



Testimony

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MILITARY SUICIDE

Preliminary Observations on Actions Needed to Enhance Prevention and Response Affecting Certain Remote Installations

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Capabilities and Management

GAO Highlights

Highlights of [GAO-22-105888](#), a testimony before the Subcommittee on Personnel, Committee on Armed Services, U.S. Senate

Why GAO Did This Study

Suicide deaths and attempts within the military community are devastating events for families. They can also harm unit morale and readiness. Remote OCONUS installations may pose challenges that increase suicide risk.

This statement examines, among other things, (1) the incidence of suicide and related risk factors among servicemembers at remote OCONUS installations during 2016-2020. It also discusses the extent to which DOD and the military services have, in relation to remote OCONUS installations (2) established and ensured implementation of policies, programs, and activities that address suicide prevention; (3) established privacy protections for servicemembers and dependents seeking suicide prevention care and integrated suicide prevention into primary care; and (4) established guidance and training for key personnel for responding to suicide deaths and attempts.

This preliminary analysis is included in GAO's draft report, which was provided to DOD in March for review and comment. For that report, GAO analyzed data, policies, and guidance; reviewed documentation from 57 installations; and interviewed DOD and military service officials.

What GAO Recommends

Based on preliminary analysis, GAO is making various recommendations, including that DOD establish a process to assess suicide risk at remote OCONUS installations, three services establish oversight of installations, and DOD develop a strategy for hiring key behavioral health personnel and improve guidance and training for commanders.

View [GAO-22-105888](#). For more information, contact Brenda S. Farrell at (202) 512-3604 or farrellb@gao.gov

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What GAO Found

The Department of Defense's (DOD) suicide prevention and response efforts have faced challenges, according to GAO's preliminary analysis. These include assessing suicide risk at remote installations outside the contiguous U.S. (OCONUS), implementing key prevention activities, integrating prevention in primary care, and providing response guidance and training for key personnel.

Suicide risk at remote OCONUS installations. GAO's preliminary analysis suggested that 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 these locations in 2016-2020. DOD and military service officials stated that suicide deaths at OCONUS installations may be lower because servicemembers assigned to installations outside the U.S. have limited access to non-military issued firearms. Separately, DOD-, service-, and installation-level officials GAO interviewed identified risk factors for suicide and related challenges at remote OCONUS installations, such as less access to mental health services and increased isolation. However, DOD has not fully assessed suicide risk at these installations. Establishing a process to do so could enhance related suicide prevention efforts.

Policies, programs, and activities. DOD and the military services have established suicide prevention policies, programs, and activities—such as training and mental health resources—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 some prevention activities, such as establishing required prevention teams at installations. By establishing oversight mechanisms, these services may have greater assurance that such activities are implemented across all installations, including remote OCONUS locations.

Privacy protection and suicide prevention in primary care. DOD and the military services have established privacy protections for servicemembers and dependents seeking suicide prevention care. DOD has also taken steps to integrate suicide prevention into primary care by establishing screening requirements and embedding behavioral health personnel in some primary care clinics. However, GAO's preliminary analysis found that DOD has experienced staffing shortages for these personnel, in part because it has not developed a strategy to address hiring challenges. By developing such a strategy, DOD can enhance the provision of behavioral health care to servicemembers and dependents, including at remote OCONUS installations.

Guidance and training for key personnel. 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, according to GAO's preliminary analysis, 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.

Chairwoman Gillibrand, Ranking Member Tillis, and Members of the Subcommittee:

Thank you for the opportunity to be here today to discuss issues related to suicide prevention in the military. 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 installations outside the contiguous United States (OCONUS) can experience unique factors and challenges that may increase their suicide risk, such as isolation and less access to mental health resources.

Our prior work found that the Department of Defense's (DOD) efforts to prevent and respond to suicide deaths and attempts have encountered challenges. In April 2021, we found, among other things, that DOD had not fully assessed the effectiveness of individual non-clinical suicide prevention efforts intended to reduce suicide risk and promote resiliency.¹ In addition, DOD did not require the use of standard definitions for suicide-related terms, potentially leading to inconsistent data reporting. As a result, we recommended that DOD develop a process to ensure that individual non-clinical suicide prevention efforts are assessed for effectiveness in the military population and that DOD develop consistent suicide definitions. DOD concurred with these recommendations. In December 2021, DOD officials told us that the Defense Suicide Prevention Office (DSPO) and the military services were collaborating to develop policy guidance for assessing the effectiveness of individual non-clinical suicide prevention efforts, and that they expected this coordination and publication process will be complete in 2022. Also, in December 2021, DOD issued a memorandum directing the immediate adoption of consistent definitions for suicide, suicide attempt, and suicidal ideation across DOD and the military services.

Separately, in April 2016, we found that actions were needed to enhance DOD's efforts to address the stigma of mental health care, and we made seven recommendations, including that DOD clarify and update policies contributing to stigma and designate an entity to coordinate stigma

¹GAO, *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).

reduction efforts.² DOD concurred with the recommendations and has taken actions to implement all of them, including by conducting a review of policies and recommending changes to language that may be stigmatizing, and by designating its Psychological Health and Readiness Council as the coordinating entity to collect and use information related to mental health care stigma.

My statement today provides preliminary analysis on 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.³ This statement is based on our draft report on suicide prevention at remote OCONUS installations, which we provided to DOD last month for review and comment. DOD provided technical comments on our draft report, which we incorporated in this statement as appropriate.

For the preliminary analysis included in our draft report, we obtained and analyzed DOD suicide data for active-duty servicemember suicide deaths and attempts during calendar years 2016 through 2020. We compared DOD suicide prevention policies against related statutory requirements

²GAO, *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).

³DOD does not have a general definition for what constitutes a remote installation. For our draft report, 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. 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 statement, we refer to only four military services within DOD.

and reviewed documentation related to the implementation of required suicide prevention activities for 57 remote OCONUS installations. We also assessed service-level oversight mechanisms for installation-level responsibilities against DOD and service requirements. We examined DOD policies governing privacy protection and integration of mental health care into primary care. We also evaluated DOD and military service procedures, resources, and training to determine the extent to which privacy protection was addressed. In addition, we evaluated DOD's efforts to integrate behavioral health providers into its primary care clinics by examining data on authorized billets and staffing levels for behavioral health personnel in OCONUS primary care clinics.

We also reviewed DOD and service guidance and training to assess the extent to which they address commanders' and suicide prevention program managers' response to suicide deaths and attempts. To address all objectives, we interviewed DOD and military service officials regarding suicide prevention policies, activities, and oversight mechanisms, including for remote OCONUS installations. We also interviewed personnel from each of the four military service's remote OCONUS installation that had the highest number of reported suicide deaths during 2016 through 2020.

The work upon which this statement is based is being conducted 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

Several entities share responsibility for implementing and overseeing the department's suicide prevention efforts. Specifically, DSPO is responsible for leading, guiding, and overseeing the department's suicide prevention program. 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 for evaluating DOD clinical suicide prevention programs.⁴ At the military

⁴Within DHA, the Office of the Armed Forces Medical Examiner and Psychological Health Center of Excellence track suicide-related data. Also, 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.

service level, 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.

In addition, 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. The structure also includes the Suicide Prevention and Risk Reduction Committee, which is a complementary action officer-level committee.

DOD's suicide prevention efforts include clinical and non-clinical efforts intended to reduce the risk of suicide. Clinical efforts include depression- and suicide-specific screening in primary care and during annual periodic health assessments.⁵ 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.

These suicide prevention efforts are guided by the Defense Strategy for Suicide Prevention, published by DOD in December 2015.⁶ DOD's strategy retains the directions, goals, and objectives identified in the 2012 National Strategy for Suicide Prevention, while adapting the terminology

⁵DOD 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)*.

⁶Department of Defense, *Department of Defense Strategy for Suicide Prevention* (December 2015). 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.

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

used in the goals and underlying objectives to be suitable for DOD.⁷ In September 2020, DOD established an integrated violence prevention policy that requires the department's suicide prevention policies and efforts to incorporate strategies for suicide prevention developed by the Centers for Disease Control and Prevention in 2017.⁸

DOD and the military services have collected statutorily required suicide data for servicemembers and dependents, including those assigned to remote OCONUS installations. Our preliminary 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 2020.⁹ Separately, DOD has taken steps to assess suicide risk broadly, but has not fully assessed risk factors for suicide and related challenges at remote OCONUS installations.

⁷Department 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). 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. The strategy identifies 13 goals and 60 underlying objectives across its four strategic directions.

⁸DOD Instruction 6400.09, *DOD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm* (Sept. 11, 2020). Centers for Disease Control and Prevention, *Preventing Suicide: A Technical Package of Policies, Programs, and Practices* (Atlanta, Ga.: 2017). The Centers for Disease Control and Prevention 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) identify and support people at risk, and (7) lessen harms and prevent future risk. According to DSPO officials, the department's suicide prevention strategy also aligns with these seven strategies.

⁹We 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.

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.¹⁰ According to our analysis of DOD data, during 2016 through 2020, DOD recorded 1,806 suicide deaths and 7,178 reported suicide attempts among all active-duty servicemembers.¹¹ Within these, DOD recorded 98 suicide deaths and 609 reported suicide attempts among active-duty servicemembers assigned to remote OCONUS installations in 2016 through 2020.

Since 2017, DSPO has also collected required data for military dependent suicide deaths, reporting suicide counts of 182 in 2017, 191 in 2018, and 202 in 2019.¹² 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 2019.¹³

¹⁰The Armed Forces Medical Examiner records manner of death determinations for active-duty servicemembers' deaths, including suicides. 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 DOD Suicide Event Reporting system.

¹¹DOD 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. See DOD Instruction 6490.16. 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.

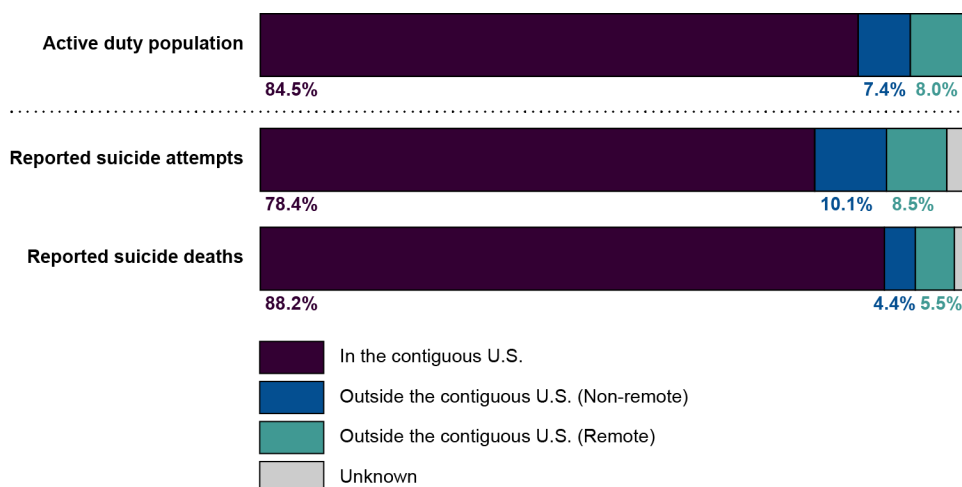
¹²For the purpose of DOD's reporting, dependents include spouses and dependent children—including biological, step-, foster, ward, pre-adoptive, and domestic partner children—who are eligible to receive military benefits under Title 10, U.S. Code, and are registered in the Defense Enrollment Eligibility Reporting System. Department of Defense (DOD), *Annual Suicide Report Calendar Year 2020* (Sept. 3, 2021).

¹³These rates reflect spouses and dependents of servicemembers across the department, including active component, Guard, and Reserve members.

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

Our preliminary 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. 1).

Figure 1: 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-22-105888

Note: 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 that 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 statement. 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 stated that the extent of suicide deaths at OCONUS installations—including remote OCONUS installations—is likely lower than at installations inside the contiguous U.S. (CONUS) 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 slightly over a quarter or fewer of the reported suicide deaths among active-duty servicemembers assigned to remote or non-remote OCONUS installations.¹⁴ However, we also 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-military issued firearms were involved in 10 percent or less of the reported suicide deaths involving servicemembers

¹⁴This analysis does not include 135 active-duty servicemember suicide deaths that were reported to the Armed Forces Medical Examiner, but not recorded in the DOD Suicide Event Reporting 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.

at remote and non-remote OCONUS installations other than in Alaska or Hawaii.¹⁵

These preliminary findings appear consistent with DOD and military service officials' hypotheses regarding the extent of suicide at remote OCONUS installations. 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 has undertaken efforts to promote safe storage of lethal means among all servicemembers.

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 our preliminary analysis. 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. However, DOD has not fully 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.
- Navy and Marine Corps suicide prevention officials stated that risk factors including lack of access to behavioral health care, barriers to 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

¹⁵Army 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 waiting period.

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 travelling 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 limitations in the installations' abilities to provide mental health care services as a challenge. 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 in 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.

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.¹⁶ DOD guidance also requires DSPO to analyze and assess data and research to identify risk factors and inform suicide prevention policies and programs.¹⁷ 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 statement, and

¹⁶White House Publication, *Reducing Military and Veteran Suicide: Advancing a Comprehensive, Cross-Sector, Evidence-Informed Public Health Strategy*, (Washington, DC: Nov. 2, 2021).

¹⁷DOD Instruction 6490.16, *Defense Suicide Prevention Program* (Nov. 6, 2017) (Incorporating change 2, Sept. 11, 2020).

taken appropriate actions. Based on our preliminary analysis, we are recommending that DOD establish such a process and take appropriate actions to address risk factors and challenges. By doing so, 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. 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.¹⁸ 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. These efforts include:

- A DOD suicide prevention instruction and strategy that generally address 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.¹⁹

¹⁸DOD 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.

¹⁹Pub. 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). 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.

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- Military service policies outlining suicide prevention program requirements intended to reduce suicides among servicemembers and their dependents.²⁰
 - DOD coordination 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.
 - Activities such as suicide prevention training and access to mental health resources.
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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 required director of psychological health—responsible for coordinating installation psychological health resources—at all remote OCONUS installations. However, the Department of the Navy has not done so for all Navy and Marine Corps installations.²¹ These professionals 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.

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. However, the Department of the Navy officials identified these required personnel for seven of 19 Navy remote OCONUS installations and none of the five remote OCONUS Marine Corps installations included in our document review. Department of the Navy officials acknowledged the inconsistent designation of installation directors of psychological health across the 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

²⁰Army 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.

²¹DOD requires each military installation to have a designated installation director of psychological health who serves as the installation’s principal consultant and advocate for psychological health. DOD Instruction 6490.09, *DOD Directors of Psychological Health* (Feb. 27, 2012) (incorporating change 2, Apr. 25, 2017).

known problem, and that they believed that where directors have been assigned, the designations were nominal and were not carried out in a manner consistent with DOD policy.

In July 2021, the Navy initiated a project to ensure compliance with the requirement for designation of installation directors of psychological health. If completed, 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. Based on our preliminary analysis, we are recommending that the Department of the Navy establish a policy that requires the designation of installation directors of psychological health at Navy and Marine Corps installations and provides implementing guidance for these personnel. By taking this action, the Department of the Navy will be better positioned to ensure this requirement is implemented consistently across Navy and Marine Corps installations.

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.²² However, there are gaps in the implementation of requirements for some Army, Navy, and Marine Corps remote OCONUS installations. For example, all Air Force installations from which we requested documentation had established required

²²For example, 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.

prevention teams, but the Army, Navy, and Marine Corps installations that we contacted had not all fully done so.²³

Each military service has taken steps, such as command- or installation-level inspections and self-assessments, to help ensure the implementation of required suicide prevention program activities. 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 do not provide these services adequate oversight to ensure the implementation of all required suicide prevention activities. For example, according to an Army official, a key mechanism for the Army's oversight of suicide prevention activities at installations is not required by Army policy and does not cover all required activities. Similarly, Navy and Marine Corps policies have not established mechanisms for service-level oversight of responsibilities carried out by higher-level commands to ensure that required suicide prevention activities are implemented across subordinate commands.

Standards for Internal Control in the Federal Government states that management should design control activities to achieve objectives and respond to risks, and to remediate identified deficiencies in the internal control system.²⁴ Based on our preliminary analysis, we are recommending that the Army, Navy, and Marine Corps establish oversight mechanisms to help ensure that all command- and installation-level suicide prevention program activities are implemented as required. Without doing so, the Army, Navy, and Marine Corps cannot have

²³Each military service requires a command- or installation-level prevention team. Army and Air Force officials stated that their services' installations implement suicide prevention requirements—such as prevention teams—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. We examined implementation of the Air Force's installation-level Community Action Board and Community Action Team; the Army's installation-level Suicide Prevention Task Force and Suicide Response Team; the Navy's command-level Command Resilience Team; and the Marine Corps' command-level Operational Stress Control and Readiness team, which is required to consist of at least 5 percent of the unit's personnel or a minimum of 20 members, whichever is greater. See Air Force Instruction 90-5001; Army Regulation 600-63; Navy, *Cultural Champion Network Quick Reference Guide* (December 2020); and Marine Corps Order 5351.1, *Combat and Operational Stress Control Program* (Feb. 22, 2013).

²⁴GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: September 2014).

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, in our preliminary analysis, we found that DHA has experienced challenges in fully staffing these positions.

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).²⁵ In addition, 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

²⁵Privacy 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.

notification standards are met.²⁶ 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.²⁷

Procedures and resources. The military departments, DOD, and the DHA have established procedures and resources that are intended to support the privacy of servicemembers and dependents. These procedures and resources are intended to help ensure that disclosures of protected health information—including those for servicemembers receiving mental health treatment—are conducted in a manner that is both secure and limited, in accordance with policy. For example:

- Army guidance states that unit command officials must be designated in writing by their commander in order to receive protected health information from health care providers.²⁸ These designations must also include the type of protected health information the command officials are eligible to receive.
- 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

²⁶These standards apply when the provider believes there is serious risk of (1) harm to self, (2) harm to others, or (3) harm to mission; when the servicemember (4) is considered special personnel, (5) is admitted or discharged from inpatient mental health treatment facilities, (6) experiences an acute mental health condition or is undergoing treatment that impairs ability to perform duties, (7) enters into or is discharged from a formal treatment program for substance abuse or dependence, or (8) receives a command-directed mental health evaluation; or (9) in special circumstances under which execution of the military mission outweighs privacy interests. 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.

²⁷According to DOD, information disclosed shall generally consist of the diagnosis, a description of the treatment prescribed or planned, impact 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. 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. DOD Instruction 6490.08.

²⁸Army Directive 2020-13, *Disclosure of Protected Health Information to Unit Command Officials* (Oct. 26, 2020).

seeking mental health treatment observe the requirements of DOD's policy.²⁹

- 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.³⁰ 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.³¹
- 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.³² 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.³³ Each of the military services has implemented supplemental efforts to educate commanders regarding their responsibilities in safeguarding protected health information.

²⁹Navy Suicide Prevention Program, *Project 1 Small ACT Suicide Prevention Handbook*.

³⁰Air Force Instruction 41-200, *Health Insurance Portability and Accountability Act (HIPAA)* (July 25, 2017).

³¹Air Force Instruction 44-172, *Mental Health* (Nov. 13, 2015).

³²Army 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.

³³DHA Administrative Instruction 74, *Workforce Training Pursuant to the Requirements of the Privacy Act and the Health Insurance Portability and Accountability Act* (Dec. 2, 2014).

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. For example, DOD requires that primary care managers annually screen adult patients for major depressive disorders and post-traumatic stress disorder using DHA-approved instruments.³⁴ In addition, DOD has embedded behavioral health personnel into primary care clinics. However, DHA has experienced staffing shortages for these personnel.

Specifically, as of October 2021, clinics at remote OCONUS installations had not filled 17 of 42 (40 percent) authorized positions for behavioral health consultants and behavioral health care facilitators.³⁵ Similarly, across all OCONUS installations, clinics had not filled 37 of 84 (44 percent) authorized positions. 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 onboarding processes.

³⁴Primary 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), 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), and 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).

³⁵Specifically, 11 of 33 authorized billets for Behavioral Health Consultants and six of nine authorized billets for Behavioral Health Care Facilitators at remote OCONUS installations were unfilled. These personnel work in primary care clinics as part of DHA's Primary Care Behavioral Health Program, and DOD's enrollment thresholds determine which primary care clinics are required to staff such 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. DHA can also authorize billets upon request of the clinic or when certain circumstances apply. The billets identified in the DHA data include both those required per the enrollment thresholds and those authorized by DHA. 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).

DHA Procedural Instruction 6025.27 requires DHA to provide oversight and management of primary care behavioral health program training, implementation, sustainment, and evaluation. Additionally, our key practices for strategic human capital management state that effective organizations develop strategies to address human capital gaps and to achieve programmatic goals and results.³⁶ However, a DHA official stated that the agency has not developed a strategy to address its staffing challenges. According to a DHA official, as of October 2021, DHA was discussing the development of a strategy to address behavioral health personnel shortages in primary care, but had not yet taken any steps. Based on our preliminary analysis, we are recommending that DHA develop a strategy to address shortages of primary care behavioral health personnel—including at remote OCONUS installations. By doing so, DHA could help ensure the services' ability to provide comprehensive and effective behavioral health care to servicemembers and dependents through primary care resources.

Gaps Exist in Suicide Response Guidance and Training for Key Personnel

DOD and the military services have established guidance that 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. However, in our preliminary analysis, we found that gaps exist in the provision and oversight of required training for these personnel.

Gaps Exist in Suicide Response Guidance and Training for Commanders

DOD and the military services have established statutorily required guidance that fully addresses commanders' response to suicide deaths, but not for suicide attempts. In addition, DOD has not established statutorily required training for commanders for responding to suicide deaths or attempts. The National Defense Authorization Act for Fiscal Year 2013 required DOD to develop a suicide prevention policy including standards for responding to attempted or completed suicides among members, including both guidance and training for commanders.³⁷

³⁶GAO, *A Model of Strategic Human Capital Management* [GAO-02-373SP](#) (Washington, D.C.: Mar. 15, 2002).

³⁷Pub. L. No. 112-239, § 582.

Guidance. 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.³⁸ However, the guidance states that it is not intended to address response to suicide attempts. Additionally, other DOD policy and guidance only addresses the response to suicide attempts generally and does not provide specific guidance for commanders.

Each military service has established a suicide prevention policy and supplemental guidance for commanders that addresses their response to suicide deaths and attempts, and officials from each service stated that they view the service-level guidance as complementary to DOD's guidance. 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 related to the reintegration of servicemembers into the unit following a suicide attempt, but Army guidance does not. An Army official stated that the Army does not have sufficient guidance from DOD to develop Army policy on reintegrating personnel into their units following a suicide attempt, and similarly, officials from each service stated they had not received guidance from DOD on this topic.

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.

Training. According to DSPO officials, the office has not established training for commanders on the response to suicide deaths or attempts. In addition, according to information from military service suicide prevention program officials, the military services have also not established training for commanders focused on the response to suicide deaths or 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 suicide deaths and will then develop a new course if the review indicates

³⁸Department of Defense, *Postvention Toolkit for a Military Suicide Loss* (2020).

it is needed. However, a DSPO official stated that the office generally considers this type of training to be within the purview of the military services.

Based on this preliminary analysis, we are making two recommendations to address the issues noted above. First, we are recommending that DOD establish guidance for commanders' response to suicide attempts—such as reintegration into the unit. By doing so, DOD can better ensure that commanders across the military services are equipped to support servicemembers returning to duty following a suicide attempt. Second, we are recommending that DOD establish training for commanders that addresses the response to suicide deaths and attempts. By establishing this training, 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.

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 statement as suicide prevention program managers.³⁹ Each military service has established or planned guidance to address responsibilities of these personnel for responding to suicide deaths and attempts. Specifically, the Navy, Air Force, and Marine Corps have established, and the Army plans to establish, guidance requiring suicide prevention program managers to assist commanders regarding all aspects of suicide prevention, including following a suicide death or attempt.

However, not all of the 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. 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.** Army officials stated that required training for suicide prevention program managers has not been available to those personnel since at least 2020 due to technical issues. According to

³⁹DOD 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 reporting requirements are met.

the officials, supplemental training has been in place during that time, but it does not meet the Army's training requirement for suicide prevention program managers. An Army official stated that new training is planned following the release of the Army's forthcoming suicide prevention policy.

- **Air Force.** According to an Air Force official, the Air Force plans to develop new suicide prevention program manager training that aligns with findings of DOD's Independent Review Commission on Sexual Assault in the Military.⁴⁰ However, the official was unable to provide an estimated time frame for its completion. The official stated that, in the interim, suicide prevention program managers will receive DOD primary prevention training, which will partially meet the service's training requirement for these personnel.

In addition, gaps exist in the oversight of training completion across all of the military services. Specifically, the Army and the Air Force have not developed a process or guidance for overseeing training completion at the service level once planned training is established, and Navy and Marine Corps processes for monitoring training completion do not provide those services with timely visibility of suicide prevention program managers who have not completed the required training. For example, officials from the Navy and the Marine Corps stated, among other things, that each service records the names of suicide prevention program managers who have completed the training, but 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.

Based on our preliminary analysis, we are making recommendations focused on the provision of required training and the oversight of completion of the required training. 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

⁴⁰Independent 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 makes recommendations related to, among other things, the establishment of a primary prevention workforce.

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 responsibilities for responding to suicide deaths and attempts, which is especially important in the absence of related training for commanders.

Chairwoman Gillibrand, Ranking Member Tillis, and Members of the Subcommittee, this completes my prepared statement. I would be pleased to respond to any questions you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact Brenda S. Farrell, Director, Defense Capabilities and Management, 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 statement. GAO staff who made key contributions to this testimony are Ryan D'Amore (Assistant Director), Serena Epstein (Analyst in Charge), Vincent Buquicchio, Christopher Gezon, Jesse Jordan, Grant Mallie, Richard Powelson, Paul Seely, Michael Silver, and Sirin Yaemsiri.

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