts to incorporate CDC's seven strategies for suicide prevention.²⁸ These strategies are: (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)

²⁴To be eligible for TRICARE, members of the Reserves also must not be covered by the Transitional Assistance Management Program, which allows servicemembers to receive 180 days of premium free health care after their active duty health care ends. Additionally, they must not be eligible for or enrolled in the Federal Employees Health Benefit Program, which provides insurance to eligible federal employees.

²⁵Office 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).

²⁶The 2012 National Strategy also identified 13 goals and 60 objectives for suicide prevention in support of the four strategic directions.

²⁷Department of Defense, *Department of Defense Strategy for Suicide Prevention*.

²⁸Centers for Disease Control and Prevention, *Preventing Suicide: A Technical Package of Policies, Programs, and Practices* (Atlanta, Ga.: 2017).

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

identify and support people at risk, and (7) lessen harms and prevent future risk.²⁹

According to DSPO officials, most of the department's non-clinical suicide prevention efforts are evidence based. These officials explained that to be considered evidence based, a suicide prevention effort must be assessed for effectiveness in addressing the risk of suicide in the military population. They added that the effectiveness of suicide prevention efforts may be different for servicemembers than for civilians because servicemembers have different risk factors, including frequent moves, occupational specialties with higher likelihood of experiencing or seeing trauma, as well as exposure to actual combat.³⁰

While DSPO officials have not formally determined the evidence base for each of the non-clinical prevention efforts at the department and military service levels, they stated that most of the non-clinical efforts for which they have oversight are evidence based.³¹ The remaining non-clinical prevention efforts are considered to be "evidence informed." This means that they have demonstrated effectiveness in the civilian population but have not been assessed for effectiveness in the military population. DSPO officials explained that most of the ongoing non-clinical prevention efforts are generally evidence based, while the newer efforts and pilot programs are generally considered evidence informed, as they are still being assessed in the military population.

DOD has developed a framework for assessing the combined effect of such prevention efforts on suicide and suicidal behaviors. According to DSPO officials, assessments of individual prevention efforts can be challenging because suicide is a relatively rare and complex outcome that

²⁹Department of Defense, *DOD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm*, DOD Instruction 6400.09 (Sept. 11, 2020).

According to DSPO officials, the department's suicide prevention strategy also aligns with these seven strategies.

³⁰Occupational specialties with a higher likelihood of experiencing or seeing trauma include infantryman, medics, and individuals responsible for removing battlefield explosive ordinances, according to DSPO officials.

³¹A DSPO official stated that this estimate does not include data dashboards/analyses, workbooks/guides, or roles (e.g., counseling services). They added that this also does not include unique non-clinical suicide prevention efforts at the military service installation level.

is the result of many interacting factors.³² These officials explained that isolating the effect of a single specific suicide prevention effort may be difficult, and noted that a single prevention effort alone is not likely to impact suicide rates. As a result, DSPO officials discussed the importance of measuring multiple suicide prevention efforts and outcomes simultaneously, and they reported taking steps to ensure that this approach to program evaluation is an integral part of their suicide prevention efforts.

Specifically, in its 2019 Annual Suicide Report, DOD outlined a department-wide framework that is organized in accordance with CDC's seven evidence-informed strategies for suicide prevention. For each CDC strategy, the department identified corresponding prevention efforts, proximal (short-term) and distal (long-term) outcomes related to those efforts, and baseline metrics intended to measure the outcomes.³³ This allows the department to assess the combined effect of its prevention efforts, including non-clinical efforts, on suicide and suicidal behaviors.³⁴ (See table 1.)

³²We refer to specific suicide prevention efforts occurring at the DOD or service-level as individual prevention efforts. For examples of individual prevention efforts, see appendix I.

³³The evaluation framework is consistent with a larger movement in the federal government, as agencies work to implement the Foundations for Evidence-Based Policymaking Act of 2018. See Pub. L. No. 115-435, 132 Stat. 5529 (2019). According to OMB guidance, this act emphasizes collaboration and coordination to advance data and evidence-building functions in the Federal Government by statutorily mandating federal evidence-building activities, open government data, and confidential information protection and statistical efficiency. See Office of Management and Budget, *Phase 1 Implementation of the Foundations for Evidence-Based Policymaking Act of 2018: Learning Agendas, Personnel, and Planning Guidance*, OMB Memorandum M-19-23 (Washington, D.C.: July 10, 2019).

³⁴These efforts also include some initiatives that are not specific to suicide prevention but may help reduce the risk of suicide, such as financial counseling.

Table 1: Examples of Centers for Disease Control (CDC) Suicide Prevention Strategies and Associated Department of Defense (DOD) Prevention Efforts, Proximal Outcomes, and Baseline Metrics

Selected CDC evidence-informed strategy	Examples of DOD prevention efforts	Proximal outcomes	Examples of DOD baseline metrics
Creating protective environments	<ul style="list-style-type: none"> • Counseling on access to lethal means training pilot • Social norms for safe firearm storage initiative • Lethal means safety video 	<ul style="list-style-type: none"> • Reduced lethality of suicidal behavior • Increased safe storage practices 	60 percent of active component servicemembers and 80 percent of Reserve component members who died by suicide used firearms as the method of death by suicide
Identifying and supporting people at risk	<ul style="list-style-type: none"> • Servicemember gatekeeper and leadership interventions • Social media training pilot • Cognitive behavior strategies for the prevention of suicide training pilot • National Guard Bureau suicide prevention and readiness initiative for the National Guard 	<ul style="list-style-type: none"> • Increased knowledge to identify and respond to at-risk individuals • Improved access to resources and care 	78 percent of all active-component servicemembers indicated suicide prevention training was at least somewhat helpful in helping them identify and respond to suicidal behavior in others
Promoting connectedness	<ul style="list-style-type: none"> • Peer-to-peer support through Military OneSource • Non-clinical counseling 	<ul style="list-style-type: none"> • Increased feeling of connectedness • Increased unit cohesion • Increased morale 	69 percent of all active-component servicemembers and 77 percent of Reserve component members reported a high sense of connectedness with others

Source: DOD. | GAO-21-300

Notes: In addition to measuring proximal outcomes, DOD also measures distal outcomes across prevention efforts. Distal outcomes are longer-term outcomes related to suicide prevention efforts—for example a reduction in rates of suicide and suicide-related behaviors.

However, these DOD baseline metrics do not provide DOD with information on the extent to which individual non-clinical prevention efforts are effective in the military population. Instead, they provide overall outcomes related to each of the seven strategies. Federal standards for internal controls for monitoring require agencies to assess the quality of their performance by evaluating the results of their activities.³⁵ Agencies can then use these assessments to determine the effectiveness of their efforts and identify the need for any corrective actions. This could include assessing the effectiveness of individual suicide prevention efforts.

DSPO officials acknowledged the value of assessing individual non-clinical suicide prevention efforts. These officials told us they are

³⁵ GAO-14-704G.

systematically evaluating all new DOD-wide prevention efforts that are being piloted. In addition, they have conducted, on an ad hoc basis, their own assessments of existing efforts in recent years.³⁶ According to DSPO officials, they are currently prioritizing evaluations of newer piloted efforts and broader, collective evaluations through their framework. Officials explained that they have not developed a process for conducting assessments of the department's individual non-clinical prevention efforts that have not been studied for effectiveness in the military population. Such a process would better position DOD and the military services to conduct assessments of individual non-clinical prevention efforts to determine whether they are effective at reducing the risk of suicide or suicide-related behaviors in the military population.

Mental Health Care Access Issues and Inconsistent Data Definitions and Reporting May Hamper the Effectiveness of the Department's Suicide Prevention Efforts

³⁶In 2019, for example, DSPO and the Office of Military Community and Family Policy evaluated a pilot training military family-life counselors and Military OneSource—a 24/7 connection for military families to information, answers, and support—counselors on how to counsel servicemembers in order to increase awareness of risk factors for suicide, safe storage of lethal means (i.e., firearms and medications), and how to intervene in a crisis. The evaluation included tests for the participants before and after receiving the training, as well as obtaining feedback from participants to better understand their perceptions of the training content. The evaluation found that over 90 percent of counselors who completed the pre- and post-training test experienced increased knowledge and counseling skills. A DSPO official noted that the evaluation also included follow-up surveys with counselors to determine ongoing effects of the training.

Perceived Stigma and Limited Staffing May Impede Servicemembers' Access to Mental Health Care Resources

Perceived Stigma

According to DOD and military officials, the perceived stigma surrounding mental health care and various challenges with clinical staffing may impede servicemembers from accessing the help that they need to reduce the risk of suicide.

DOD and military service officials identified the perceived stigma surrounding mental health care as a continued impediment to suicide prevention. Specifically, this stigma may discourage servicemembers from seeking help for themselves or for their colleagues, including help from mental health providers as well as from chaplains, Military OneSource counselors, military and family life counselors and other non-clinical supports. Along with RAND and the department, we have previously reported that perceived stigma creates an impediment to servicemembers seeking mental health care, a key component of the department's suicide prevention efforts. For example,

- **GAO.** In 2016, we reported that a DOD-wide survey found that about 37 percent of active duty servicemembers and 39 percent of reservists surveyed during 2010 and 2011 thought seeking mental health care through the military would probably or definitely damage a person's career.³⁷ Specific concerns included the fear of losing a security clearance or the ability to carry a weapon and living up to the competitive military image.
- **RAND.** A 2014 RAND report identified servicemembers' concerns that seeking mental health care may affect their careers, their ability to obtain and maintain a security clearance, their colleagues' perception of them, as well as servicemembers' perception of themselves, among other factors.³⁸
- **Army.** In 2019, the Army conducted an internal epidemiological study in response to a cluster of suicides at a military installation and found that addressing concerns related to perceived stigma in seeking mental health care was important to inform risk mitigation and health promotion strategies.

³⁷[GAO-16-404](#).

³⁸Joie D. Acosta et al., *Mental Health Stigma in the Military* (Santa Monica, Calif.: RAND Corporation, 2014).

-
- **Special Operations Command.** An internal 2017 Special Operations Command report found that the attitude within the Special Operations Forces towards suicidal individuals was a barrier to seeking help.³⁹ Special Operations officials told us that reporting a suicidal ideation is likely to keep a servicemember off a special operations team for an extended period. Officials also noted that some servicemembers do return to their team following behavioral treatment, but there is a widely held perception that reporting suicidal ideation will derail a special operations career.
 - **DOD.** In its 2019 Annual Suicide Report, DOD reported that active component servicemembers cited several reasons for not seeking help, including loss of privacy, fear of negative perception by chain of command or peers, and perceived negative effect to their career.⁴⁰ The report describes a number of suicide prevention efforts, including a new training pilot program called Resources Exist, Asking Can Help. This pilot program is designed to encourage servicemembers to seek help before life challenges become overwhelming by addressing sources of stigma and recognizing that seeking help equates to inner strength.

Staffing Challenges

Military service officials provided a number of examples related to shortages of mental health staff that affect servicemembers' ability to obtain needed assistance. These shortages may reflect in part, those seen nationally. According to the Department of Health and Human Services' Health Resources and Services Administration, the nation faces a current shortage in the mental health workforce.⁴¹

The following examples were provided:

- Officials with one medical command told us that they have concerns about the level of mental health care staffing needed to meet the increasing demand for mental health care due to a shortage of mental health care staff. According to these officials, even as new providers are recruited, they are concerned that there are not enough active

³⁹Special Operations Command employs special operations forces from the Army, Navy, Air Force, and Marine Corps to conduct global special operations and activities.

⁴⁰Department of Defense, *Annual Suicide Report: Calendar Year 2019*.

⁴¹U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, *Designated Health Professional Shortage Area Statistics* (Dec. 31, 2020).

duty and DOD civilian mental health care providers to meet the growing demand for mental health services.

- Officials at one of the military installations included in our review noted the difficulty of maintaining staffing levels for mental health providers. Specifically, these officials told us that the inability to maintain staffing levels for mental health providers makes it challenging for servicemembers to see mental health staff in a timely manner. The officials further told us that, due to duty station transfers and retirements, their mental health provider staffing level would soon be reduced by 50 percent. As a result, these officials found it difficult to manage their walk-in service for behavioral health patients, specifically same-day patients seeking mental health care due to emotional distress.

Although officials we spoke with identified examples of staffing difficulties, in its 2020 report to Congress, DOD reported that its preliminary analysis showed it was meeting its patient access standards for servicemembers seeking mental health treatment.⁴² DOD also reported that DHA is working with the military services to improve its recruitment and retention strategies for mental health providers. Specifically, these efforts include steps for enhancing processes related to monitoring supply and demand and forecasting critical losses or vacancies to inform recruitment and retention strategies. DHA has also established a recruiting team to direct efforts for recruiting critical or mental health positions that are hard to fill.

Impediments Related to Data Definitions and Reporting of Suicide Data Potentially Hamper the Department's Prevention Efforts

The use of inconsistent definitions for suicide-related terms and the publication of two annual suicide event reports based on some of the same data impedes the department's consistency and efficiency when reporting its suicide data, potentially hampering suicide prevention efforts.

⁴²Department of Defense, *Report to the Committees on Armed Services of the Senate and the House of Representatives: Section 720 of the National Defense Authorization Act for Fiscal Year 2020 (Public Law 116-92) Strategy to Recruit and Retain Mental Health Providers* (November 2020).

DOD's access standards as of the time of its November 2020 report were 1 day or less for urgent/acute care; 7 days or less for routine care; 28 days or less for an initial specialty appointment; and 28 days or less for wellness or preventative care.

Inconsistent Definitions of Key Suicide-Related Terms	<p>We found that the department does not require the use of standard definitions for suicide-related terms, potentially leading to inconsistent data reporting across the military services. DOD requires that the military services centrally report suicide-related incidents. These data are used to develop the DODSER Annual Report. The data are also used to conduct surveillance on suicide and related behaviors, which can help the department develop more targeted prevention efforts.</p> <p>DOD's department-wide policy on suicide prevention includes definitions for suicide-related terms, including suicide, suicide attempt, and suicidal ideation.⁴³ However, we found that the military services' definitions of key suicide-related terms, such as suicide attempt, may differ.⁴⁴ According to DSPO officials, each military service has some flexibility to tailor its suicide prevention policies and programs to meet their unique organizational needs. These officials also noted that the varying definitions are a result of previous DOD policies that did not require service-level adoption of DOD definitions. (See table 2.)</p>
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Table 2: Department of Defense (DOD) and Military Service-Specific Definitions for Suicide Attempt

Entity	Suicide attempt definition
DOD	A non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior.
Army	A self-inflicted potentially injurious behavior with a nonfatal outcome for which there is evidence (either explicit or implicit) of intent to die. A suicide attempt may or may not result in injury. Therefore, this category includes behaviors where there is evidence that the individual intended to die, but the event resulted in no injuries.
Navy	A self-inflicted potentially injurious behavior with a non-fatal outcome for which there is evidence (either explicit or implicit) of intent to die. A suicide attempt may or may not result in injury.
Air Force	Any nonfatal, self-directed, potentially injurious behavior accompanied by evidence of intent to die which as a result of the behavior, results in medical care/treatment (including mental health care) or evacuation from the Area of Responsibility. A suicide attempt may or may not result in injury. ^a
Marine Corps	A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

Source: Departments of Defense, Army, Navy, and Air Force. | GAO-21-300

^aDOD defines area of responsibility as the geographical area associated with a combatant command within which a geographic combatant commander has authority to plan and conduct operations.

Inconsistencies with suicide-related definitions may result in differences across the military services with the classification and reporting of suicidal

⁴³Department of Defense, *Defense Suicide Prevention Program*.

⁴⁴The military services' definitions for suicidal ideation also differ from the definition in DOD's policy.

behaviors. For example, the Air Force has a more limited definition for suicide attempt than the other military services classifying an incident as a suicide attempt only if it results in medical care or evacuation from an area of responsibility.⁴⁵ This limited definition potentially may result in the under-reporting of suicidal behaviors for the Air Force as compared to the other military services.

Officials with the Psychological Health Center of Excellence stated that variability in definitions could negatively affect the reliability and validity of findings that are being published in the department's suicide report. Federal standards for internal control direct agencies to use information that is appropriate, current, complete, and accurate.⁴⁶ This could include the use of standard definitions for suicide-related terms.

DSPO officials told us that there are plans to submit a set of standard definitions for suicide-related terms to the DOD Dictionary of Military and Associated Terms and to require the military services to adopt those terms to ensure consistency across the department. DSPO officials noted that having consistent definitions was a general best practice and would also ensure that suicide-related data, such as data on suicide attempts and suicidal ideation, are collected and reported consistently by the military services. However, as of December 2020, there was no officially approved timeline for issuing these definitions and establishing a requirement to use them, according to DSPO officials. Until standard definitions for suicide-related terms are established, any inconsistencies in the data being reported are likely to affect the ability of DOD to use the data to assess the effectiveness of its suicide prevention efforts, as well as its ability to identify and address any shortcomings.

Duplicative Suicide Reports

The department publishes two separate suicide reports each year, which result in inefficient use of staff that could potentially be used for other suicide prevention activities.

The two annual reports on suicide published by the department are the following:

⁴⁵DOD defines area of responsibility as the geographical area associated with a combatant command within which a geographic combatant commander has authority to plan and conduct operations.

⁴⁶GAO-14-704G.

-
- **DOD Suicide Event Report (DODSER) Annual Report.** This report, which has been produced since 2008, provides detailed surveillance on suicide-related behaviors, including data on suicide rates among servicemembers that are adjusted for comparison with the civilian population. Currently, the Psychological Health Center of Excellence is responsible for producing this report. The most recent report was released in April 2020 and reported on 2018 data.⁴⁷ The estimated cost to produce this report was approximately \$51,000.
 - **Annual Suicide Report.** This report, produced by DSPO since 2019, provides annual suicide counts and unadjusted suicide rates for servicemembers and their dependents as directed by the Undersecretary of Defense for Personnel and Readiness.⁴⁸ DSPO officials stated that the report is intended to provide a more timely release of official annual DOD suicide death counts and rates to the public than the DODSER Annual Report. The most recent Annual Suicide Report was issued in October 2020 and reports on 2019 data for servicemembers and 2018 data for military family members.⁴⁹ The

⁴⁷Psychological Health Center of Excellence officials told us that the delay between a reporting year's end and the publication of the annual DODSER Annual Report is generally around 18 months. For example, the DODSER Annual Report for 2018 was publicly released in April 2020, about 16 months from the end of 2018.

⁴⁸The Undersecretary of Defense for Personnel and Readiness issued a memorandum on October 30, 2018 that directed DSPO to publish an annual suicide report to serve as DOD's official source for unadjusted suicide rates and counts, among other requirements. The Carl Levin and Howard P. "Buck" McKeon National Defense Authorization Act for Fiscal Year 2015 (FY 2015 NDAA) required DOD to establish and implement a policy to collect, report, and assess any suicide or attempted suicide involving a member of the Armed Forces, including reserve components; and any death that is reported as a suicide involving a dependent of a member of the Armed Forces. Pub. L. No. 113–291, § 567, 128 Stat. 3292, 3385–86 (2014). The National Defense Authorization Act for Fiscal Year 2020 (FY 2020 NDAA) requires DOD to report on the number of suicides, attempted suicides, and known cases of suicidal ideation involving a member of the Armed Forces, including the reserve components, listed by Armed Force and any suicides involving a dependent of a member. Pub. L. No. 116–92, § 741, 133 Stat. 1198, 1467–68 (2019).

⁴⁹The 2018 data on military family members is aligned with the approximate 2-year lag in civilian suicide death reporting.

estimated cost to produce this report was approximately \$1.4 million.⁵⁰

Officials with the Psychological Health Center of Excellence told us that both reports are based on some of the same data and provide some of the same types of information. For example, according to the officials, the unadjusted rates of deaths by suicide presented in each report are nearly identical. However, officials also noted some differences between the reports. For instance, the DODSER Annual Report includes statistical tables detailing suicide counts by demographic information, health status, and mental health factors, among other information. It also includes data on suicide attempts. The Annual Suicide Report also presents the status of ongoing and future policy and programmatic efforts, as well as suicide data for military family members.

Producing two annual suicide reports that contain some of the same information results in an inefficient use of staffing resources. For example, officials with the Psychological Health Center of Excellence told us that DSPO tasked them with performing some of the data analysis, as well as with ensuring that reported data were consistent between the two reports since some data included in the Annual Suicide Report is taken from the DODSER Annual Report. These officials explained that the additional analysis significantly increased their workload, which included data analysis, writing, coordinating reviews through the chain of command, attending extra meetings with the Suicide Prevention General Officer Steering Committee, and coordinating the two reports with the military services. We have reported that effective collaboration can help reduce or better manage duplication of federal programs.⁵¹ DOD's two annual suicide reports—internally produced by two separate offices—have

⁵⁰According to DSPO officials, the total cost of the 2019 Annual Suicide Report included \$1,054,000 for contract support and \$352,000 in DOD labor. DSPO officials noted that the contract support fee represented a range of services related to the Annual Suicide Report, including data gathering and analysis, report drafting, and technical editing, among other tasks. DSPO officials noted that this estimate did not include the purchase of suicide-related data for military dependents—that cost was included in the cost estimate of the 2018 Annual Suicide Report, and represented \$542,000 of the \$1,127,000 contract support component of that report. DSPO officials noted that the tasks associated with the 2019 Annual Suicide Report were on a larger scale than the prior year's report to address the requirements in section 741 of the NDAA 2020.

⁵¹GAO-15-49SP.

elements of duplication.⁵² By improving internal collaboration on the production of the two annual reports, DOD can improve staff efficiency and minimize duplication in its efforts, potentially freeing resources for other suicide prevention activities.

Limited Access to Military Resources and Difficulties Collecting Data May Additionally Hamper Suicide Prevention Efforts for the Reserve Components

Members of the Reserve Component Have Limited Access to Military Suicide Prevention Resources Compared to Active Component Servicemembers

Members of the National Guard and Reserves typically spend most of their time as civilians and may not live near military installations where support services are provided. As a result, they do not always have access to suicide prevention efforts offered at military installations that are more readily available to active component servicemembers. For example, while an active component servicemember at risk for suicide could have their firearm removed and safely stored in an installation armory, Reserve component officials noted that it would be difficult for them to intervene, remove, and safely store a member's firearm if the individual was not located at an installation.⁵³ Additionally, because the National Guard is under the authority of the Adjutant General in each state, a National Guard member's access to suicide prevention efforts may depend on the state where they serve. As a result, National Guard

⁵²GAO-15-49SP. We define duplication as occurring when two or more agencies or programs are engaged in the same activities or provide the same services to the same beneficiaries and fragmentation as those circumstances in which more than one federal agency, or organization within an agency, is involved in the same broad area of national need, and opportunities exist to improve service delivery.

⁵³Officials from one reserve component explained that they had tried to develop memoranda of understanding with local police departments for safe firearms storage, but doing so would require additional steps and legal expertise that they did not have the resources to address.

officials noted that their suicide prevention programs are not always consistent across states.

Additional Challenges for Reserve Component Members

In addition to challenges in accessing health care, some Reserve component members may lack full-time employment or experience homelessness. These additional challenges are unique to the members of the National Guard and Reserves, as compared to active component servicemembers who are employed and have access to housing benefits. These challenges represent potential risk factors for death by suicide. For example, the Department of Veterans Affairs found that homelessness was associated with higher rates of suicide attempts among veterans, and unemployment may also be associated with suicide risk.

Source: GAO analysis of Department of Defense and Department of Veterans Affairs data. | GAO-21-300

Limited access to health insurance coverage offered through the military may also present challenges for Reserve component members who need mental health care. Unless ordered to active duty for longer than 30 days, members of the National Guard and Reserves do not automatically qualify for health care coverage through TRICARE, and those who do qualify may opt not to enroll or participate due to existing health insurance coverage, the cost of TRICARE premiums, or other reasons. Some Reserve component officials told us that information about members who receive mental health care while in civilian status is not available to them unless it is self-reported by a member. As a result, these officials may not have access to complete and accurate information on their members' mental health care issues, including suicide-related behaviors, which may make it more difficult to design and execute prevention efforts.

The Reserve Components Face Challenges Collecting Complete and Accurate Suicide-Related Data for Their Members

The Reserve components are responsible for collecting and reporting data on suicide and suicide attempts for their members. With Reserve component members spending most of their time in civilian status, Reserve component officials told us that they face challenges collecting complete and accurate data on suicides and suicide attempts. Reserve component officials told us they must rely on self-reporting from their members or from other avenues of communication, such as information from family members or friends. Consequently, the information received may be less complete and less accurate than for their active component counterparts. The reporting of this information may also be delayed. Officials with the Armed Forces Medical Examiner System told us that if a member of the National Guard or Reserves dies by suicide after their most recent drill and are not scheduled to report for another three months, it is difficult for officials to learn about the death in a timely manner.

Once alerted to an incident, Reserve component officials say they rely on local officials such as law enforcement and coroners for information on deaths by suicide. However, Reserve component and DOD officials also told us this information may be difficult to obtain. For example, a Reserve official noted that it can be challenging to get forensic investigative information from local law enforcement if the Reserve component member is not on active duty status at the time of their death. Armed

Forces Medical Examiner System officials also noted that in some cases local coroners refuse to provide information to them and explained that local jurisdictions are not required to do so.

Conclusions

DOD has responded to the growing rate of death by suicide among the military population with a variety of suicide prevention efforts, including those that are non-clinical. However, the department does not know the full extent to which its individual prevention efforts are effective for the military population. In addition, because the military services use different definitions for some key suicide-related terms, such as suicide attempt, they are likely reporting inconsistent suicide-related data. Furthermore, the reporting of these data in two annual suicide reports produced by two different offices results in an inefficient use of staff resources that could be better used for other suicide prevention activities. Developing a process to ensure individual non-clinical suicide prevention efforts are assessed for effectiveness, requiring the development and use of consistent suicide-related definitions, and enhancing collaboration on the production of annual suicide reports will better position the department in its efforts to prevent suicide among its members.

Recommendations for Executive Action

We are making the following three recommendations to DOD:

The Undersecretary of Defense for Personnel and Readiness should require DSPO to 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.
(Recommendation 1)

The Undersecretary of Defense for Personnel and Readiness should require DSPO to collaborate with the military services to develop consistent suicide-related definitions to be used department-wide and require them to be used in the updated DOD and military service policies.
(Recommendation 2)

The Undersecretary of Defense for Personnel and Readiness should enhance collaboration between DSPO and the Psychological Health Center of Excellence on the production of their annual suicide reports to minimize duplication of efforts. (Recommendation 3)

Agency Comments

We provided a draft of this product to DOD for review and comment. In its written comments, reproduced in appendix II, DOD concurred with each of our recommendations. However, DOD requested some modifications to our first recommendation on the assessment of individual non-clinical

suicide prevention efforts. Specifically, the department expressed concern with our use of the term “individual” when referring to these efforts to avoid confusion with individual servicemembers. To address this concern, we clarified the use and context of the term “individual” in the report. Secondly, DOD requested that we add the requirement that DOD-wide program evaluation criteria be used to assess the non-clinical suicide prevention efforts. While we understand the department’s interest in having a standardized approach to these assessments, our recommendation is broad enough to allow DOD flexibility on how to implement it. As a result, we did not make this change. For the remaining recommendations, DOD noted that DSPO would provide assistance to the military services in the development of consistent suicide-related definitions and that DSPO and the Psychological Health Center of Excellence are actively collaborating to identify ways to remove unnecessary duplication in their annual reports. DOD also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to appropriate congressional committees and the Secretary of Defense. In addition, the report will be available at no charge on GAO’s website at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or at draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs can be found on the last page of this report. Other major contributors to this report are listed in appendix III.



Debra A. Draper
Director, Health Care

Appendix I: Examples of Non-clinical Suicide Prevention Efforts in the Department of Defense

The Department of Defense (DOD) and the military services (Army, Navy, Air Force, and Marine Corps) provide a range of non-clinical suicide prevention efforts to reduce suicide risk and promote resiliency among the military population. Officials from the Defense Suicide Prevention Office (DSPO) provided us with a list of examples of suicide prevention efforts across the department. (See table 3.) DSPO officials noted that their list does not include the department's research collaborations or partnerships and prevention efforts that may be unique to military installations. It also does not include efforts that have broader missions but may also help reduce the risk of death by suicide, such as financial literacy programs and transition support.

Table 3: Defense Suicide Prevention Office's List of Non-clinical Suicide Prevention Efforts across the Department of Defense (DOD) and Military Services

DOD
Cognitive Behavior Strategies for the Prevention of Suicide Training Pilot ^a
Counseling on Access to Lethal Means Training Pilot ^a
Postvention Toolkit ^a
Rational Thinking – Emotional Regulation – Problem-Solving Training Pilot ^a
Recognizing the Signs of Intent to Die by Suicide on Social Media Training Pilot ^a
Resources Exist, Asking Can Help Training Pilot ^a
Safe Messaging and Reporting on Military Suicide ^a
Signs of Suicide for Secondary Students in DOD Schools
Yellow Ribbon Suicide Prevention Education Training ^a
Zero Suicide Pilot ^b
Army
Ask, Care, Escort - Suicide Intervention
Ask, Care, Escort
Behavioral Health Pulse
Behavioral Health Readiness and Suicide Risk Reduction Review Tool
Commanders Risk Reduction Tool
Deployment Cycle Resilience Training
Engage Training Program
Master Resilience Training (Soldier, Teen, Family, Executive)
Suicide Prevention Pilot
Navy
Deployed Resiliency Counselor
Families Over Coming Under Stress (FOCUS)
Navy's Safe Harbor

**Appendix I: Examples of Non-clinical Suicide
Prevention Efforts in the Department of
Defense**

Reserve Psychological Health Outreach Program

Suicide Alertness For Everyone: Tell, Ask, Listen, KeepSafe (SafeTALK)

Applied Suicide Intervention Skills Training (ASIST)

Sailor Assistance and Intercept for Life (SAIL)

Suicide Prevention Gatekeeper Training

Suicide Prevention General Military Training

Air Force

Air Force Resilience Training

Annual Bystander Intervention Training

Ask, Care, Escort

Equip and Empower Families Suicide Prevention Training

Limited Privilege Suicide Prevention Program

Resilience Tactical Pause

Suicide Prevention Program 11 Elements

Time-Based Prevention/Lethal Means Safety

True North

Wingman Connect

Marine Corps

Collaborative Assessment and Management of Suicidality Pilot Evaluation

Command Individual Risk and Resiliency Assessment System

Marine Awareness and Prevention Integrated Training

Marine Intercept Program

Operational Stress Control and Readiness Training

Unit Marine Awareness and Prevention Integrated Training

Special Operations Command

Special Operations Cognitive Agility Training Program

Special Operations Forces Suicide Prevention Workbook for Chaplains

National Guard Bureau

Applied Suicide Intervention Skills Training (ASIST)^c

Army National Guard Resilience Program

Ask, Care, Escort

Ask, Care, Escort - Suicide Intervention^c

Commanders Tool: URI QC for Suicide High Risk Threat Responses^c

National Guard Bureau and VA Readjustment Counseling Service Vet Center Initiative

Suicide Alertness For Everyone: Tell, Ask, Listen, KeepSafe (SafeTALK)^c

Sample National Guard State-Level Initiatives: Supportive Services Council, Embedded Clinicians, Behavioral Health Primary Prevention, and Retention

Start Training

**Appendix I: Examples of Non-clinical Suicide
Prevention Efforts in the Department of
Defense**

Suicide Prevention and Readiness Initiative for the National Guard
Warrior Resilience and Fitness Innovation Incubator Prevention Programs

Source: Defense Suicide Prevention Office. | GAO-21-300

^aDOD collaborated with all military services.

^bDOD collaborated with the Air Force.

^cApplicable only for the Army National Guard.

Appendix II: Comments from the Department of Defense



DEFENSE SUICIDE PREVENTION OFFICE
DEFENSE HUMAN RESOURCES ACTIVITY
4800 MARK CENTER DRIVE, SUITE 05J25-01
ALEXANDRIA, VA 22350-4000

March 19, 2021

Debra Draper
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Draper:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) Draft Report, GAO-21-300, “DEFENSE HEALTH CARE: DoD Needs to Fully Assess Its Non-Clinical Suicide Prevention Efforts and Address Any Impediments to Effectiveness,” dated March 5, 2021 (GAO Code 104169).

The Department concurs with the recommendations in this report and is currently taking steps to address them. The Department, however, proposes modifications to the recommendation concerning the development of a process to ensure individual non-clinical suicide prevention efforts are assessed for effectiveness in the military population. Our proposed edits included in the enclosed response will help standardize the approach for the Service-level assessments and ensure the approach is aligned with the Centers for Disease Control and Prevention’s best practices. The Department also requests that the enclosed technical comments prepared by various Departmental entities also be considered in preparing the final version of the report.

Katherine Roddy, Director of Policy, Plans, and Partnerships, Defense Suicide Prevention Office, is the point of contact for this action. She may be reached at katherine.j.roddy2.civ@mail.mil, or (703) 473-8145.

Sincerely,

Karin Orvis

Dr. Karin A. Orvis
Director

Enclosures:
As stated

**GAO DRAFT REPORT DATED MARCH 5, 2021
GAO-21-300 (GAO CODE 104169)**

**“DEFENSE HEALTH CARE: DOD NEEDS TO FULLY ASSESS ITS NON-CLINICAL
SUICIDE PREVENTION EFFORTS AND ADDRESS ANY IMPEDIMENTS TO
EFFECTIVENESS”**

**DEPARTMENT OF DEFENSE COMMENTS
TO THE GAO RECOMMENDATION**

RECOMMENDATION 1: The GAO recommends that the Undersecretary of Defense for Personnel and Readiness should require DSPO to 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.

DoD RESPONSE: Concur, but respectfully request modification to the recommendation language to read as follows: “The Undersecretary of Defense for Personnel and Readiness should require DSPO to collaborate with the Military Services to ensure all Service-level non-clinical suicide prevention efforts are assessed for effectiveness in the military population using the DoD-wide program evaluation criteria.” We recommend using “Service-level” rather than “individual,” as the latter could be misinterpreted as the effectiveness of a program for an individual Service member. The addition of language regarding the DoD-wide evaluation criteria will allow the Department to better standardize the approach for Service-level assessments and ensure the approach is aligned with the Centers for Disease Control and Prevention’s best practices.

RECOMMENDATION 2: The GAO recommends that the Undersecretary of Defense for Personnel and Readiness should require DSPO to collaborate with the military services to develop consistent suicide-related definitions to be used department-wide and require them to be used department-wide and require them to be used in the updated DOD and military service policies.

DoD RESPONSE: Concur. DSPO will also continue to provide assistance to the Military Services on their implementation.

RECOMMENDATION 3: The GAO recommends that the Undersecretary for Personnel and Readiness should enhance collaboration between DSPO and the Psychological Health Center of Excellence on the production of their annual suicide reports to minimize duplication of efforts.

DoD RESPONSE: Concur. DSPO and Psychological Health Center of Excellence are actively collaborating to identify ways to remove unnecessary duplication.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Debra A. Draper, (202) 512-7114 or draperd@gao.gov.

Staff Acknowledgments

In addition to the contact named above, Bonnie Anderson (Assistant Director), Luke Baron (Analyst-in-Charge), and Aaron Safer-Lichtenstein made key contributions to this report. Also contributing were Jacquelyn Hamilton, Aaron Holling, Ethiene Salgado-Rodriguez, and Caitlin Scoville.

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